

1.1 moves to amend H.F. No. 4706 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 DEPARTMENT OF HEALTH FINANCE

1.5 Section 1. 62J.811 PROVIDER BALANCE BILLING REQUIREMENTS.

1.6 Subdivision 1. Requirements. (a) Each health provider and health facility shall comply
1.7 with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the
1.8 "No Surprises Act," including any federal regulations adopted under that act, to the extent
1.9 that it imposes requirements that apply in this state but are not required under the laws of
1.10 this state. This section does not require compliance with any provision of the No Surprises
1.11 Act before January 1, 2022.

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

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

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

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

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

2.6 (e) The commissioner shall inform the health care provider or facility of the complaint
2.7 or findings of a compliance review and shall provide an opportunity for the health care
2.8 provider or facility to submit information the health care provider or facility considers
2.9 relevant to further review and investigation of the complaint or the findings of the compliance
2.10 review. The health care provider or facility must submit any such information to the
2.11 commissioner within 30 days of receipt of notification of a complaint or compliance review
2.12 under this section.

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

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

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

2.24 (2) if, after taking the action in clause (1) compliance has not been achieved, the
2.25 commissioner of health shall notify the provider or facility that the provider or facility is in
2.26 violation of this section and that the commissioner is imposing a civil monetary penalty. If
2.27 the commissioner determines that more than one health care provider or facility was
2.28 responsible for a violation, the commissioner may impose a civil money penalty against
2.29 each health care provider or facility. The amount of a civil money penalty shall be up to
2.30 \$100 for each violation, but shall not exceed \$25,000 for identical violations during a
2.31 calendar year; and

2.32 (3) no civil money penalty shall be imposed under this section for violations that occur
2.33 prior to January 1, 2023. Warnings must be issued and any compliance issues must be

3.1 referred to the federal government for enforcement pursuant to the federal No Surprises Act
3.2 or other applicable federal laws and regulations.

3.3 (h) A health care provider or facility may contest whether the finding of facts constitute
3.4 a violation of this section according to the contested case proceeding in sections 14.57 to
3.5 14.62, subject to appeal according to sections 14.63 to 14.68.

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

3.9 (j) Any data collected by the commissioner of health as part of an active investigation
3.10 or active compliance review under this section are classified as protected nonpublic data
3.11 pursuant to section 13.02, subdivision 13, in the case of data not on individuals and
3.12 confidential pursuant to section 13.02, subdivision 3, in the case of data on individuals.
3.13 Data describing the final disposition of an investigation or compliance review are classified
3.14 as public.

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

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

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

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

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

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

3.31 **Subd. 5. Coverage restrictions or limitations.** If emergency services are provided by
3.32 a nonparticipating provider, with or without prior authorization, the health plan company

4.1 shall not impose coverage restrictions or limitations that are more restrictive than apply to
 4.2 emergency services received from a participating provider. Cost-sharing requirements that
 4.3 apply to emergency services received out-of-network must be the same as the cost-sharing
 4.4 requirements that apply to services received in-network and shall count toward the in-network
 4.5 deductible. All coverage and charges for emergency services must comply with all
 4.6 requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including
 4.7 any federal regulations adopted under that act.

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

4.9 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**
 4.10 **PROTECTIONS AGAINST BALANCE BILLING.**

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

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

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

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

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

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

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

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

4.31 ~~(e)~~ (b) The services described in paragraph (a), ~~clause~~ clauses (1) and (2), as defined in
 4.32 Division BB, Title I of the Consolidated Appropriations Act, 2021, and any federal

5.1 ~~regulations adopted under that act, are not unauthorized provider services~~ subject to balance
 5.2 billing if the enrollee gives advance written informed consent to the ~~prior to receiving~~
 5.3 services from the nonparticipating provider acknowledging that the use of a provider, or
 5.4 the services to be rendered, may result in costs not covered by the health plan. The informed
 5.5 consent must comply with all requirements of Division BB, Title I of the Consolidated
 5.6 Appropriations Act, 2021, including any federal regulations adopted under that act.

5.7 Subd. 2. **Prohibition Cost-sharing requirements and independent dispute**
 5.8 **resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating
 5.9 provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing
 5.10 requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and
 5.11 coverage limitations, as those applicable to services received by the enrollee from a
 5.12 participating provider. A health plan company must apply any enrollee cost sharing
 5.13 requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider
 5.14 services to the enrollee's annual out-of-pocket limit to the same extent payments to a
 5.15 participating provider would be applied.

5.16 (b) A health plan company ~~must attempt to negotiate the reimbursement, less any~~
 5.17 ~~applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services~~
 5.18 ~~with the nonparticipating provider. If a health plan company's and nonparticipating provider's~~
 5.19 ~~attempts to negotiate reimbursement for the health care services do not result in a resolution,~~
 5.20 ~~the health plan company or provider may elect to refer the matter for binding arbitration,~~
 5.21 ~~chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by~~
 5.22 ~~both parties prior to engaging an arbitrator in accordance with this section. The cost of~~
 5.23 ~~arbitration must be shared equally between the parties~~ and nonparticipating provider shall
 5.24 initiate open negotiations of disputed amounts. If there is no agreement, either party may
 5.25 initiate the federal independent dispute resolution process pursuant to Division BB, Title I
 5.26 of the Consolidated Appropriations Act, 2021, including any federal regulations adopted
 5.27 under that act.

5.28 (c) ~~The commissioner of health, in consultation with the commissioner of the Bureau~~
 5.29 ~~of Mediation Services, must develop a list of professionals qualified in arbitration, for the~~
 5.30 ~~purpose of resolving disputes between a health plan company and nonparticipating provider~~
 5.31 ~~arising from the payment for unauthorized provider services. The commissioner of health~~
 5.32 ~~shall publish the list on the Department of Health website, and update the list as appropriate.~~

5.33 (d) ~~The arbitrator must consider relevant information, including the health plan company's~~
 5.34 ~~payments to other nonparticipating providers for the same services, the circumstances and~~
 5.35 ~~complexity of the particular case, and the usual and customary rate for the service based on~~

6.1 ~~information available in a database in a national, independent, not-for-profit corporation,~~
 6.2 ~~and similar fees received by the provider for the same services from other health plans in~~
 6.3 ~~which the provider is nonparticipating, in reaching a decision.~~

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

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

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

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

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

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

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

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

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

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

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

6.32 (i) an acute condition;

- 7.1 (ii) a life-threatening mental or physical illness;
- 7.2 (iii) pregnancy ~~beyond the first trimester of pregnancy~~;
- 7.3 (iv) a physical or mental disability defined as an inability to engage in one or more major
- 7.4 life activities, provided that the disability has lasted or can be expected to last for at least
- 7.5 one year, or can be expected to result in death; or
- 7.6 (v) a disabling or chronic condition that is in an acute phase; or
- 7.7 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected
- 7.8 lifetime of 180 days or less.

7.9 For all requests for authorization under this paragraph, the health plan company must grant

7.10 the request for authorization unless the enrollee does not meet the criteria provided in this

7.11 paragraph.

7.12 (b) The health plan company shall prepare a written plan that provides a process for

7.13 coverage determinations regarding continuity of care of up to 120 days for new enrollees

7.14 who request continuity of care with their former provider, if the new enrollee:

7.15 (1) is receiving culturally appropriate services and the health plan company does not

7.16 have a provider in its preferred provider network with special expertise in the delivery of

7.17 those culturally appropriate services within the time and distance requirements of section

7.18 62D.124, subdivision 1; or

7.19 (2) does not speak English and the health plan company does not have a provider in its

7.20 preferred provider network who can communicate with the enrollee, either directly or through

7.21 an interpreter, within the time and distance requirements of section 62D.124, subdivision

7.22 1.

7.23 The written plan must explain the criteria that will be used to determine whether a need for

7.24 continuity of care exists and how it will be provided.

7.25 (c) This subdivision applies only to group coverage and continuation and conversion

7.26 coverage, and applies only to changes in health plans made by the employer.

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

7.28 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse

7.29 determination that does not require a medical necessity determination, the external review

7.30 must be based on whether the adverse determination was in compliance with the enrollee's

7.31 health benefit plan and any applicable state and federal law.

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

8.5 (c) For an external review of any issue in an adverse determination by a health plan
8.6 company, other than a health plan company licensed under chapter 62D, that requires a
8.7 medical necessity determination, the external review must determine whether the adverse
8.8 determination was consistent with the definition of medically necessary care in section
8.9 62Q.53, subdivision 2.

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

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

8.19 Subd. 5b. **Non-claims-based payments.** (a) Beginning in 2024, all health plan companies
8.20 and third-party administrators shall submit to a private entity designated by the commissioner
8.21 of health all non-claims-based payments made to health care providers. The data shall be
8.22 submitted in a form, manner, and frequency specified by the commissioner. Non-claims-based
8.23 payments are payments to health care providers designed to pay for value of health care
8.24 services over volume of health care services and include alternative payment models or
8.25 incentives, payments for infrastructure expenditures or investments, and payments for
8.26 workforce expenditures or investments. Non-claims-based payments submitted under this
8.27 subdivision must, to the extent possible, be attributed to a health care provider in the same
8.28 manner in which claims-based data are attributed to a health care provider and, where
8.29 appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses
8.30 of health care spending.

8.31 (b) Data collected under this subdivision are nonpublic data as defined in section 13.02.
8.32 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary
8.33 data prepared under this subdivision may be derived from nonpublic data. The commissioner

9.1 shall establish procedures and safeguards to protect the integrity and confidentiality of any
9.2 data maintained by the commissioner.

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

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

9.7 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
9.8 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
9.9 designee shall only use the data submitted under subdivisions 4 ~~and~~ 5, and 5b for the
9.10 following purposes:

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

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

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

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

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

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

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

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

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

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

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

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

10.7 ~~(d) The commissioner or the commissioner's designee may use the data submitted under~~
 10.8 ~~subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,~~
 10.9 ~~2023.~~

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

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

10.14 Subd. 7. **Outcomes reporting; savings determination.** (a) ~~Beginning November 1,~~
 10.15 ~~2016, and~~ Each November 1 ~~thereafter~~, the commissioner of health shall determine the
 10.16 actual total private and public health care and long-term care spending for Minnesota
 10.17 residents related to each health indicator projected in subdivision 6 for the most recent
 10.18 calendar year available. The commissioner shall determine the difference between the
 10.19 projected and actual spending for each health indicator and for each year, and determine
 10.20 the savings attributable to changes in these health indicators. The assumptions and research
 10.21 methods used to calculate actual spending must be determined to be appropriate by an
 10.22 independent actuarial consultant. If the actual spending is less than the projected spending,
 10.23 the commissioner, in consultation with the commissioners of human services and management
 10.24 and budget, shall use the proportion of spending for state-administered health care programs
 10.25 to total private and public health care spending for each health indicator for the calendar
 10.26 year two years before the current calendar year to determine the percentage of the calculated
 10.27 aggregate savings amount accruing to state-administered health care programs.

10.28 (b) The commissioner may use the data submitted under section 62U.04, subdivisions
 10.29 ~~4 and~~ 5, and 5b, to complete the activities required under this section, but may only report
 10.30 publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

11.1 Sec. 10. [115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND
11.2 WASTEWATER TREATMENT FACILITIES.

11.3 Subdivision 1. Purpose; membership. The advisory council on water supply systems
11.4 and wastewater treatment facilities shall advise the commissioners of health and the Pollution
11.5 Control Agency regarding classification of water supply systems and wastewater treatment
11.6 facilities, qualifications and competency evaluation of water supply system operators and
11.7 wastewater treatment facility operators, and additional laws, rules, and procedures that may
11.8 be desirable for regulating the operation of water supply systems and of wastewater treatment
11.9 facilities. The advisory council is composed of 11 voting members, of whom:

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

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

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

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

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

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

11.27 Subd. 2. Geographic representation. At least one of the water supply system operators
11.28 and at least one of the wastewater treatment facility operators must be from outside the
11.29 seven-county metropolitan area, and one wastewater treatment facility operator must be
11.30 from the Metropolitan Council.

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

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

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

12.5 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

12.6 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
12.7 filing with the commissioner as prescribed by statute and for the issuance of original and
12.8 renewal permits, licenses, registrations, and certifications issued under authority of the
12.9 commissioner. The expiration dates of the various licenses, permits, registrations, and
12.10 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
12.11 application and examination fees and a penalty fee for renewal applications submitted after
12.12 the expiration date of the previously issued permit, license, registration, and certification.
12.13 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
12.14 registrations, and certifications when the application therefor is submitted during the last
12.15 three months of the permit, license, registration, or certification period. Fees proposed to
12.16 be prescribed in the rules shall be first approved by the Department of Management and
12.17 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
12.18 in an amount so that the total fees collected by the commissioner will, where practical,
12.19 approximate the cost to the commissioner in administering the program. All fees collected
12.20 shall be deposited in the state treasury and credited to the state government special revenue
12.21 fund unless otherwise specifically appropriated by law for specific purposes.

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

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

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

13.1	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
13.2	Healthcare Organizations (JCAHO) and	
13.3	American Osteopathic Association (AOA)	
13.4	hospitals	
13.5	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
13.6	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
13.7		\$183 plus \$100 per bed between July 1, 2018,
13.8		and June 30, 2020. \$183 plus \$105 per bed
13.9		beginning July 1, 2020.

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

13.13	Outpatient surgical centers	\$3,712
13.14	Boarding care homes	\$183 plus \$91 per bed
13.15	Supervised living facilities	\$183 plus \$91 per bed.
13.16	Assisted living facilities with dementia care	\$3,000 plus \$100 per resident.
13.17	Assisted living facilities	\$2,000 plus \$75 per resident.

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

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

13.24	Prospective payment surveys for hospitals	\$	900
13.25	Swing bed surveys for nursing homes	\$	1,200
13.26	Psychiatric hospitals	\$	1,400
13.27	Rural health facilities	\$	1,100
13.28	Portable x-ray providers	\$	500
13.29	Home health agencies	\$	1,800
13.30	Outpatient therapy agencies	\$	800
13.31	End stage renal dialysis providers	\$	2,100
13.32	Independent therapists	\$	800
13.33	Comprehensive rehabilitation outpatient facilities	\$	1,200
13.34	Hospice providers	\$	1,700
13.35	Ambulatory surgical providers	\$	1,800

14.1	Hospitals	\$ 4,200
14.2	Other provider categories or additional	Actual surveyor costs: average surveyor cost x number of hours for the survey process.
14.3	resurveys required to complete initial	
14.4	certification	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.13 ~~(f)~~ (h) "Designated rural area" means a statutory and home rule charter city or township
 15.14 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision
 15.15 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

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

15.19 ~~(h)~~ (j) "Mental health professional" means an individual providing clinical services in
 15.20 the treatment of mental illness who is qualified in at least one of the ways specified in section
 15.21 245.462, subdivision 18.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16.31 (2) for ~~midlevel practitioners~~ advanced practice providers agreeing to practice in
16.32 designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing

17.1 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
17.2 level;

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

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

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

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

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

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

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

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

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

18.5 (1) be a medical or dental resident; a licensed pharmacist; or be enrolled in a training or
18.6 education program to become a dentist, dental therapist, advanced dental therapist, mental
18.7 health professional, alcohol and drug counselor, pharmacist, public health employee, public
18.8 health nurse, ~~midlevel practitioner~~ advanced practice provider, acupuncture practitioner,
18.9 registered nurse, or a licensed practical nurse. The commissioner may also consider
18.10 applications submitted by graduates in eligible professions who are licensed and in practice;
18.11 and

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

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

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

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

18.24 Subd. 4. **Loan forgiveness.** (a) The commissioner of health may select applicants each
18.25 year for participation in the loan forgiveness program, within the limits of available funding.
18.26 For public health employees, available funds are limited to the appropriations funded in
18.27 fiscal year 2022. In considering applications from applicants who are mental health
18.28 professionals, the commissioner shall give preference to applicants who work in rural or
18.29 culturally specific organizations. In considering applications from all other applicants, the
18.30 commissioner shall give preference to applicants who document diverse cultural
18.31 competencies. Except as provided in paragraph (b), the commissioner shall distribute
18.32 available funds for loan forgiveness proportionally among the eligible professions according
18.33 to the vacancy rate for each profession in the required geographic area, facility type, teaching

19.1 area, patient group, or specialty type specified in subdivision 2. The commissioner shall
19.2 allocate funds for physician loan forgiveness so that 75 percent of the funds available are
19.3 used for rural physician loan forgiveness and 25 percent of the funds available are used for
19.4 underserved urban communities, physicians agreeing to provide at least 25 percent of the
19.5 physician's yearly patient encounters to patients in an underserved patient population, and
19.6 pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified
19.7 applicants each year to use the entire allocation of funds for any eligible profession, the
19.8 remaining funds may be allocated proportionally among the other eligible professions
19.9 according to the vacancy rate for each profession in the required geographic area, patient
19.10 group, or facility type specified in subdivision 2. Applicants are responsible for securing
19.11 their own qualified educational loans. The commissioner shall select participants based on
19.12 their suitability for practice serving the required geographic area or facility type specified
19.13 in subdivision 2, as indicated by experience or training. The commissioner shall give
19.14 preference to applicants closest to completing their training. Except as specified in paragraph
19.15 (c), for each year that a participant meets the service obligation required under subdivision
19.16 3, up to a maximum of four years, the commissioner shall make annual disbursements
19.17 directly to the participant equivalent to 15 percent of the average educational debt for
19.18 indebted graduates in their profession in the year closest to the applicant's selection for
19.19 which information is available, not to exceed the balance of the participant's qualifying
19.20 educational loans. Before receiving loan repayment disbursements and as requested, the
19.21 participant must complete and return to the commissioner a confirmation of practice form
19.22 provided by the commissioner verifying that the participant is practicing as required under
19.23 subdivisions 2 and 3. The participant must provide the commissioner with verification that
19.24 the full amount of loan repayment disbursement received by the participant has been applied
19.25 toward the designated loans. After each disbursement, verification must be received by the
19.26 commissioner and approved before the next loan repayment disbursement is made.
19.27 Participants who move their practice remain eligible for loan repayment as long as they
19.28 practice as required under subdivision 2.

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

19.31 (c) For each year that a participant who is a nurse and who has agreed to teach according
19.32 to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner
19.33 shall make annual disbursements directly to the participant equivalent to 15 percent of the
19.34 average annual educational debt for indebted graduates in the nursing profession in the year

20.1 closest to the participant's selection for which information is available, not to exceed the
 20.2 balance of the participant's qualifying educational loans.

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

20.4 **144.1503 HOME AND COMMUNITY-BASED SERVICES EMPLOYEE**
 20.5 **SCHOLARSHIP AND LOAN FORGIVENESS PROGRAM.**

20.6 Subdivision 1. **Creation.** The home and community-based services employee scholarship
 20.7 and loan forgiveness grant program is established for the purpose of assisting to assist
 20.8 qualified provider applicants to fund in funding employee scholarships and qualified
 20.9 educational loan repayments for education, training, field experience, and examinations in
 20.10 nursing and, other health care fields, and licensure as an assisted living director under section
 20.11 144A.20, subdivision 4.

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

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

20.21 Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals
 20.22 who are 65 years of age and older in home and community-based settings, including housing
 20.23 with services establishments as defined in section 144D.01, subdivision 4; assisted living
 20.24 facilities as defined in section 144G.08, subdivision 7; adult day care as defined in section
 20.25 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision
 20.26 3.

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

20.32 Subd. 4. **Home and community-based services employee scholarship and loan**
 20.33 **forgiveness program.** Each qualifying provider under this section must propose a home

21.1 and community-based services employee scholarship and loan forgiveness program. Providers
21.2 must establish criteria by which funds are to be distributed among employees. At a minimum,
21.3 the scholarship and loan forgiveness program must cover employee costs and repay qualified
21.4 educational loans of employees related to a course of study that is expected to lead to career
21.5 advancement with the provider or in the field of long-term care, including home care, care
21.6 of persons with disabilities, ~~or nursing,~~ or management as a licensed assisted living director.

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

21.13 Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an
21.14 application to the commissioner. Applications must contain a complete description of the
21.15 employee scholarship and loan forgiveness program being proposed by the applicant,
21.16 including the need for the organization to enhance the education of its workforce, the process
21.17 for determining which employees will be eligible for scholarships or loan repayment, any
21.18 other sources of funding for scholarships or loan repayment, the expected degrees or
21.19 credentials eligible for scholarships or loan repayment, the amount of funding sought for
21.20 the scholarship and loan forgiveness program, a proposed budget detailing how funds will
21.21 be spent, and plans for retaining eligible employees after completion of their scholarship
21.22 or repayment of their loan.

21.23 Subd. 7. **Selection process.** The commissioner shall determine a maximum award for
21.24 grants and make grant selections based on the information provided in the grant application,
21.25 including the demonstrated need for an applicant provider to enhance the education of its
21.26 workforce, the proposed employee scholarship and loan forgiveness selection process, the
21.27 applicant's proposed budget, and other criteria as determined by the commissioner.
21.28 Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant
21.29 agreement do not lapse until the grant agreement expires.

21.30 Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for
21.31 reimbursement and a report to the commissioner on a schedule determined by the
21.32 commissioner and on a form supplied by the commissioner. The report shall include the
21.33 amount spent on scholarships and loan repayment; the number of employees who received
21.34 scholarships and the number of employees for whom loans were repaid; and, for each
21.35 scholarship or loan forgiveness recipient, the name of the recipient, the current position of

22.1 the recipient, the amount awarded or loan amount repaid, the educational institution attended,
22.2 the nature of the educational program, and the expected or actual program completion date.
22.3 During the grant period, the commissioner may require and collect from grant recipients
22.4 other information necessary to evaluate the program.

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

22.6 Subdivision 1. **Definition.** (a) For purposes of this section, the following definitions
22.7 apply.

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

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

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

22.14 (1) enrolled in the PSLF program;

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

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

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

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

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

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

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

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

22.30 (b) For each year that a participant meets the eligibility requirements described in
22.31 subdivision 2, the commissioner shall make an annual disbursement directly to the participant

23.1 in an amount equal to the minimum loan payments required to be paid by the participant
 23.2 under the participant's repayment plan under the PSLF program for the previous loan year.
 23.3 Before receiving the annual loan repayment disbursement, the participant must complete
 23.4 and return to the commissioner a confirmation of practice form provided by the
 23.5 commissioner, verifying that the participant continues to meet the eligibility requirements
 23.6 under subdivision 2.

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

23.10 Subd. 4. **Penalty for nonfulfillment.** If a participant does not fulfill the required
 23.11 minimum commitment of service as required under subdivision 2, or the secretary of
 23.12 education determines that the participant does not meet eligibility requirements for the PSLF
 23.13 program, the commissioner shall collect from the participant the total amount paid to the
 23.14 participant under the hospital nursing loan forgiveness program plus interest at a rate
 23.15 established according to section 270C.40. The commissioner shall deposit the money
 23.16 collected in the health care access fund to be credited to the health professional education
 23.17 loan forgiveness program account established in section 144.1501, subdivision 2. The
 23.18 commissioner shall allow waivers of all or part of the money owed to the commissioner as
 23.19 a result of a nonfulfillment penalty if emergency circumstances prevent fulfillment of the
 23.20 service commitment or if the PSLF program is discontinued before the participant's service
 23.21 commitment is fulfilled.

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

23.23 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**
 23.24 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**
 23.25 **PROGRAMS.**

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

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

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

24.4 ~~(2)~~ (3) "eligible dental therapy program" means a dental therapy education program or
 24.5 advanced dental therapy education program that is located in Minnesota and is either:

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

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

24.8 ~~(3)~~ (4) "eligible mental health professional program" means a program that is located
 24.9 in Minnesota and is listed as a mental health professional program by the appropriate
 24.10 accrediting body for clinical social work, psychology, marriage and family therapy, or
 24.11 licensed professional clinical counseling, or is a candidate for accreditation;

24.12 ~~(4)~~ (5) "eligible pharmacy program" means a program that is located in Minnesota and
 24.13 is currently accredited as a doctor of pharmacy program by the Accreditation Council on
 24.14 Pharmacy Education;

24.15 ~~(5)~~ (6) "eligible physician assistant program" means a program that is located in
 24.16 Minnesota and is currently accredited as a physician assistant program by the Accreditation
 24.17 Review Commission on Education for the Physician Assistant, or is a candidate for
 24.18 accreditation;

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

24.22 ~~(6)~~ (8) "mental health professional" means an individual providing clinical services in
 24.23 the treatment of mental illness who meets one of the qualifications under section 245.462,
 24.24 subdivision 18; and

24.25 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician
 24.26 assistants, advanced practice registered nurses, pharmacists, physicians, dentists, dental
 24.27 therapists, advanced dental therapists, or mental health professionals in Minnesota.

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

25.1 (b) Funds may be used for:

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

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

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

25.8 (4) travel and lodging for students;

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

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

25.11 (7) evaluations;

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

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

25.16 **Subd. 2a. Health professional rural and underserved clinical rotations grant**
25.17 **program.** (a) The commissioner of health shall award health professional training site grants
25.18 to eligible physician, physician assistant, advanced practice registered nurse, pharmacy,
25.19 dentistry, dental therapy, and mental health professional programs to augment existing
25.20 clinical training programs by adding rural and underserved rotations or clinical training
25.21 experiences, such as credential or certificate rural tracks or other specialized training. For
25.22 physician and dentist training, the expanded training must include rotations in primary care
25.23 settings such as community clinics, hospitals, health maintenance organizations, or practices
25.24 in rural communities.

25.25 (b) Funds may be used for:

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

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

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

25.30 (4) travel and lodging for students;

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

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

26.2 (7) evaluations;

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

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

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

26.19 Subd. 4. **Consideration of applications.** The commissioner shall review each application
26.20 to determine whether or not the application is complete and whether the program and the
26.21 project are eligible for a grant. In evaluating applications, the commissioner shall score each
26.22 application based on factors including, but not limited to, the applicant's clarity and
26.23 thoroughness in describing the project and the problems to be addressed, the extent to which
26.24 the applicant has demonstrated that the applicant has made adequate provisions to ensure
26.25 proper and efficient operation of the training program once the grant project is completed,
26.26 the extent to which the proposed project is consistent with the goal of increasing access to
26.27 primary care and mental health services for rural and underserved urban communities, the
26.28 extent to which the proposed project incorporates team-based primary care, and project
26.29 costs and use of funds.

26.30 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
26.31 to be given to an eligible program based on the relative score of each eligible program's
26.32 application and rural locations if applicable under subdivision 2b, other relevant factors
26.33 discussed during the review, and the funds available to the commissioner. Appropriations
26.34 made to the program do not cancel and are available until expended. During the grant period,

27.1 the commissioner may require and collect from programs receiving grants any information
 27.2 necessary to evaluate the program.

27.3 Sec. 19. [144.1507] PRIMARY CARE RURAL RESIDENCY TRAINING GRANT
 27.4 PROGRAM.

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

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

27.8 (1) is located in Minnesota;

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

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

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

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

27.19 Subd. 2. Rural residency training program. (a) The commissioner of health shall
 27.20 award rural residency training program grants to eligible programs to plan and implement
 27.21 rural residency training programs. A rural residency training program grant shall not exceed
 27.22 \$250,000 per resident per year for the first year of planning and development, and \$225,000
 27.23 for each of the following years.

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

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

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

27.28 (3) establishing new rural residency training programs;

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

27.30 (5) travel and lodging for new residents;

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

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

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

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

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

28.16 Subd. 4. **Consideration of grant applications.** The commissioner shall review each
 28.17 application to determine if the residency program application is complete, if the proposed
 28.18 rural residency program and residency slots are eligible for a grant, and if the program is
 28.19 eligible for federal graduate medical education funding, and when funding becomes available.
 28.20 The commissioner shall award grants to support training programs in family medicine,
 28.21 general internal medicine, general pediatrics, psychiatry, geriatrics, and general surgery.

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

28.25 Sec. 20. **[144.1508] MENTAL HEALTH PROVIDER SUPERVISION GRANT**
 28.26 **PROGRAM.**

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

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

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

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

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

29.8 (1) provide at least 50 percent of the provider's yearly patient encounters to state public
29.9 program enrollees or patients receiving sliding fee schedule discounts through a formal
29.10 sliding fee schedule meeting the standards established by the United States Department of
29.11 Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;
29.12 or

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

29.14 Subd. 4. **Application; grant award.** A mental health provider seeking a grant under
29.15 this section must apply to the commissioner at a time and in a manner specified by the
29.16 commissioner. The commissioner shall review each application to determine if the application
29.17 is complete, the mental health provider is eligible for a grant, and the proposed project is
29.18 an allowable use of grant funds. The commissioner shall give preference to grant applicants
29.19 who work in rural or culturally specific organizations. The commissioner must determine
29.20 the grant amount awarded to applicants that the commissioner determines will receive a
29.21 grant.

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

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

29.26 (2) to establish a program to provide supervision to multiple interns or clinical trainees;
29.27 or

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

29.30 Subd. 6. **Program oversight.** During the grant period, the commissioner may require
29.31 grant recipients to provide the commissioner with information necessary to evaluate the
29.32 program.

30.1 Sec. 21. [144.1509] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT
30.2 PROGRAM.

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

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

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

30.9 Subd. 2. Grant program established. A mental health professional scholarship program
30.10 is established to assist mental health providers in funding employee scholarships for master's
30.11 level education programs in order to create a pathway to becoming a mental health
30.12 professional.

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

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

30.20 (2) a mental health certified family peer specialist who meets the qualifications in section
30.21 245I.04, subdivision 12;

30.22 (3) a mental health certified peer specialist who meets the qualifications in section
30.23 245I.04, subdivision 10;

30.24 (4) a mental health practitioner who meets a qualification in section 245I.04, subdivision
30.25 4;

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

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

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

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

31.3 (1) primarily provide at least 50 percent of the provider's yearly patient encounters to
31.4 state public program enrollees or patients receiving sliding fee schedule discounts through
31.5 a formal sliding fee schedule meeting the standards established by the United States
31.6 Department of Health and Human Services under Code of Federal Regulations, title 42,
31.7 section 51c.303; or

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

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

31.15 Subd. 6. **Application requirements.** An eligible provider seeking a grant under this
31.16 section must submit an application to the commissioner. An application must contain a
31.17 complete description of the employee scholarship program being proposed by the applicant,
31.18 including the need for the mental health provider to enhance the education of its workforce,
31.19 the process the mental health provider will use to determine which employees will be eligible
31.20 for scholarships, any other funding sources for scholarships, the amount of funding sought
31.21 for the scholarship program, a proposed budget detailing how funds will be spent, and plans
31.22 to retain eligible employees after completion of the education program.

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

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

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

32.1 (1) to provide employees with tuition reimbursement for a master's level program in a
32.2 discipline that will allow the employee to qualify as a mental health professional; or
32.3 (2) for resources and supports, such as child care and transportation, that allow an
32.4 employee to attend a master's level program specified in clause (1).

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

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

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

32.15 (b) "Accredited clinical training" means the clinical training provided by a medical
32.16 education program that is accredited through an organization recognized by the Department
32.17 of Education, the Centers for Medicare and Medicaid Services, or another national body
32.18 that reviews the accrediting organizations for multiple disciplines and whose standards for
32.19 recognizing accrediting organizations are reviewed and approved by the commissioner of
32.20 health.

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

32.22 (d) "Clinical medical education program" means the accredited clinical training of
32.23 physicians, medical students and residents, doctor of pharmacy practitioners, doctors of
32.24 chiropractic, dentists, advanced practice nurses, clinical nurse specialists, certified registered
32.25 nurse anesthetists, nurse practitioners, and certified nurse midwives, physician assistants,
32.26 dental therapists and advanced dental therapists, psychologists, clinical social workers,
32.27 community paramedics, community health workers, and other medical professions as
32.28 determined by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34.19 Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign
 34.20 and submit a medical education grant verification report (GVR) to verify that the correct
 34.21 grant amount was forwarded to each eligible entity. If the teaching institution fails to submit
 34.22 the GVR by the stated deadline, or to request and meet the deadline for an extension, the
 34.23 sponsoring institution is required to return the full amount of funds received to the
 34.24 commissioner within 30 days of receiving notice from the commissioner. The commissioner
 34.25 shall distribute returned funds to the appropriate training sites in accordance with the
 34.26 commissioner's approval letter.

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

34.30 Sec. 23. **[144.2182] CHANGE OF SEX.**

34.31 Subdivision 1. **Request to make change.** A person whose birth is registered in Minnesota
 34.32 may request that the commissioner change or remove the sex, if any, assigned to that person

35.1 on the person's original birth certificate. If the person is a minor, a parent or guardian may
 35.2 make the request on behalf of the minor.

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

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

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

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

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

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

35.29 Sec. 24. Minnesota Statutes 2020, section 144.383, is amended to read:

35.30 **144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.**

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

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

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

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

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

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

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

36.20 Sec. 25. Minnesota Statutes 2020, section 144.554, is amended to read:

36.21 **144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND**
 36.22 **FEES.**

36.23 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
 36.24 living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities,
 36.25 the commissioner shall collect a fee for the review and approval of architectural, mechanical,
 36.26 and electrical plans and specifications submitted before construction begins for each project
 36.27 relative to construction of new buildings, additions to existing buildings, or remodeling or
 36.28 alterations of existing buildings. All fees collected in this section shall be deposited in the
 36.29 state treasury and credited to the state government special revenue fund. Fees must be paid
 36.30 at the time of submission of final plans for review and are not refundable. The fee is
 36.31 calculated as follows:

36.32 Construction project total estimated cost		Fee
36.33 \$0 - \$10,000		\$30 <u>\$45</u>

37.1	\$10,001 - \$50,000	\$150 <u>\$225</u>
37.2	\$50,001 - \$100,000	\$300 <u>\$450</u>
37.3	\$100,001 - \$150,000	\$450 <u>\$675</u>
37.4	\$150,001 - \$200,000	\$600 <u>\$900</u>
37.5	\$200,001 - \$250,000	\$750 <u>\$1,125</u>
37.6	\$250,001 - \$300,000	\$900 <u>\$1,350</u>
37.7	\$300,001 - \$350,000	\$1,050 <u>\$1,575</u>
37.8	\$350,001 - \$400,000	\$1,200 <u>\$1,800</u>
37.9	\$400,001 - \$450,000	\$1,350 <u>\$2,025</u>
37.10	\$450,001 - \$500,000	\$1,500 <u>\$2,250</u>
37.11	\$500,001 - \$550,000	\$1,650 <u>\$2,475</u>
37.12	\$550,001 - \$600,000	\$1,800 <u>\$2,700</u>
37.13	\$600,001 - \$650,000	\$1,950 <u>\$2,925</u>
37.14	\$650,001 - \$700,000	\$2,100 <u>\$3,150</u>
37.15	\$700,001 - \$750,000	\$2,250 <u>\$3,375</u>
37.16	\$750,001 - \$800,000	\$2,400 <u>\$3,600</u>
37.17	\$800,001 - \$850,000	\$2,550 <u>\$3,825</u>
37.18	\$850,001 - \$900,000	\$2,700 <u>\$4,050</u>
37.19	\$900,001 - \$950,000	\$2,850 <u>\$4,275</u>
37.20	\$950,001 - \$1,000,000	\$3,000 <u>\$4,500</u>
37.21	\$1,000,001 - \$1,050,000	\$3,150 <u>\$4,725</u>
37.22	\$1,050,001 - \$1,100,000	\$3,300 <u>\$4,950</u>
37.23	\$1,100,001 - \$1,150,000	\$3,450 <u>\$5,175</u>
37.24	\$1,150,001 - \$1,200,000	\$3,600 <u>\$5,400</u>
37.25	\$1,200,001 - \$1,250,000	\$3,750 <u>\$5,625</u>
37.26	\$1,250,001 - \$1,300,000	\$3,900 <u>\$5,850</u>
37.27	\$1,300,001 - \$1,350,000	\$4,050 <u>\$6,075</u>
37.28	\$1,350,001 - \$1,400,000	\$4,200 <u>\$6,300</u>
37.29	\$1,400,001 - \$1,450,000	\$4,350 <u>\$6,525</u>
37.30	\$1,450,001 - \$1,500,000	\$4,500 <u>\$6,750</u>
37.31	\$1,500,001 and over	\$4,800 <u>\$7,200</u>

37.32 **Sec. 26. [144.7051] DEFINITIONS.**

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

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

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

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

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

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

38.12 Sec. 27. **[144.7053] HOSPITAL NURSE STAFFING COMMITTEES.**

38.13 Subdivision 1. **Hospital nurse staffing committee required.** Each hospital must establish
38.14 and maintain a functioning hospital nurse staffing committee. A hospital may assign the
38.15 functions and duties of a hospital nurse staffing committee to an existing committee, provided
38.16 the existing committee meets the membership requirements applicable to a hospital nurse
38.17 staffing committee.

38.18 Subd. 2. **Committee membership.** (a) At least 35 percent of the committee's membership
38.19 must be direct care registered nurses typically assigned to a specific unit for an entire shift,
38.20 and at least 15 percent of the committee's membership must be other direct care workers
38.21 typically assigned to a specific unit for an entire shift. Direct care registered nurses and
38.22 other direct care workers who are members of a collective bargaining unit shall be appointed
38.23 or elected to the committee according to the guidelines of the applicable collective bargaining
38.24 agreement. If there is no collective bargaining agreement, direct care registered nurses shall
38.25 be elected to the committee by direct care registered nurses employed by the hospital, and
38.26 other direct care workers shall be elected to the committee by other direct care workers
38.27 employed by the hospital.

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

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

39.1 Subd. 4. Meeting frequency. Each hospital nurse staffing committee must meet at least
 39.2 quarterly.

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

39.7 (b) Each hospital nurse staffing committee must:

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

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

39.11 (3) review the documentation of compliance maintained by the hospital under section
 39.12 144.7056, subdivision 5;

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

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

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

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

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

39.21 Sec. 28. Minnesota Statutes 2020, section 144.7055, is amended to read:

39.22 **144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.**

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

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

39.28 ~~(c)~~ (b) "Nonmanagerial care staff" means registered nurses, licensed practical nurses,
 39.29 and other health care workers, which may include but is not limited to nursing assistants,
 39.30 nursing aides, patient care technicians, and patient care assistants, who perform

40.1 nonmanagerial direct patient care functions for more than 50 percent of their scheduled
40.2 hours on a given patient care unit.

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

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

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

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

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

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

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

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

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

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

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

41.3 (c) Core staffing plans must ensure that:

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

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

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

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

41.12 (5) daily staffing schedules do not interfere with applicable collective bargaining
41.13 agreements.

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

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

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

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

41.25 (3) unit-specific demands on direct care registered nurses' time, including: frequency of
41.26 admissions, discharges, and transfers; frequency and complexity of patient evaluations and
41.27 assessments; frequency and complexity of nursing care planning; planning for patient
41.28 discharge; assessing for patient referral; patient education; and implementing infectious
41.29 disease protocols;

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

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

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

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

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

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

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

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

42.19 **Subd. 3. Standard electronic reporting developed of core staffing plans.** ~~(a) Hospitals~~
 42.20 Each hospital must submit the core staffing plans approved by the hospital's nurse staffing
 42.21 committee to the Minnesota Hospital Association by January 1, 2014. The Minnesota
 42.22 Hospital Association shall include each reporting hospital's core staffing plan plans on the
 42.23 Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1,
 42.24 2014 by June 1, 2024. Hospitals shall submit to the Minnesota Hospital Association any
 42.25 substantial changes updates to the a core staffing plan shall be updated within 30 days of
 42.26 the approval of the updates by the hospital's nurse staffing committee or of amendment
 42.27 through arbitration. The Minnesota Hospital Association shall update the Minnesota Hospital
 42.28 Quality Report website with the updated core staffing plans within 30 days of receipt of the
 42.29 updated plan.

42.30 **Subd. 4. Standard electronic reporting of direct patient care report.** ~~(b)~~ The Minnesota
 42.31 Hospital Association shall include on its website for each reporting hospital on a quarterly
 42.32 basis the actual direct patient care hours per patient and per unit. Hospitals must submit the

43.1 direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly
43.2 thereafter.

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

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

43.7 Sec. 29. **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS.**

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

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

43.12 Subd. 3. **Public posting of compliance with plan.** For each publicly posted core staffing
43.13 plan, a hospital must post a notice stating whether the current staffing on the unit complies
43.14 with the hospital's core staffing plan for that unit. The public notice of compliance must
43.15 include a list of the number of nonmanagerial care staff working on the unit during the
43.16 current shift and the number of patients assigned to each direct care registered nurse working
43.17 on the unit during the current shift. The list must enumerate the nonmanagerial care staff
43.18 by health care worker type. The public notice of compliance must be posted immediately
43.19 adjacent to the publicly posted core staffing plan.

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

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

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

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

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

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

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

44.9 Sec. 30. **[144.7059] RETALIATION PROHIBITED.**

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

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

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

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

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

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

44.21 Sec. 31. **[144.8611] DRUG OVERDOSE AND SUBSTANCE ABUSE PREVENTION.**

44.22 Subdivision 1. **Strategies.** The commissioner of health shall support collaboration and
 44.23 coordination between state and community partners to develop, refine, and expand
 44.24 comprehensive funding to address the drug overdose epidemic by implementing three
 44.25 strategies: (1) regional multidisciplinary overdose prevention teams to implement overdose
 44.26 prevention in local communities and local public health organizations; (2) enhance supportive
 44.27 services for the homeless who are at risk of overdose by providing emergency and short-term
 44.28 housing subsidies through the Homeless Overdose Prevention Hub; and (3) enhance employer
 44.29 resources to promote health and well-being of employees through the recovery friendly
 44.30 workplace initiative. These strategies address the underlying social conditions that impact
 44.31 health status.

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

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

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

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

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

45.28 Subd. 6. **Evaluation.** The commissioner of health shall design, conduct, and evaluate
45.29 each of the components of the drug overdose and substance abuse prevention program using
45.30 measures such as mortality, morbidity, homelessness, workforce wellness, employee
45.31 retention, and program reach.

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

46.1 Sec. 32. Minnesota Statutes 2020, section 144.9501, subdivision 9, is amended to read:

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

46.6 Sec. 33. **[144.9981] CLIMATE RESILIENCY.**

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

46.9 (1) increase awareness of climate change;

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

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

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

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

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

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

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

46.28 (3) a description of the objectives, a work plan, and a timeline for implementation; and

46.29 (4) the community or group the grant proposes to focus on.

47.1 Sec. 34. [145.361] LONG COVID; SUPPORTING SURVIVORS AND MONITORING
47.2 IMPACT.

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

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

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

47.14 (2) more accurately target intervention resources for communities and patients and their
47.15 families;

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

47.18 (4) promote high quality research to provide better information for long COVID
47.19 prevention and control and to address public concerns and questions about long COVID.

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

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

47.29 Subd. 5. **Grant recipient and contractor eligibility.** The commissioner of health shall
47.30 award contracts and competitive grants to organizations that serve communities
47.31 disproportionately impacted by COVID-19 and long COVID including but not limited to
47.32 rural and low-income areas, Black and African Americans, African immigrants, American

48.1 Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities.
48.2 Organizations may also address intersectionality within such groups.

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

48.8 Sec. 35. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to
48.9 read:

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

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

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

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

48.21 (c) "988 Hotline" or "Lifeline Center" means a state identified center that is a member
48.22 of the National Suicide Prevention Lifeline network that responds to statewide or regional
48.23 988 contacts.

48.24 (d) "988 administrator" means the administrator of the 988 National Suicide Prevention
48.25 Lifeline.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

49.28 Sec. 38. [145.871] UNIVERSAL, VOLUNTARY HOME VISITING PROGRAM.

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

50.1 individuals and entities are eligible for a grant under this section: community health boards;
 50.2 nonprofit organizations; Tribal Nations; and health care providers, including doulas,
 50.3 community health workers, perinatal health educators, early childhood family education
 50.4 home visiting providers, nurses, community health technicians, and local public health
 50.5 nurses.

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

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

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

50.11 (i) maternal and newborn health;

50.12 (ii) school readiness and achievement;

50.13 (iii) family economic self-sufficiency;

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

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

50.16 (vi) reduction in crime or domestic violence.

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

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

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

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

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

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

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

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

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

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

51.18 Sec. 39. Minnesota Statutes 2020, section 145.924, is amended to read:

51.19 **145.924 AIDS PREVENTION GRANTS.**

51.20 (a) The commissioner may award grants to community health boards as defined in section
 51.21 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
 51.22 evaluation and counseling services to populations at risk for acquiring human
 51.23 immunodeficiency virus infection, including, but not limited to, minorities, adolescents,
 51.24 intravenous drug users, and homosexual men.

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

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

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

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

52.11 **Sec. 40. [145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**
 52.12 **DEVELOPMENT GRANT PROGRAM.**

52.13 Subdivision 1. **Establishment.** The commissioner of health shall establish the community
 52.14 solutions for a healthy child development grant program. The purposes of the program are
 52.15 to:

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

52.22 (2) reduce racial disparities in children's health and development from prenatal to grade
 52.23 3; and

52.24 (3) promote racial and geographic equity.

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

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

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

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

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

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

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

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

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

53.13 Subd. 3. Community solutions advisory council; establishment; duties;

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

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

53.18 (2) two members representing the Latino community;

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

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

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

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

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

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

53.29 (c) The community solutions advisory council shall:

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

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

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

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

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

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

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

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

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

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

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

54.19 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**
54.20 **grant awards.** (a) The commissioner, in consultation with the community solutions advisory
54.21 council, shall develop a request for proposals for healthy child development grants. In
54.22 developing the proposals and awarding the grants, the commissioner shall consider building
54.23 on the capacity of communities to promote child and family well-being and address social
54.24 determinants of healthy child development. Proposals must focus on increasing racial equity
54.25 and healthy child development and reducing health disparities experienced by children of
54.26 Black, nonwhite people of color, and American Indian communities from prenatal to grade
54.27 3 and their families.

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

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

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

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

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

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

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

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

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

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

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

55.20 Sec. 41. **[145.9272] LEAD REMEDIATION IN SCHOOLS AND CHILD CARE**
 55.21 **SETTINGS GRANT PROGRAM.**

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

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

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

56.1 Sec. 42. **[145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND**
 56.2 **EDUCATION GRANT PROGRAM.**

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

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

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

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

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

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

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

56.30 Sec. 43. **[145.9282] COMMUNITY HEALTH WORKERS; REDUCING HEALTH**
 56.31 **DISPARITIES WITH COMMUNITY-LED CARE.**

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

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

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

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

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

57.19 Sec. 44. **[145.9283] REDUCING HEALTH DISPARITIES AMONG PEOPLE WITH**
 57.20 **DISABILITIES; GRANTS.**

57.21 Subdivision 1. **Goal and establishment.** The commissioner of health shall support
 57.22 collaboration and coordination between state and community partners to address equity
 57.23 barriers to health care and preventative services for chronic diseases among people with
 57.24 disabilities. The commissioner of health, in consultation with the Olmstead Implementation
 57.25 Office, Department of Human Services, Board on Aging, health care professionals, local
 57.26 public health, and other community organizations that serve people with disabilities, shall
 57.27 routinely identify priorities and action steps to address identified gaps in services, resources,
 57.28 and tools.

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

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

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

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

58.10 Sec. 45. **[145.9292] PUBLIC HEALTH AMERICORPS.**

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

58.15 Sec. 46. **[145.987] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

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

58.23 Subd. 2. **Minnesota collaborative to prevent infant mortality.** (a) The Minnesota
 58.24 collaborative to prevent infant mortality is established. The goal of the Minnesota
 58.25 collaborative to prevent infant mortality program is to:

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

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

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

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

59.9 Subd. 3. Grants authorized. (a) The commissioner of health shall award grants to
59.10 eligible applicants to convene, coordinate, and implement data-driven strategies and culturally
59.11 relevant activities to improve infant health by reducing preterm births, sleep-related infant
59.12 deaths, and congenital malformations and by addressing social and environmental
59.13 determinants of health. Grants shall be awarded to support community nonprofit
59.14 organizations, Tribal governments, and community health boards. Grants shall be awarded
59.15 to all federally recognized Tribal governments whose proposals demonstrate the ability to
59.16 implement programs designed to achieve the purposes in subdivision 2 and other requirements
59.17 of this section. An eligible applicant must submit an application to the commissioner of
59.18 health on a form designated by the commissioner and by the deadline established by the
59.19 commissioner. The commissioner shall award grants to eligible applicants in metropolitan
59.20 and rural areas of the state and may consider geographic representation in grant awards.

59.21 (b) Grantee activities shall:

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

59.23 (2) be based on community input;

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

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

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

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

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

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

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

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

60.12 (1) partnership development and capacity building;

60.13 (2) Tribal support;

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

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

60.16 (5) health equity.

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

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

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

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

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

61.1 primary and specialty medical care providers, early childhood education and child care
61.2 programs, developmental disabilities assessment and intervention programs, mental health
61.3 services, family and social support programs, child advocacy and legal services, public
61.4 health and human services and resources, and other appropriate early childhood information.

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

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

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

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

61.21 (b) The commissioner shall:

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

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

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

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

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

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

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

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

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

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

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

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

62.26 (1) parenting classes or groups;

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

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

62.29 (4) correctional staff training;

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

62.31 (6) family-focused reentry planning.

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

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

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

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

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

63.12 (2) partnership building and community engagement;

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

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

63.16 Sec. 47. **[145.988] MINNESOTA SCHOOL HEALTH INITIATIVE.**

63.17 Subdivision 1. **Purpose.** (a) The purpose of the Minnesota School Health Initiative is
 63.18 to implement evidence-based practices to strengthen and expand health promotion and
 63.19 health care delivery activities in schools to improve the holistic health of students. To better
 63.20 serve students, the Minnesota School Health Initiative shall utilize the best practices of the
 63.21 school-based health center model.

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

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

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

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

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

64.5 (1) health care providers;

64.6 (2) community clinics;

64.7 (3) hospitals;

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

64.9 (5) health care foundations or nonprofit organizations;

64.10 (6) higher education institutions; or

64.11 (7) local health departments.

64.12 Subd. 3. **Expansion of Minnesota school-based health centers.** (a) The commissioner
 64.13 of health shall administer a program to provide grants to school districts and school-based
 64.14 health centers to support existing centers and facilitate the growth of school-based health
 64.15 centers in Minnesota.

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

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

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

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

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

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

64.29 (1) preventative health care;

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

- 65.1 (3) mental health care and crisis management;
- 65.2 (4) acute care for illness and injury;
- 65.3 (5) oral health care;
- 65.4 (6) vision care;
- 65.5 (7) nutritional counseling;
- 65.6 (8) substance abuse counseling;
- 65.7 (9) referral to a specialist, medical home, or hospital for care;
- 65.8 (10) additional services that address social determinants of health; and
- 65.9 (11) emerging services such as mobile health and telehealth.

65.10 Subd. 5. **Sponsoring organization.** A sponsoring organization that agrees to operate a
65.11 school-based health center must enter into a memorandum of agreement with the school or
65.12 district. The memorandum of agreement must require the sponsoring organization to be
65.13 financially responsible for the operation of school-based health centers in the school or
65.14 district and must identify the costs that are the responsibility of the school or district, such
65.15 as Internet access, custodial services, utilities, and facility maintenance. To the greatest
65.16 extent possible, a sponsoring organization must bill private insurers, medical assistance,
65.17 and other public programs for services provided in the school-based health center in order
65.18 to maintain the financial sustainability of the school-based health center.

65.19 Subd. 6. **Technical assistance and oversight.** (a) For the purposes of carrying out the
65.20 grant program under this section, including for administrative purposes, the commissioner
65.21 shall award contracts to appropriate entities to assist in training and provide technical
65.22 assistance to grantees.

65.23 (b) Contracts awarded under paragraph (a) may be used to provide technical assistance
65.24 and training in the areas of:

- 65.25 (1) needs assessment;
- 65.26 (2) community engagement and capacity building;
- 65.27 (3) community asset building and risk behavior reduction;
- 65.28 (4) dental provider training in calibration;
- 65.29 (5) dental services related equipment, instruments, supplies;
- 65.30 (6) communications;

- 66.1 (7) community, school, health care, work site, and other site-specific strategies;
66.2 (8) health equity;
66.3 (9) data collection and analysis; and
66.4 (10) evaluation.

66.5 Sec. 48. Minnesota Statutes 2020, section 145A.131, subdivision 1, is amended to read:

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

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

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

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

66.24 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
66.25 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
66.26 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive
66.27 an increase equal to ten percent of the grant award to the community health board under
66.28 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
66.29 the last six months of the year. For calendar years beginning on or after January 1, 2016,
66.30 the amount distributed under this paragraph shall be adjusted each year based on available
66.31 funding and the number of eligible community health boards.

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

67.5 Sec. 49. Minnesota Statutes 2020, section 145A.131, subdivision 5, is amended to read:

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

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

67.14 (c) Notwithstanding paragraph (b), if a community health board can demonstrate that
67.15 foundational public health responsibilities are fulfilled, the community health board may
67.16 use funding for foundational public health responsibilities for local priorities developed
67.17 through the community health assessment and community health improvement planning
67.18 process.

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

67.24 Sec. 50. Minnesota Statutes 2020, section 145A.14, is amended by adding a subdivision
67.25 to read:

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

67.29 Sec. 51. Minnesota Statutes 2020, section 149A.01, subdivision 2, is amended to read:

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

- 68.1 (1) take charge of or remove from the place of death a dead human body;
- 68.2 (2) prepare a dead human body for final disposition, in any manner; or
- 68.3 (3) arrange, direct, or supervise a funeral, memorial service, or graveside service.

68.4 Sec. 52. Minnesota Statutes 2020, section 149A.01, subdivision 3, is amended to read:

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

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

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

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

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

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

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

68.19 (c) Noncompensated persons with the right to control the dead human body, under section
68.20 149A.80, subdivision 2, may remove a body from the place of death; transport the body;
68.21 prepare the body for disposition, except embalming; or arrange for final disposition of the
68.22 body, provided that all actions are in compliance with this chapter.

68.23 (d) Persons serving internships pursuant to section 149A.20, subdivision 6, ~~or~~ students
68.24 officially registered for a practicum or clinical through a program of mortuary science
68.25 accredited by the American Board of Funeral Service Education, or transfer care specialists
68.26 registered pursuant to section 149A.47 are not required to be licensed, provided that the
68.27 persons or students are registered with the commissioner and act under the direct and
68.28 exclusive supervision of a person holding a current license to practice mortuary science in
68.29 Minnesota.

68.30 (e) Notwithstanding this subdivision, nothing in this section shall be construed to prohibit
68.31 an institution or entity from establishing, implementing, or enforcing a policy that permits

69.1 only persons licensed by the commissioner to remove or cause to be removed a dead body
69.2 or body part from the institution or entity.

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

69.8 Sec. 53. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision
69.9 to read:

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

69.12 Sec. 54. Minnesota Statutes 2020, section 149A.02, subdivision 13a, is amended to read:

69.13 Subd. 13a. **Direct supervision.** "Direct supervision" means overseeing the performance
69.14 of an individual. For the purpose of a clinical, practicum, ~~or~~ internship, or registration, direct
69.15 supervision means that the supervisor is available to observe and correct, as needed, the
69.16 performance of the trainee or registrant. The mortician supervisor is accountable for the
69.17 actions of the clinical student, practicum student, ~~or~~ intern, or registrant throughout the
69.18 course of the training. The supervising mortician is accountable for any violations of law
69.19 or rule, in the performance of their duties, by the clinical student, practicum student, ~~or~~
69.20 intern, or registrant.

69.21 Sec. 55. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision
69.22 to read:

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

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

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

70.1 Sec. 57. Minnesota Statutes 2020, section 149A.03, is amended to read:

70.2 **149A.03 DUTIES OF COMMISSIONER.**

70.3 The commissioner shall:

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

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

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

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

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

70.11 (v) licensing and operation of a crematory;

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

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

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

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

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

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

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

70.23 (9) educate the public about the existence and content of the laws and rules for mortuary
70.24 science licensing and the removal, preparation, transportation, arrangements for disposition,
70.25 and final disposition of dead human bodies to enable consumers to file complaints against
70.26 licensees and others who may have violated those laws or rules;

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

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

71.5 Sec. 58. Minnesota Statutes 2020, section 149A.09, is amended to read:

71.6 **149A.09 DENIAL; REFUSAL TO REISSUE; REVOCATION; SUSPENSION;**
 71.7 **LIMITATION OF LICENSE, REGISTRATION, OR PERMIT.**

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

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

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

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

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

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

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

72.1 (7) has a conservator or guardian appointed;

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

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

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

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

72.11 Subd. 2. **Hearings related to refusal to renew, suspension, or revocation of license,**
72.12 **registration, or permit.** If the regulatory agency proposes to deny renewal, suspend, or
72.13 revoke a license, registration, or permit issued under this chapter, the regulatory agency
72.14 must first notify, in writing, the person against whom the action is proposed to be taken and
72.15 provide an opportunity to request a hearing under the contested case provisions of sections
72.16 14.57 to 14.62. If the subject of the proposed action does not request a hearing by notifying
72.17 the regulatory agency, by mail, within 20 calendar days after the receipt of the notice of
72.18 proposed action, the regulatory agency may proceed with the action without a hearing and
72.19 the action will be the final order of the regulatory agency.

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

72.24 Subd. 4. **Limitations or qualifications placed on license, registration, or permit.** The
72.25 regulatory agency may, where the facts support such action, place reasonable limitations
72.26 or qualifications on the right to practice mortuary science or, to operate a funeral
72.27 establishment or crematory, or to conduct activities or actions permitted under this chapter.

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

73.1 Sec. 59. Minnesota Statutes 2020, section 149A.11, is amended to read:

73.2 **149A.11 PUBLICATION OF DISCIPLINARY ACTIONS.**

73.3 The regulatory agencies shall report all disciplinary measures or actions taken to the
 73.4 commissioner. At least annually, the commissioner shall publish and make available to the
 73.5 public a description of all disciplinary measures or actions taken by the regulatory agencies.
 73.6 The publication shall include, for each disciplinary measure or action taken, the name and
 73.7 business address of the licensee, registrant, or intern; the nature of the misconduct; and
 73.8 the measure or action taken by the regulatory agency.

73.9 Sec. 60. **149A.47] TRANSFER CARE SPECIALIST.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.12 (b) To renew a registration, the transfer care specialist must submit a completed renewal
 74.13 application as provided by the commissioner and the appropriate fees specified in section
 74.14 149A.65. Every five years, the renewal application must include proof of completion of a
 74.15 training program that meets the requirements in subdivision 4.

74.16 Sec. 61. Minnesota Statutes 2020, section 149A.60, is amended to read:

74.17 **149A.60 PROHIBITED CONDUCT.**

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

74.25 Sec. 62. Minnesota Statutes 2020, section 149A.61, subdivision 4, is amended to read:

74.26 Subd. 4. **Licensees, registrants, and interns.** A licensee, registrant, or intern regulated
 74.27 under this chapter may report to the commissioner any conduct that the licensee, registrant,
 74.28 or intern has personal knowledge of, and reasonably believes constitutes grounds for,
 74.29 disciplinary action under this chapter.

75.1 Sec. 63. Minnesota Statutes 2020, section 149A.61, subdivision 5, is amended to read:

75.2 Subd. 5. **Courts.** The court administrator of district court or any court of competent
75.3 jurisdiction shall report to the commissioner any judgment or other determination of the
75.4 court that adjudges or includes a finding that a licensee, registrant, or intern is a person who
75.5 is mentally ill, mentally incompetent, guilty of a felony or gross misdemeanor, guilty of
75.6 violations of federal or state narcotics laws or controlled substances acts; appoints a guardian
75.7 or conservator for the licensee, registrant, or intern; or commits a licensee, registrant, or
75.8 intern.

75.9 Sec. 64. Minnesota Statutes 2020, section 149A.62, is amended to read:

75.10 **149A.62 IMMUNITY; REPORTING.**

75.11 Any person, private agency, organization, society, association, licensee, registrant, or
75.12 intern who, in good faith, submits information to a regulatory agency under section 149A.61
75.13 or otherwise reports violations or alleged violations of this chapter, is immune from civil
75.14 liability or criminal prosecution. This section does not prohibit disciplinary action taken by
75.15 the commissioner against any licensee, registrant, or intern pursuant to a self report of a
75.16 violation.

75.17 Sec. 65. Minnesota Statutes 2020, section 149A.63, is amended to read:

75.18 **149A.63 PROFESSIONAL COOPERATION.**

75.19 A licensee, clinical student, practicum student, registrant, intern, or applicant for licensure
75.20 under this chapter that is the subject of or part of an inspection or investigation by the
75.21 commissioner or the commissioner's designee shall cooperate fully with the inspection or
75.22 investigation. Failure to cooperate constitutes grounds for disciplinary action under this
75.23 chapter.

75.24 Sec. 66. Minnesota Statutes 2020, section 149A.65, subdivision 2, is amended to read:

75.25 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

75.26 (1) \$75 for the initial and renewal registration of a mortuary science intern;

75.27 (2) \$125 for the mortuary science examination;

75.28 (3) \$200 for issuance of initial and renewal mortuary science licenses;

75.29 (4) \$100 late fee charge for a license renewal; ~~and~~

75.30 (5) \$250 for issuing a mortuary science license by endorsement; and

76.1 (6) \$1,170 for the initial and renewal registration of a transfer care specialist.

76.2 Sec. 67. Minnesota Statutes 2020, section 149A.70, subdivision 3, is amended to read:

76.3 Subd. 3. **Advertising.** No licensee, registrant, clinical student, practicum student, or
76.4 intern shall publish or disseminate false, misleading, or deceptive advertising. False,
76.5 misleading, or deceptive advertising includes, but is not limited to:

76.6 (1) identifying, by using the names or pictures of, persons who are not licensed to practice
76.7 mortuary science in a way that leads the public to believe that those persons will provide
76.8 mortuary science services;

76.9 (2) using any name other than the names under which the funeral establishment, alkaline
76.10 hydrolysis facility, or crematory is known to or licensed by the commissioner;

76.11 (3) using a surname not directly, actively, or presently associated with a licensed funeral
76.12 establishment, alkaline hydrolysis facility, or crematory, unless the surname had been
76.13 previously and continuously used by the licensed funeral establishment, alkaline hydrolysis
76.14 facility, or crematory; and

76.15 (4) using a founding or establishing date or total years of service not directly or
76.16 continuously related to a name under which the funeral establishment, alkaline hydrolysis
76.17 facility, or crematory is currently or was previously licensed.

76.18 Any advertising or other printed material that contains the names or pictures of persons
76.19 affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state
76.20 the position held by the persons and shall identify each person who is licensed or unlicensed
76.21 under this chapter.

76.22 Sec. 68. Minnesota Statutes 2020, section 149A.70, subdivision 4, is amended to read:

76.23 Subd. 4. **Solicitation of business.** No licensee shall directly or indirectly pay or cause
76.24 to be paid any sum of money or other valuable consideration for the securing of business
76.25 or for obtaining the authority to dispose of any dead human body.

76.26 For purposes of this subdivision, licensee includes a registered intern or transfer care
76.27 specialist or any agent, representative, employee, or person acting on behalf of the licensee.

76.28 Sec. 69. Minnesota Statutes 2020, section 149A.70, subdivision 5, is amended to read:

76.29 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,
76.30 ~~or~~ intern, or transfer care specialist shall offer, solicit, or accept a commission, fee, bonus,
76.31 rebate, or other reimbursement in consideration for recommending or causing a dead human

77.1 body to be disposed of by a specific body donation program, funeral establishment, alkaline
77.2 hydrolysis facility, crematory, mausoleum, or cemetery.

77.3 Sec. 70. Minnesota Statutes 2020, section 149A.70, subdivision 7, is amended to read:

77.4 Subd. 7. **Unprofessional conduct.** No licensee, registrant, or intern shall engage in or
77.5 permit others under the licensee's, registrant's, or intern's supervision or employment to
77.6 engage in unprofessional conduct. Unprofessional conduct includes, but is not limited to:

77.7 (1) harassing, abusing, or intimidating a customer, employee, or any other person
77.8 encountered while within the scope of practice, employment, or business;

77.9 (2) using profane, indecent, or obscene language within the immediate hearing of the
77.10 family or relatives of the deceased;

77.11 (3) failure to treat with dignity and respect the body of the deceased, any member of the
77.12 family or relatives of the deceased, any employee, or any other person encountered while
77.13 within the scope of practice, employment, or business;

77.14 (4) the habitual overindulgence in the use of or dependence on intoxicating liquors,
77.15 prescription drugs, over-the-counter drugs, illegal drugs, or any other mood altering
77.16 substances that substantially impair a person's work-related judgment or performance;

77.17 (5) revealing personally identifiable facts, data, or information about a decedent, customer,
77.18 member of the decedent's family, or employee acquired in the practice or business without
77.19 the prior consent of the individual, except as authorized by law;

77.20 (6) intentionally misleading or deceiving any customer in the sale of any goods or services
77.21 provided by the licensee;

77.22 (7) knowingly making a false statement in the procuring, preparation, or filing of any
77.23 required permit or document; or

77.24 (8) knowingly making a false statement on a record of death.

77.25 Sec. 71. Minnesota Statutes 2020, section 149A.90, subdivision 2, is amended to read:

77.26 Subd. 2. **Removal from place of death.** No person subject to regulation under this
77.27 chapter shall remove or cause to be removed any dead human body from the place of death
77.28 without being licensed or registered by the commissioner. Every dead human body shall be
77.29 removed from the place of death by a licensed mortician or funeral director, except as
77.30 provided in section 149A.01, subdivision 3, or 149A.47.

78.1 Sec. 72. Minnesota Statutes 2020, section 149A.90, subdivision 4, is amended to read:

78.2 Subd. 4. **Certificate of removal.** No dead human body shall be removed from the place
78.3 of death by a mortician ~~or~~, funeral director, or transfer care specialist or by a noncompensated
78.4 person with the right to control the dead human body without the completion of a certificate
78.5 of removal and, where possible, presentation of a copy of that certificate to the person or a
78.6 representative of the legal entity with physical or legal custody of the body at the death site.
78.7 The certificate of removal shall be in the format provided by the commissioner that contains,
78.8 at least, the following information:

78.9 (1) the name of the deceased, if known;

78.10 (2) the date and time of removal;

78.11 (3) a brief listing of the type and condition of any personal property removed with the
78.12 body;

78.13 (4) the location to which the body is being taken;

78.14 (5) the name, business address, and license number of the individual making the removal;
78.15 and

78.16 (6) the signatures of the individual making the removal and, where possible, the individual
78.17 or representative of the legal entity with physical or legal custody of the body at the death
78.18 site.

78.19 Sec. 73. Minnesota Statutes 2020, section 149A.90, subdivision 5, is amended to read:

78.20 Subd. 5. **Retention of certificate of removal.** A copy of the certificate of removal shall
78.21 be given, where possible, to the person or representative of the legal entity having physical
78.22 or legal custody of the body at the death site. The original certificate of removal shall be
78.23 retained by the individual making the removal and shall be kept on file, at the funeral
78.24 establishment to which the body was taken, for a period of three calendar years following
78.25 the date of the removal. If the removal was performed by a transfer care specialist not
78.26 employed by the funeral establishment to which the body was taken, the transfer care
78.27 specialist shall retain a copy of the certificate on file at the transfer care specialist's business
78.28 address as registered with the commissioner for a period of three calendar years following
78.29 the date of removal. Following this period, and subject to any other laws requiring retention
78.30 of records, the funeral establishment may then place the records in storage or reduce them
78.31 to microfilm, microfiche, laser disc, or any other method that can produce an accurate
78.32 reproduction of the original record, for retention for a period of ten calendar years from the
78.33 date of the removal of the body. At the end of this period and subject to any other laws

79.1 requiring retention of records, the funeral establishment may destroy the records by shredding,
 79.2 incineration, or any other manner that protects the privacy of the individuals identified in
 79.3 the records.

79.4 Sec. 74. Minnesota Statutes 2020, section 149A.94, subdivision 1, is amended to read:

79.5 Subdivision 1. **Generally.** (a) Every dead human body lying within the state, except
 79.6 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
 79.7 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
 79.8 the state for the purpose of disposition elsewhere; and the remains of any dead human body
 79.9 after dissection or anatomical study, shall be decently buried or entombed in a public or
 79.10 private cemetery, alkaline hydrolyzed, or cremated within a reasonable time after death.
 79.11 Where final disposition of a body will not be accomplished within 72 hours following death
 79.12 or release of the body by a competent authority with jurisdiction over the body, the body
 79.13 must be properly embalmed, refrigerated, or packed with dry ice. A body may not be kept
 79.14 in refrigeration for a period exceeding six calendar days, or packed in dry ice for a period
 79.15 that exceeds four calendar days, from the time of death or release of the body from the
 79.16 coroner or medical examiner. A body may be kept in refrigeration for up to 30 calendar
 79.17 days from the time of death or release of the body from the coroner or medical examiner,
 79.18 provided the dignity of the body is maintained and the funeral establishment complies with
 79.19 paragraph (b) if applicable. A body may be kept in refrigeration for more than 30 calendar
 79.20 days from the time of death or release of the body from the coroner or medical examiner in
 79.21 accordance with paragraphs (c) and (d).

79.22 (b) For a body to be kept in refrigeration for between 15 and 30 calendar days, no later
 79.23 than the 14th day of keeping the body in refrigeration the funeral establishment must notify
 79.24 the person with the right to control final disposition that the body will be kept in refrigeration
 79.25 for more than 14 days and that the person with the right to control final disposition has the
 79.26 right to seek other arrangements.

79.27 (c) For a body to be kept in refrigeration for more than 30 calendar days, the funeral
 79.28 establishment must:

79.29 (1) report at least the following to the commissioner on a form and in a manner prescribed
 79.30 by the commissioner: body identification details determined by the commissioner, the funeral
 79.31 establishment's plan to achieve final disposition of the body within the permitted time frame,
 79.32 and other information required by the commissioner; and

79.33 (2) store each refrigerated body in a manner that maintains the dignity of the body.

80.1 (d) Each report filed with the commissioner under paragraph (c) authorizes a funeral
80.2 establishment to keep a body in refrigeration for an additional 30 calendar days.

80.3 (e) Failure to submit a report required by paragraph (c) subjects a funeral establishment
80.4 to enforcement under this chapter.

80.5 Sec. 75. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
80.6 read:

80.7 Subd. 1a. **Bona fide labor organization.** "Bona fide labor organization" means a labor
80.8 union that represents or is actively seeking to represent workers of a medical cannabis
80.9 manufacturer.

80.10 Sec. 76. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
80.11 read:

80.12 Subd. 5d. **Indian lands.** "Indian lands" means all lands within the limits of any Indian
80.13 reservation within the boundaries of Minnesota and any lands within the boundaries of
80.14 Minnesota title which are either held in trust by the United States or over which an Indian
80.15 Tribe exercises governmental power.

80.16 Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
80.17 read:

80.18 Subd. 5e. **Labor peace agreement.** "Labor peace agreement" means an agreement
80.19 between a medical cannabis manufacturer and a bona fide labor organization that protects
80.20 the state's interests by, at a minimum, prohibiting the labor organization from engaging in
80.21 picketing, work stoppages, or boycotts against the manufacturer. This type of agreement
80.22 shall not mandate a particular method of election or certification of the bona fide labor
80.23 organization.

80.24 Sec. 78. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
80.25 read:

80.26 Subd. 15. **Tribal medical cannabis board.** "Tribal medical cannabis board" means an
80.27 agency established by each federally recognized Tribal government and duly authorized by
80.28 each Tribe's governing body to perform regulatory oversight and monitor compliance with
80.29 a Tribal medical cannabis program and applicable regulations.

81.1 Sec. 79. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
81.2 read:

81.3 Subd. 16. **Tribal medical cannabis program.** "Tribal medical cannabis program" means
81.4 a program established by a federally recognized Tribal government within the boundaries
81.5 of Minnesota regarding the commercial production, processing, sale or distribution, and
81.6 possession of medical cannabis and medical cannabis products.

81.7 Sec. 80. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
81.8 read:

81.9 Subd. 17. **Tribal medical cannabis program patient.** "Tribal medical cannabis program
81.10 patient" means a person who possesses a valid registration verification card or equivalent
81.11 document that is issued under the laws or regulations of a Tribal Nation within the boundaries
81.12 of Minnesota and that verifies that the person is enrolled in or authorized to participate in
81.13 that Tribal Nation's Tribal medical cannabis program.

81.14 Sec. 81. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

81.15 Subdivision 1. **Medical cannabis manufacturer registration and renewal.** (a) The
81.16 commissioner shall register ~~two~~ at least four and up to ten in-state manufacturers for the
81.17 production of all medical cannabis within the state. ~~A The registration agreement between~~
81.18 ~~the commissioner and a manufacturer is valid for two years, unless revoked under subdivision~~
81.19 ~~1a, and is nontransferable. The commissioner shall register new manufacturers or reregister~~
81.20 ~~the existing manufacturers by December 1 every two years, using the factors described in~~
81.21 ~~this subdivision. The commissioner shall accept applications after December 1, 2014, if one~~
81.22 ~~of the manufacturers registered before December 1, 2014, ceases to be registered as a~~
81.23 ~~manufacturer. The commissioner's determination that no manufacturer exists to fulfill the~~
81.24 ~~duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County~~
81.25 ~~District Court. Once the commissioner has registered more than two manufacturers,~~
81.26 registration renewal for at least one manufacturer must occur each year. The commissioner
81.27 shall begin registering additional manufacturers by December 1, 2022. The commissioner
81.28 shall renew a registration if the manufacturer meets the factors described in this subdivision
81.29 and submits the registration renewal fee under section 152.35.

81.30 (b) An individual or entity seeking registration or registration renewal under this
81.31 subdivision must apply to the commissioner in a form and manner established by the
81.32 commissioner. As part of the application, the applicant must submit an attestation signed
81.33 by a bona fide labor organization stating that the applicant has entered into a labor peace

82.1 agreement. Before accepting applications for registration or registration renewal, the
 82.2 commissioner must publish on the Office of Medical Cannabis website the application
 82.3 scoring criteria established by the commissioner to determine whether the applicant meets
 82.4 requirements for registration or registration renewal. Data submitted during the application
 82.5 process are private data on individuals or nonpublic data as defined in section 13.02 until
 82.6 the manufacturer is registered under this section. Data on a manufacturer that is registered
 82.7 are public data, unless the data are trade secret or security information under section 13.37.

82.8 ~~(b)~~ (c) As a condition for registration, ~~a manufacturer must agree to~~ or registration
 82.9 renewal:

82.10 ~~(1) begin supplying medical cannabis to patients by July 1, 2015; and~~

82.11 ~~(2)~~ (1) a manufacturer must comply with all requirements under sections 152.22 to
 82.12 152.37;

82.13 (2) if the manufacturer is a business entity, the manufacturer must be incorporated in
 82.14 the state or otherwise formed or organized under the laws of the state; and

82.15 (3) the manufacturer must fulfill commitments made in the application for registration
 82.16 or registration renewal, including but not limited to maintenance of a labor peace agreement.

82.17 ~~(e)~~ (d) The commissioner shall consider the following factors when determining which
 82.18 manufacturer to register or when determining whether to renew a registration:

82.19 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
 82.20 converting the medical cannabis into an acceptable delivery method under section 152.22,
 82.21 subdivision 6;

82.22 (2) the qualifications of the manufacturer's employees;

82.23 (3) the long-term financial stability of the manufacturer;

82.24 (4) the ability to provide appropriate security measures on the premises of the
 82.25 manufacturer;

82.26 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
 82.27 production needs required by sections 152.22 to 152.37; ~~and~~

82.28 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
 82.29 qualifying medical condition;

82.30 (7) the manufacturer's inclusion of leadership or beneficial ownership, as defined in
 82.31 section 302A.011, subdivision 41, by:

- 83.1 (i) minority persons as defined in section 116M.14, subdivision 6;
- 83.2 (ii) women;
- 83.3 (iii) individuals with disabilities as defined in section 363A.03, subdivision 12; or
- 83.4 (iv) military veterans who satisfy the requirements of section 197.447;
- 83.5 (8) the extent to which registering the manufacturer or renewing the registration will
- 83.6 expand service to a currently underserved market;
- 83.7 (9) the extent to which registering the manufacturer or renewing the registration will
- 83.8 promote development in a low-income area as defined in section 116J.982, subdivision 1,
- 83.9 paragraph (e);
- 83.10 (10) beneficial ownership as defined in section 302A.011, subdivision 41, of the
- 83.11 manufacturer by Minnesota residents; and
- 83.12 (11) other factors the commissioner determines are necessary to protect patient health
- 83.13 and ensure public safety.
- 83.14 (e) Commitments made by an applicant in the applicant's application for registration or
- 83.15 registration renewal, including but not limited to maintenance of a labor peace agreement,
- 83.16 shall be an ongoing material condition of maintaining a manufacturer registration.
- 83.17 ~~(d)~~ (f) If an officer, director, or controlling person of the manufacturer pleads or is found
- 83.18 guilty of intentionally diverting medical cannabis to a person other than allowed by law
- 83.19 under section 152.33, subdivision 1, the commissioner may decide not to renew the
- 83.20 registration of the manufacturer, provided the violation occurred while the person was an
- 83.21 officer, director, or controlling person of the manufacturer.
- 83.22 ~~(e) The commissioner shall require each medical cannabis manufacturer to contract with~~
- 83.23 ~~an independent laboratory to test medical cannabis produced by the manufacturer. The~~
- 83.24 ~~commissioner shall approve the laboratory chosen by each manufacturer and require that~~
- 83.25 ~~the laboratory report testing results to the manufacturer in a manner determined by the~~
- 83.26 ~~commissioner.~~
- 83.27 Sec. 82. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
- 83.28 read:
- 83.29 Subd. 1d. **Background study.** (a) Before the commissioner registers a manufacturer or
- 83.30 renews a registration, each officer, director, and controlling person of the manufacturer
- 83.31 must consent to a background study and must submit to the commissioner a completed
- 83.32 criminal history records check consent form, a full set of classifiable fingerprints, and the

84.1 required fees. The commissioner must submit these materials to the Bureau of Criminal
84.2 Apprehension. The bureau must conduct a Minnesota criminal history records check, and
84.3 the superintendent is authorized to exchange fingerprints with the Federal Bureau of
84.4 Investigation to obtain national criminal history record information. The bureau must return
84.5 the results of the Minnesota and federal criminal history records checks to the commissioner.

84.6 (b) The commissioner must not register a manufacturer or renew a registration if an
84.7 officer, director, or controlling person of the manufacturer has been convicted of, pled guilty
84.8 to, or received a stay of adjudication for:

84.9 (1) a violation of state or federal law related to theft, fraud, embezzlement, breach of
84.10 fiduciary duty, or other financial misconduct that is a felony under Minnesota law or would
84.11 be a felony if committed in Minnesota; or

84.12 (2) a violation of state or federal law relating to unlawful manufacture, distribution,
84.13 prescription, or dispensing of a controlled substance that is a felony under Minnesota law
84.14 or would be a felony if committed in Minnesota.

84.15 Sec. 83. Minnesota Statutes 2020, section 152.29, subdivision 4, is amended to read:

84.16 Subd. 4. **Report.** (a) Each manufacturer shall report to the commissioner on a monthly
84.17 basis the following information on each individual patient for the month prior to the report:

84.18 (1) the amount and dosages of medical cannabis distributed;

84.19 (2) the chemical composition of the medical cannabis; and

84.20 (3) the tracking number assigned to any medical cannabis distributed.

84.21 (b) For transactions involving Tribal medical cannabis program patients, each
84.22 manufacturer shall report to the commissioner on a weekly basis the following information
84.23 on each individual Tribal medical cannabis program patient for the week prior to the report:

84.24 (1) the name of the Tribal medical cannabis program in which the Tribal medical cannabis
84.25 program patient is enrolled;

84.26 (2) the amount and dosages of medical cannabis distributed;

84.27 (3) the chemical composition of the medical cannabis; and

84.28 (4) the tracking number assigned to the medical cannabis distributed.

85.1 Sec. 84. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
85.2 read:

85.3 Subd. 5. **Distribution to Tribal medical cannabis program patient.** (a) A manufacturer
85.4 may distribute medical cannabis in accordance with subdivisions 1 to 4 to a Tribal medical
85.5 cannabis program patient.

85.6 (b) Prior to distribution, the Tribal medical cannabis program patient must provide to
85.7 the manufacturer:

85.8 (1) a valid medical cannabis registration verification card or equivalent document issued
85.9 by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program
85.10 patient is authorized to use medical cannabis on Indian lands over which the Tribe has
85.11 jurisdiction; and

85.12 (2) a valid photographic identification card issued by the Tribal medical cannabis
85.13 program, valid driver's license, or valid state identification card.

85.14 (c) A manufacturer shall distribute medical cannabis to a Tribal medical cannabis program
85.15 patient only in a form allowed under section 152.22, subdivision 6.

85.16 Sec. 85. **[152.291] TRIBAL MEDICAL CANNABIS PROGRAM;**
85.17 **MANUFACTURERS.**

85.18 Subdivision 1. **Manufacturer.** Notwithstanding the requirements and limitations in
85.19 section 152.29, subdivision 1, paragraph (a), a Tribal medical cannabis program operated
85.20 by a federally recognized Indian Tribe located in Minnesota shall be recognized as a medical
85.21 cannabis manufacturer.

85.22 Subd. 2. **Manufacturer transportation.** (a) A manufacturer registered with a Tribal
85.23 medical cannabis program may transport medical cannabis to testing laboratories in the
85.24 state and to other Indian lands.

85.25 (b) A manufacturer registered with a Tribal medical cannabis program must staff a motor
85.26 vehicle used to transport medical cannabis with at least two employees of the manufacturer.
85.27 Each employee in the transport vehicle must carry identification specifying that the employee
85.28 is an employee of the manufacturer, and one employee in the transport vehicle must carry
85.29 a detailed transportation manifest that includes the place and time of departure, the address
85.30 of the destination, and a description and count of the medical cannabis being transported.

86.1 Sec. 86. Minnesota Statutes 2020, section 152.30, is amended to read:

86.2 **152.30 PATIENT DUTIES.**

86.3 (a) A patient shall apply to the commissioner for enrollment in the registry program by
86.4 submitting an application as required in section 152.27 and an annual registration fee as
86.5 determined under section 152.35.

86.6 (b) As a condition of continued enrollment, patients shall agree to:

86.7 (1) continue to receive regularly scheduled treatment for their qualifying medical
86.8 condition from their health care practitioner; and

86.9 (2) report changes in their qualifying medical condition to their health care practitioner.

86.10 (c) A patient shall only receive medical cannabis from a registered manufacturer or
86.11 Tribal medical cannabis program but is not required to receive medical cannabis products
86.12 from only a registered manufacturer or Tribal medical cannabis program.

86.13 Sec. 87. Minnesota Statutes 2020, section 152.32, is amended to read:

86.14 **152.32 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPATION OR**
86.15 **PARTICIPATION IN A TRIBAL MEDICAL CANNABIS PROGRAM.**

86.16 Subdivision 1. **Presumption.** (a) There is a presumption that a patient enrolled in the
86.17 registry program under sections 152.22 to 152.37 or a Tribal medical cannabis program
86.18 patient enrolled in a Tribal medical cannabis program is engaged in the authorized use of
86.19 medical cannabis.

86.20 (b) The presumption may be rebutted:

86.21 (1) by evidence that a patient's conduct related to use of medical cannabis was not for
86.22 the purpose of treating or alleviating the patient's qualifying medical condition or symptoms
86.23 associated with the patient's qualifying medical condition; or

86.24 (2) by evidence that a Tribal medical cannabis program patient's use of medical cannabis
86.25 was not for a purpose authorized by the Tribal medical cannabis program.

86.26 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
86.27 are not violations under this chapter:

86.28 (1) use or possession of medical cannabis or medical cannabis products by a patient
86.29 enrolled in the registry program, ~~or~~; possession by a registered designated caregiver or the
86.30 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed

87.1 on the registry verification; or use or possession of medical cannabis or medical cannabis
87.2 products by a Tribal medical cannabis program patient;

87.3 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
87.4 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
87.5 conducting testing on medical cannabis, or employees of the laboratory; and

87.6 (3) possession of medical cannabis or medical cannabis products by any person while
87.7 carrying out the duties required under sections 152.22 to 152.37.

87.8 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
87.9 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

87.10 (c) The commissioner, members of a Tribal medical cannabis board, the commissioner's
87.11 or Tribal medical cannabis board's staff, the commissioner's or Tribal medical cannabis
87.12 board's agents or contractors, and any health care practitioner are not subject to any civil or
87.13 disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any
87.14 business, occupational, or professional licensing board or entity, solely for the participation
87.15 in the registry program under sections 152.22 to 152.37 or in a Tribal medical cannabis
87.16 program. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary
87.17 penalties by the Board of Pharmacy when acting in accordance with the provisions of
87.18 sections 152.22 to 152.37. Nothing in this section affects a professional licensing board
87.19 from taking action in response to violations of any other section of law.

87.20 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
87.21 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
87.22 for any injury, loss of property, personal injury, or death caused by any act or omission
87.23 while acting within the scope of office or employment under sections 152.22 to 152.37.

87.24 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
87.25 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
87.26 search warrant.

87.27 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
87.28 employee may release data or information about an individual contained in any report,
87.29 document, or registry created under sections 152.22 to 152.37 or any information obtained
87.30 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

87.31 (g) No information contained in a report, document, or registry or obtained from a patient
87.32 or a Tribal medical cannabis program patient under sections 152.22 to 152.37 may be

88.1 admitted as evidence in a criminal proceeding unless independently obtained or in connection
88.2 with a proceeding involving a violation of sections 152.22 to 152.37.

88.3 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
88.4 of a gross misdemeanor.

88.5 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
88.6 Court, a Tribal court, or the professional responsibility board for providing legal assistance
88.7 to prospective or registered manufacturers or others related to activity that is no longer
88.8 subject to criminal penalties under state law pursuant to sections 152.22 to 152.37, or for
88.9 providing legal assistance to a Tribal medical cannabis program.

88.10 (j) Possession of a registry verification or application for enrollment in the program by
88.11 a person entitled to possess or apply for enrollment in the registry program, or possession
88.12 of a verification or equivalent issued by a Tribal medical cannabis program by a person
88.13 entitled to possess such verification, does not constitute probable cause or reasonable
88.14 suspicion, nor shall it be used to support a search of the person or property of the person
88.15 possessing or applying for the registry verification or equivalent, or otherwise subject the
88.16 person or property of the person to inspection by any governmental agency.

88.17 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
88.18 lease to and may not otherwise penalize a person solely for the person's status as a patient
88.19 enrolled in the registry program under sections 152.22 to 152.37 or for the person's status
88.20 as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program,
88.21 unless failing to do so would violate federal law or regulations or cause the school or landlord
88.22 to lose a monetary or licensing-related benefit under federal law or regulations.

88.23 (b) For the purposes of medical care, including organ transplants, a registry program
88.24 enrollee's use of medical cannabis under sections 152.22 to 152.37, or a Tribal medical
88.25 cannabis program patient's use of medical cannabis as authorized by the Tribal medical
88.26 cannabis program, is considered the equivalent of the authorized use of any other medication
88.27 used at the discretion of a physician or advanced practice registered nurse and does not
88.28 constitute the use of an illicit substance or otherwise disqualify a patient from needed medical
88.29 care.

88.30 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
88.31 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
88.32 may not discriminate against a person in hiring, termination, or any term or condition of
88.33 employment, or otherwise penalize a person, if the discrimination is based upon either any
88.34 of the following:

89.1 (1) the person's status as a patient enrolled in the registry program under sections 152.22
89.2 to 152.37; ~~or~~

89.3 (2) the person's status as a Tribal medical cannabis program patient enrolled in a Tribal
89.4 medical cannabis program; or

89.5 ~~(2)~~ (3) a patient's positive drug test for cannabis components or metabolites, unless the
89.6 patient used, possessed, or was impaired by medical cannabis on the premises of the place
89.7 of employment or during the hours of employment.

89.8 (d) An employee who is required to undergo employer drug testing pursuant to section
89.9 181.953 may present verification of enrollment in the patient registry or of enrollment in a
89.10 Tribal medical cannabis program as part of the employee's explanation under section 181.953,
89.11 subdivision 6.

89.12 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
89.13 time with a minor child solely based on the person's status as a patient enrolled in the registry
89.14 program under sections 152.22 to 152.37 or on the person's status as a Tribal medical
89.15 cannabis program patient enrolled in a Tribal medical cannabis program. There shall be no
89.16 presumption of neglect or child endangerment for conduct allowed under sections 152.22
89.17 to 152.37 or under a Tribal medical cannabis program, unless the person's behavior is such
89.18 that it creates an unreasonable danger to the safety of the minor as established by clear and
89.19 convincing evidence.

89.20 Sec. 88. Minnesota Statutes 2020, section 152.33, subdivision 1, is amended to read:

89.21 Subdivision 1. **Intentional diversion; criminal penalty.** In addition to any other
89.22 applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
89.23 transfers medical cannabis to a person other than another registered manufacturer, a patient,
89.24 a registered designated caregiver, a Tribal medical cannabis program patient, or, if listed
89.25 on the registry verification, a parent, legal guardian, or spouse of a patient is guilty of a
89.26 felony punishable by imprisonment for not more than two years or by payment of a fine of
89.27 not more than \$3,000, or both. A person convicted under this subdivision may not continue
89.28 to be affiliated with the manufacturer and is disqualified from further participation under
89.29 sections 152.22 to 152.37.

90.1 Sec. 89. Minnesota Statutes 2020, section 152.35, is amended to read:

90.2 **152.35 FEES; DEPOSIT OF REVENUE.**

90.3 (a) The commissioner shall collect an enrollment fee of ~~\$200~~ \$40 from patients enrolled
 90.4 under this section 152.27. ~~If the patient provides evidence of receiving Social Security~~
 90.5 ~~disability insurance (SSDI), Supplemental Security Income (SSI), veterans disability, or~~
 90.6 ~~railroad disability payments, or being enrolled in medical assistance or MinnesotaCare, then~~
 90.7 ~~the fee shall be \$50. For purposes of this section:~~

90.8 ~~(1) a patient is considered to receive SSDI if the patient was receiving SSDI at the time~~
 90.9 ~~the patient was transitioned to retirement benefits by the United States Social Security~~
 90.10 ~~Administration; and~~

90.11 ~~(2) veterans disability payments include VA dependency and indemnity compensation.~~
 90.12 ~~Unless a patient provides evidence of receiving payments from or participating in one of~~
 90.13 ~~the programs specifically listed in this paragraph, the commissioner of health must collect~~
 90.14 ~~the \$200 enrollment fee from a patient to enroll the patient in the registry program. The fees~~
 90.15 ~~shall be payable annually and are due on the anniversary date of the patient's enrollment.~~
 90.16 ~~The fee amount shall be deposited in the state treasury and credited to the state government~~
 90.17 ~~special revenue fund.~~

90.18 (b) The commissioner shall collect ~~an~~ a registration application fee of \$20,000 from
 90.19 each entity submitting an application for registration as a medical cannabis manufacturer.
 90.20 Revenue from the fee shall be deposited in the state treasury and credited to the state
 90.21 government special revenue fund. If the commissioner decides not to register an entity that
 90.22 applies for registration, the commissioner shall reimburse the entity \$10,000 of the entity's
 90.23 registration fee no later than 30 days after providing the entity with notice of the decision.

90.24 (c) The commissioner shall establish and collect ~~an annual~~ a biennial registration renewal
 90.25 fee from a medical cannabis manufacturer equal to the cost of regulating and inspecting the
 90.26 manufacturer in that year for the upcoming registration period. Revenue from the fee amount
 90.27 shall be deposited in the state treasury and credited to the state government special revenue
 90.28 fund.

90.29 (d) A medical cannabis manufacturer may charge patients enrolled in the registry program
 90.30 a reasonable fee for costs associated with the operations of the manufacturer. The
 90.31 manufacturer may establish a sliding scale of patient fees based upon a patient's household
 90.32 income and may accept private donations to reduce patient fees.

91.1 Sec. 90. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to
91.2 read:

91.3 Sec. 44. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING**
91.4 **EDUCATION GRANT PROGRAM.**

91.5 (a) The commissioner of health shall develop a grant program, in consultation with the
91.6 relevant mental health licensing boards, to:

91.7 (1) provide for the continuing education necessary for social workers, marriage and
91.8 family therapists, psychologists, and professional clinical counselors to become supervisors
91.9 for individuals pursuing licensure in mental health professions;

91.10 (2) cover the costs when supervision is required for professionals becoming supervisors;
91.11 and

91.12 (3) cover the supervisory costs for mental health practitioners pursuing licensure at the
91.13 professional level.

91.14 (b) Social workers, marriage and family therapists, psychologists, and professional
91.15 clinical counselors obtaining continuing education and social workers, marriage and family
91.16 therapists, and clinical counselors needing supervised hours to become licensed under this
91.17 section must:

91.18 (1) be members of communities of color or underrepresented communities as defined
91.19 in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health
91.20 professional shortage area; and

91.21 (2) ~~work for community mental health providers and~~ agree to deliver at least 25 percent
91.22 of their yearly patient encounters to state public program enrollees or patients receiving
91.23 sliding fee schedule discounts through a formal sliding fee schedule meeting the standards
91.24 established by the United States Department of Health and Human Services under Code of
91.25 Federal Regulations, title 42, section 51, chapter 303.

91.26 Sec. 91. **BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM**
91.27 **PROPOSAL.**

91.28 Subdivision 1. **Contract for analysis of proposal.** The commissioner of health shall
91.29 contract with the University of Minnesota School of Public Health and the Carlson School
91.30 of Management to conduct an analysis of the benefits and costs of a legislative proposal for
91.31 a universal health care financing system and a similar analysis of the current health care
91.32 financing system to assist the state in comparing the proposal to the current system.

92.1 Subd. 2. **Proposal.** The commissioner of health, with input from the commissioners of
 92.2 human services and commerce, shall submit to the University of Minnesota for analysis a
 92.3 legislative proposal known as the Minnesota Health Plan that would offer a universal health
 92.4 care plan designed to meet the following principles:

92.5 (1) ensure all Minnesotans are covered;

92.6 (2) cover all necessary care, including dental, vision and hearing, mental health, chemical
 92.7 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
 92.8 and home care; and

92.9 (3) allow patients to choose their doctors, hospitals, and other providers.

92.10 Subd. 3. **Proposal analysis.** (a) The analysis must measure the performance of both the
 92.11 Minnesota Health Plan and the current health care financing system over a ten-year period
 92.12 to contrast the impact on:

92.13 (1) the number of people covered versus the number of people who continue to lack
 92.14 access to health care because of financial or other barriers, if any;

92.15 (2) the completeness of the coverage and the number of people lacking coverage for
 92.16 dental, long-term care, medical equipment or supplies, vision and hearing, or other health
 92.17 services that are not covered, if any;

92.18 (3) the adequacy of the coverage, the level of underinsured in the state, and whether
 92.19 people with coverage can afford the care they need or whether cost prevents them from
 92.20 accessing care;

92.21 (4) the timeliness and appropriateness of the care received and whether people turn to
 92.22 inappropriate care such as emergency rooms because of a lack of proper care in accordance
 92.23 with clinical guidelines; and

92.24 (5) total public and private health care spending in Minnesota under the current system
 92.25 versus under the legislative proposal, including all spending by individuals, businesses, and
 92.26 government. "Total public and private health care spending" means spending on all medical
 92.27 care including but not limited to dental, vision and hearing, mental health, chemical
 92.28 dependency treatment, prescription drugs, medical equipment and supplies, long-term care,
 92.29 and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket
 92.30 payments, or other funding from government, employers, or other sources. Total public and
 92.31 private health care spending also includes the costs associated with administering, delivering,
 92.32 and paying for the care. The costs of administering, delivering, and paying for the care
 92.33 includes all expenses by insurers, providers, employers, individuals, and government to

93.1 select, negotiate, purchase, and administer insurance and care including but not limited to
93.2 coverage for health care, dental, long-term care, prescription drugs, medical expense portions
93.3 of workers compensation and automobile insurance, and the cost of administering and
93.4 paying for all health care products and services that are not covered by insurance. The
93.5 analysis of total health care spending shall examine whether there are savings or additional
93.6 costs under the legislative proposal compared to the existing system due to:

93.7 (i) reduced insurance, billing, underwriting, marketing, evaluation, and other
93.8 administrative functions including savings from global budgeting for hospitals and
93.9 institutional care instead of billing for individual services provided;

93.10 (ii) reduced prices on medical services and products including pharmaceuticals due to
93.11 price negotiations, if applicable under the proposal;

93.12 (iii) changes in utilization, better health outcomes, and reduced time away from work
93.13 due to prevention, early intervention, health-promoting activities, and to the extent possible
93.14 given available data and resources;

93.15 (iv) shortages or excess capacity of medical facilities and equipment under either the
93.16 current system or the proposal;

93.17 (v) the impact on state, local, and federal government non-health-care expenditures such
93.18 as reduced crime and out-of-home placement costs due to mental health or chemical
93.19 dependency coverage; and

93.20 (vi) job losses or gains in health care delivery, health billing and insurance administration,
93.21 and elsewhere in the economy under the proposal due to implementation of the reforms and
93.22 the resulting reduction of insurance and administrative burdens on businesses.

93.23 (b) The analysts may consult with authors of the legislative proposal to gain understanding
93.24 or clarification of the specifics of the proposal. The analysis shall assume that the provisions
93.25 in the proposal are not preempted by federal law or that the federal government gives a
93.26 waiver to the preemptions.

93.27 (c) The commissioner shall issue a final report by January 15, 2023, and may provide
93.28 interim reports and status updates to the governor and the chairs and ranking minority
93.29 members of the legislative committees with jurisdiction over health and human services
93.30 policy and finance.

94.1 Sec. 92. **DIRECTION TO THE COMMISSIONER OF HEALTH; EXPANSION OF**
 94.2 **THE NURSING WORKFORCE REPORT.**

94.3 The commissioner of health shall expand the commissioner's existing license renewal
 94.4 questionnaires authorized under Minnesota Statutes, sections 144.051 and 144.052, to
 94.5 include the collection, analysis, and reporting of data on the following topics:

- 94.6 (1) Minnesota's supply of active licensed registered nurses;
 94.7 (2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;
 94.8 (3) reasons licensed registered nurses are leaving direct care positions at hospitals; and
 94.9 (4) reasons licensed registered nurses are choosing not to renew their licenses and leaving
 94.10 the profession.

94.11 Sec. 93. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

94.12 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
 94.13 Recovery Program.

94.14 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
 94.15 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
 94.16 of victims who experienced trauma, including historical trauma, resulting from
 94.17 government-sponsored activities, and to address the health and wellness needs of the families
 94.18 and heirs of these victims.

94.19 (b) The commissioner, in consultation with family members of victims who experienced
 94.20 trauma resulting from government-sponsored activities and with community-based
 94.21 organizations that provide culturally appropriate services to victims experiencing trauma
 94.22 and their families, shall award competitive grants to applicants for projects to provide the
 94.23 following services to victims who experienced trauma resulting from government-sponsored
 94.24 activities and their families and heirs:

94.25 (1) health and wellness services, which may include services and support to address
 94.26 physical health, mental health, and cultural needs;

94.27 (2) remembrance and legacy preservation activities;

94.28 (3) cultural awareness services; and

94.29 (4) community resources and services to promote healing for victims who experienced
 94.30 trauma resulting from government-sponsored activities and their families and heirs.

95.1 (c) In awarding grants under this section, the commissioner must prioritize grant awards
95.2 to community-based organizations experienced in providing support and services to victims
95.3 and families who experienced trauma resulting from government-sponsored activities.

95.4 Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information
95.5 required by the commissioner to evaluate the grant program, in a time and manner specified
95.6 by the commissioner.

95.7 Subd. 4. **Report.** By January 15, 2023, the commissioner must submit a status report
95.8 on the operation and results of the grant program, to the extent possible. The report must
95.9 be submitted to the chairs and ranking minority members of the legislative committees with
95.10 jurisdiction over health care. The report must include information on grant program activities
95.11 to date, services offered by grant recipients, and an assessment of the need to continue to
95.12 offer services to victims, families, and heirs who experienced trauma resulting from
95.13 government-sponsored activities.

95.14 Sec. 94. **IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE**
95.15 **SPENDING AND LOW-VALUE CARE; REPORT.**

95.16 (a) The commissioner of health shall develop recommendations for strategies to reduce
95.17 the volume and growth of administrative spending by health care organizations and group
95.18 purchasers and the amount of low-value care delivered to Minnesota residents. In support
95.19 of the development of recommendations, the commissioner shall:

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

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

95.24 (3) conduct an environmental scan and key informant interviews with experts in health
95.25 care finance, health economics, health care management or administration, or the
95.26 administration of health insurance benefits to identify drivers of spending growth for spending
95.27 on administrative services or the provision of low-value care; and

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

96.1 (b) By December 15, 2024, the commissioner shall report the recommendations to the
 96.2 chairs and ranking members of the legislative committees with jurisdiction over health and
 96.3 human services financing and policy.

96.4 **Sec. 95. INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE**
 96.5 **BEDSIDE ACT.**

96.6 (a) By April 1, 2024, each hospital must establish and convene a hospital nurse staffing
 96.7 committee as described under Minnesota Statutes, section 144.7053.

96.8 (b) By June 1, 2024, each hospital must implement core staffing plans developed by its
 96.9 hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota
 96.10 Statutes, section 144.7056.

96.11 (c) By June 1, 2024, each hospital must submit to the commissioner of health core
 96.12 staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

96.13 **Sec. 96. PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

96.14 The commissioner shall develop a plan to assess readiness of rural communities and
 96.15 rural health care providers to adopt value-based, global budgeting, or alternative payment
 96.16 systems and recommend steps needed to implement. The commissioner may use the
 96.17 development of case studies and modeling of alternate payment systems to demonstrate
 96.18 value-based payment systems that ensure a baseline level of essential community or regional
 96.19 health services and address population health needs. The commissioner shall develop
 96.20 recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial
 96.21 viability of rural health care systems in the context of spending growth targets. The
 96.22 commissioner shall share findings with the Minnesota Health Care Spending Growth Target
 96.23 Commission.

96.24 **Sec. 97. PROGRAM TO DISTRIBUTE COVID-19 TESTS, MASKS, AND**
 96.25 **RESPIRATORS.**

96.26 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

96.27 (b) "Antigen test" means a lateral flow immunoassay intended for the qualitative detection
 96.28 of nucleocapsid protein antigens from the SARS-CoV-2 virus in nasal swabs, that has
 96.29 emergency use authorization from the United States Food and Drug Administration and
 96.30 that is authorized for nonprescription home use with self-collected nasal swabs.

97.1 (c) "COVID-19 test" means a test authorized by the United States Food and Drug
97.2 Administration to detect the presence of genetic material of the SARS-CoV-2 virus either
97.3 through a molecular method that detects the RNA or nucleic acid component of the virus,
97.4 such as polymerase chain reaction or isothermal amplification, or through a rapid lateral
97.5 flow immunoassay that detects the nucleocapsid protein antigens from the SARS-CoV-2
97.6 virus.

97.7 (d) "KN95 respirator" means a type of filtering facepiece respirator that is commonly
97.8 made and used in China, is designed and tested to meet an international standard, and does
97.9 not include an exhalation valve.

97.10 (e) "Mask" means a face covering intended to contain droplets and particles in a person's
97.11 breath, cough, or sneeze.

97.12 (f) "Respirator" means a face covering that filters the air and fits closely on the face to
97.13 filter out particles, including the SARS-CoV-2 virus.

97.14 Subd. 2. **Program established.** In order to help reduce the number of cases of COVID-19
97.15 in the state, the commissioner of health must administer a program to distribute to individuals
97.16 in Minnesota, COVID-19 tests, including antigen tests; and masks and respirators, including
97.17 KN95 respirators and similar respirators approved by the Centers for Disease Control and
97.18 Prevention and authorized by the commissioner for distribution under this program. Masks
97.19 and respirators distributed under this program may include child-sized masks and respirators,
97.20 if such masks and respirators are available and the commissioner finds there is a need for
97.21 them. COVID-19 tests, masks, and respirators must be distributed at no cost to the individuals
97.22 receiving them and may be shipped directly to individuals; distributed through local health
97.23 departments, COVID community coordinators, and other community-based organizations;
97.24 and distributed through other means determined by the commissioner. The commissioner
97.25 may prioritize distribution under this section to communities and populations who are
97.26 disproportionately impacted by COVID-19 or who have difficulty accessing COVID-19
97.27 tests, masks, or respirators.

97.28 Subd. 3. **Process to order COVID-19 tests, masks, and respirators.** The commissioner
97.29 may establish a process for individuals to order COVID-19 tests, masks, and respirators to
97.30 be shipped directly to the individual.

97.31 Subd. 4. **Notice.** An entity distributing KN95 respirators or similar respirators under this
97.32 section may include with the respirators a notice that individuals with a medical condition
97.33 that may make it difficult to wear a KN95 respirator or similar respirator should consult
97.34 with a health care provider before use.

98.1 Subd. 5. **Coordination.** The commissioner may coordinate this program with other state
98.2 and federal programs that distribute COVID-19 tests, masks, or respirators to the public.

98.3 Sec. 98. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

98.4 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

98.5 (b) "Commissioner" means the commissioner of health.

98.6 (c) "Non-claims-based payments" means payments to health care providers designed to
98.7 support and reward value of health care services over volume of health care services and
98.8 includes alternative payment models or incentives, payments for infrastructure expenditures
98.9 or investments, and payments for workforce expenditures or investments.

98.10 (d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02,
98.11 subdivision 9.

98.12 (e) "Primary care services" means integrated, accessible health care services provided
98.13 by clinicians who are accountable for addressing a large majority of personal health care
98.14 needs, developing a sustained partnership with patients, and practicing in the context of
98.15 family and community. Primary care services include but are not limited to preventive
98.16 services, office visits, administration of vaccines, annual physicals, pre-operative physicals,
98.17 assessments, care coordination, development of treatment plans, management of chronic
98.18 conditions, and diagnostic tests.

98.19 Subd. 2. **Report.** (a) To provide the legislature with information needed to meet the
98.20 evolving health care needs of Minnesotans, the commissioner shall report to the legislature
98.21 by February 15, 2023, on the volume and distribution of health care spending across payment
98.22 models used by health plan companies and third-party administrators, with a particular focus
98.23 on value-based care models and primary care spending.

98.24 (b) The report must include specific health plan and third-party administrator estimates
98.25 of health care spending for claims-based payments and non-claims-based payments for the
98.26 most recent available year, reported separately for Minnesotans enrolled in state health care
98.27 programs, Medicare Advantage, and commercial health insurance. The report must also
98.28 include recommendations on changes needed to gather better data from health plan companies
98.29 and third-party administrators on the use of value-based payments that pay for value of
98.30 health care services provided over volume of services provided, promote the health of all
98.31 Minnesotans, reduce health disparities, and support the provision of primary care services
98.32 and preventive services.

98.33 (c) In preparing the report, the commissioner shall:

99.1 (1) describe the form, manner, and timeline for submission of data by health plan
 99.2 companies and third-party administrators to produce estimates as specified in paragraph
 99.3 (b);

99.4 (2) collect summary data that permits the computation of:

99.5 (i) the percentage of total payments that are non-claims-based payments; and

99.6 (ii) the percentage of payments in item (i) that are for primary care services;

99.7 (3) where data was not directly derived, specify the methods used to estimate data
 99.8 elements;

99.9 (4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses
 99.10 of the magnitude of primary care payments using data collected by the commissioner under
 99.11 Minnesota Statutes, section 62U.04; and

99.12 (5) conduct interviews with health plan companies and third-party administrators to
 99.13 better understand the types of non-claims-based payments and models in use, the purposes
 99.14 or goals of each, the criteria for health care providers to qualify for these payments, and the
 99.15 timing and structure of health plan companies or third-party administrators making these
 99.16 payments to health care provider organizations.

99.17 (d) Health plan companies and third-party administrators must comply with data requests
 99.18 from the commissioner under this section within 60 days after receiving the request.

99.19 (e) Data collected under this section are nonpublic data. Notwithstanding the definition
 99.20 of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared
 99.21 under this section may be derived from nonpublic data. The commissioner shall establish
 99.22 procedures and safeguards to protect the integrity and confidentiality of any data maintained
 99.23 by the commissioner.

99.24 **Sec. 99. SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM**
 99.25 **CARE FACILITIES.**

99.26 **Subdivision 1. Temporary grant program for long-term care safety**
 99.27 **improvements.** The commissioner of health shall develop, implement, and manage a
 99.28 temporary, competitive grant process for state-licensed long-term care facilities to improve
 99.29 their ability to reduce the transmission of COVID-19 or other similar conditions.

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

99.32 (b) "Eligible facility" means:

100.1 (1) an assisted living facility licensed under chapter 144G;

100.2 (2) a supervised living facility licensed under chapter 144;

100.3 (3) a board and care facility that is not federally certified and is licensed under chapter
100.4 144; and

100.5 (4) a nursing home that is not federally certified and is licensed under chapter 144A.

100.6 (c) "Eligible project" means a modernization project to update, remodel or replace
100.7 outdated equipment, systems, technology, or physical spaces.

100.8 Subd. 3. **Program.** (a) The commissioner of health shall award improvement grants to
100.9 an eligible facility. An improvement grant shall not exceed \$1,250,000.

100.10 (b) Funds may be used to improve the safety, quality of care, and livability of aging
100.11 infrastructure in a Department of Health licensed eligible facility with an emphasis on
100.12 reducing the transmission risk of COVID-19 and other infections. Projects include but are
100.13 not limited to:

100.14 (1) heating, ventilation, and air-conditioning systems improvements to reduce airborne
100.15 exposures;

100.16 (2) physical space changes for infection control; and

100.17 (3) technology improvements to reduce social isolation and improve resident or client
100.18 well-being.

100.19 (c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not
100.20 lapse until expended by the grantee.

100.21 Subd. 4. **Applications.** An eligible facility seeking a grant shall apply to the
100.22 commissioner. The application must include a description of the resident population
100.23 demographics, the problem the proposed project will address, a description of the project
100.24 including construction and remodeling drawings or specifications, sources of funds for the
100.25 project, including any in-kind resources, uses of funds for the project, the results expected,
100.26 and a plan to maintain or operate any facility or equipment included in the project. The
100.27 applicant must describe achievable objectives, a timetable, and roles and capabilities of
100.28 responsible individuals and organization. An applicant must submit to the commissioner
100.29 evidence that competitive bidding was used to select contractors for the project.

100.30 Subd. 5. **Consideration of applications.** The commissioner shall review each application
100.31 to determine if the application is complete and if the facility and the project are eligible for
100.32 a grant. In evaluating applications, the commissioner shall develop a standardized scoring

101.1 system that assesses: (1) the applicant's understanding of the problem, description of the
101.2 project and the likelihood of a successful outcome of the project; (2) the extent to which
101.3 the project will reduce the transmission of COVID-19; (3) the extent to which the applicant
101.4 has demonstrated that it has made adequate provisions to ensure proper and efficient operation
101.5 of the facility once the project is completed; (4) and other relevant factors as determined
101.6 by the commissioner. During application review, the commissioner may request additional
101.7 information about a proposed project, including information on project cost. Failure to
101.8 provide the information requested disqualifies an applicant.

101.9 Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant
101.10 to be given to an eligible facility based on the relative score of each eligible facility's
101.11 application, other relevant factors discussed during the review, and the funds available to
101.12 the commissioner. During the grant period and within one year after completion of the grant
101.13 period, the commissioner may collect from an eligible facility receiving a grant, any
101.14 information necessary to evaluate the program.

101.15 Subd. 7. **Expiration.** This section expires June 30, 2025.

101.16 Sec. 100. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
101.17 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

101.20 (b) "Commissioner" means the commissioner of health.

101.21 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
101.22 medical device, or medical intervention that maintains life by sustaining, restoring, or
101.23 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
101.24 to sustain patient cleanliness and comfort.

101.25 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
101.26 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
101.27 preferences of a patient with an advanced serious illness who is nearing the end of their
101.28 life are honored.

101.29 (e) "POLST form" means a portable medical form used to communicate a physician's
101.30 order to help ensure that a patient's medical treatment preferences are conveyed to emergency
101.31 medical service personnel and other health care providers.

101.32 Subd. 2. **Study.** (a) The commissioner, in consultation with the advisory committee
101.33 established in paragraph (c), shall study the issues related to creating a statewide registry

102.1 of POLST forms to ensure that a patient's medical treatment preferences are followed by
102.2 all health care providers. The registry must allow for the submission of completed POLST
102.3 forms and for the forms to be accessed by health care providers and emergency medical
102.4 service personnel in a timely manner, for the provision of care or services.

102.5 (b) As a part of the study, the commissioner shall develop recommendations on the
102.6 following:

102.7 (1) electronic capture, storage, and security of information in the registry;

102.8 (2) procedures to protect the accuracy and confidentiality of information submitted to
102.9 the registry;

102.10 (3) limits as to who can access the registry;

102.11 (4) where the registry should be housed;

102.12 (5) ongoing funding models for the registry; and

102.13 (6) any other action needed to ensure that patients' rights are protected and that their
102.14 health care decisions are followed.

102.15 (c) The commissioner shall create an advisory committee with members representing
102.16 physicians, physician assistants, advanced practice registered nurses, nursing homes,
102.17 emergency medical system providers, hospice and palliative care providers, the disability
102.18 community, attorneys, medical ethicists, and the religious community.

102.19 Subd. 3. **Report.** The commissioner shall submit a report on the results of the study,
102.20 including recommendations on establishing a statewide registry of POLST forms, to the
102.21 chairs and ranking minority members of the legislative committees with jurisdiction over
102.22 health and human services policy and finance by February 1, 2023.

102.23 Sec. 101. **REVISOR INSTRUCTION.**

102.24 (a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article
102.25 3, section 44, as Minnesota Statutes, section 144.1504. The revisor of statutes may make
102.26 any necessary cross-reference changes.

102.27 (b) The revisor of statutes shall correct cross-references in Minnesota Statutes to conform
102.28 with the relettering of paragraphs in Minnesota Statutes, section 144.1501, subdivision 1.

102.29 (c) In Minnesota Statutes, section 144.7055, the revisor shall renumber paragraphs (b)
102.30 to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051.
102.31 The revisor shall make any necessary changes to sentence structure for this renumbering

103.1 while preserving the meaning of the text. The revisor shall also make necessary
 103.2 cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
 103.3 renumbering.

103.4 (d) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and
 103.5 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall
 103.6 also make necessary cross-reference changes consistent with the renumbering.

103.7 (e) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and
 103.8 145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall
 103.9 also make necessary cross-reference changes consistent with the renumbering.

103.10 ARTICLE 2

103.11 DEPARTMENT OF HEALTH POLICY

103.12 Section 1. Minnesota Statutes 2021 Supplement, section 144.0724, subdivision 4, is
 103.13 amended to read:

103.14 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 103.15 submit to the federal database MDS assessments that conform with the assessment schedule
 103.16 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,
 103.17 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The
 103.18 commissioner of health may substitute successor manuals or question and answer documents
 103.19 published by the United States Department of Health and Human Services, Centers for
 103.20 Medicare and Medicaid Services, to replace or supplement the current version of the manual
 103.21 or document.

103.22 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987
 103.23 (OBRA) used to determine a case mix classification for reimbursement include ~~the following:~~

103.24 (1) a new admission comprehensive assessment, which must have an assessment reference
 103.25 date (ARD) within 14 calendar days after admission, excluding readmissions;

103.26 (2) an annual comprehensive assessment, which must have an ARD within 92 days of
 103.27 a previous quarterly review assessment or a previous comprehensive assessment, which
 103.28 must occur at least once every 366 days;

103.29 (3) a significant change in status comprehensive assessment, which must have an ARD
 103.30 within 14 days after the facility determines, or should have determined, that there has been
 103.31 a significant change in the resident's physical or mental condition, whether an improvement

104.1 or a decline, and regardless of the amount of time since the last comprehensive assessment
 104.2 or quarterly review assessment;

104.3 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the
 104.4 previous quarterly review assessment or a previous comprehensive assessment;

104.5 (5) any significant correction to a prior comprehensive assessment, if the assessment
 104.6 being corrected is the current one being used for RUG classification;

104.7 (6) any significant correction to a prior quarterly review assessment, if the assessment
 104.8 being corrected is the current one being used for RUG classification;

104.9 (7) a required significant change in status assessment when:

104.10 (i) all speech, occupational, and physical therapies have ended. If the most recent OBRA
 104.11 comprehensive or quarterly assessment completed does not result in a rehabilitation case
 104.12 mix classification, then the significant change in status assessment is not required. The ARD
 104.13 of this assessment must be set on day eight after all therapy services have ended; and

104.14 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most
 104.15 recent OBRA comprehensive or quarterly assessment completed, then the significant change
 104.16 in status assessment is not required. The ARD of this assessment must be set on day 15 after
 104.17 isolation has ended; and

104.18 (8) any modifications to the most recent assessments under clauses (1) to (7).

104.19 (c) In addition to the assessments listed in paragraph (b), the assessments used to
 104.20 determine nursing facility level of care include the following:

104.21 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
 104.22 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
 104.23 Aging; and

104.24 (2) a nursing facility level of care determination as provided for under section 256B.0911,
 104.25 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
 104.26 under section 256B.0911, by a county, tribe, or managed care organization under contract
 104.27 with the Department of Human Services.

104.28 Sec. 2. Minnesota Statutes 2020, section 144.1201, subdivision 2, is amended to read:

104.29 Subd. 2. ~~By-product nuclear~~ Byproduct material. "~~By-product nuclear~~ Byproduct
 104.30 material" means ~~a radioactive material, other than special nuclear material, yielded in or~~
 104.31 ~~made radioactive by exposure to radiation created incident to the process of producing or~~
 104.32 ~~utilizing special nuclear material.;~~

105.1 (1) any radioactive material, except special nuclear material, yielded in or made
 105.2 radioactive by exposure to the radiation incident to the process of producing or using special
 105.3 nuclear material;

105.4 (2) the tailings or wastes produced by the extraction or concentration of uranium or
 105.5 thorium from ore processed primarily for its source material content, including discrete
 105.6 surface wastes resulting from uranium solution extraction processes. Underground ore
 105.7 bodies depleted by these solution extraction operations do not constitute byproduct material
 105.8 within this definition;

105.9 (3) any discrete source of radium-226 that is produced, extracted, or converted after
 105.10 extraction for commercial, medical, or research activity, or any material that:

105.11 (i) has been made radioactive by use of a particle accelerator; and

105.12 (ii) is produced, extracted, or converted after extraction for commercial, medical, or
 105.13 research activity; and

105.14 (4) any discrete source of naturally occurring radioactive material, other than source
 105.15 nuclear material, that:

105.16 (i) the United States Nuclear Regulatory Commission, in consultation with the
 105.17 Administrator of the Environmental Protection Agency, the Secretary of Energy, the Secretary
 105.18 of Homeland Security, and the head of any other appropriate federal agency determines
 105.19 would pose a threat similar to the threat posed by a discrete source of radium-226 to the
 105.20 public health and safety or the common defense and security; and

105.21 (ii) is extracted or converted after extraction for use in a commercial, medical, or research
 105.22 activity.

105.23 Sec. 3. Minnesota Statutes 2020, section 144.1201, subdivision 4, is amended to read:

105.24 Subd. 4. **Radioactive material.** "Radioactive material" means a matter that emits
 105.25 radiation. Radioactive material includes special nuclear material, source nuclear material,
 105.26 and ~~by-product nuclear~~ byproduct material.

105.27 Sec. 4. Minnesota Statutes 2021 Supplement, section 144.1481, subdivision 1, is amended
 105.28 to read:

105.29 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
 105.30 a ~~16-member~~ 21-member Rural Health Advisory Committee. The committee shall consist

106.1 of the following members, all of whom must reside outside the seven-county metropolitan
106.2 area, as defined in section 473.121, subdivision 2:

106.3 (1) two members from the house of representatives of the state of Minnesota, one from
106.4 the majority party and one from the minority party;

106.5 (2) two members from the senate of the state of Minnesota, one from the majority party
106.6 and one from the minority party;

106.7 (3) a volunteer member of an ambulance service based outside the seven-county
106.8 metropolitan area;

106.9 (4) a representative of a hospital located outside the seven-county metropolitan area;

106.10 (5) a representative of a nursing home located outside the seven-county metropolitan
106.11 area;

106.12 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

106.13 (7) a dentist licensed under chapter 150A;

106.14 (8) ~~a midlevel practitioner~~ an advanced practice provider;

106.15 (9) a registered nurse or licensed practical nurse;

106.16 (10) a licensed health care professional from an occupation not otherwise represented
106.17 on the committee;

106.18 (11) a representative of an institution of higher education located outside the seven-county
106.19 metropolitan area that provides training for rural health care providers; ~~and~~

106.20 (12) a member of a Tribal nation;

106.21 (13) a representative of a local public health agency or community health board;

106.22 (14) a health professional or advocate with experience working with people with mental
106.23 illness;

106.24 (15) a representative of a community organization that works with individuals
106.25 experiencing health disparities;

106.26 (16) an individual with expertise in economic development, or an employer working
106.27 outside the seven-county metropolitan area; and

106.28 ~~(12)~~ (17) three consumers, at least one of whom must be an advocate for persons who
106.29 ~~are mentally ill or developmentally disabled~~ from a community experiencing health
106.30 disparities.

107.1 The commissioner will make recommendations for committee membership. Committee
107.2 members will be appointed by the governor. In making appointments, the governor shall
107.3 ensure that appointments provide geographic balance among those areas of the state outside
107.4 the seven-county metropolitan area. The chair of the committee shall be elected by the
107.5 members. The advisory committee is governed by section 15.059, except that the members
107.6 do not receive per diem compensation.

107.7 Sec. 5. Minnesota Statutes 2020, section 144.497, is amended to read:

107.8 **144.497 ST ELEVATION MYOCARDIAL INFARCTION.**

107.9 The commissioner of health shall assess ~~and report on~~ the quality of care provided in
107.10 the state for ST elevation myocardial infarction response and treatment. The commissioner
107.11 shall:

107.12 (1) utilize and analyze data provided by ST elevation myocardial infarction receiving
107.13 centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that
107.14 does not identify individuals or associate specific ST elevation myocardial infarction heart
107.15 attack events with an identifiable individual; and

107.16 ~~(2) quarterly post a summary report of the data in aggregate form on the Department of~~
107.17 ~~Health website;~~

107.18 ~~(3) annually inform the legislative committees with jurisdiction over public health of~~
107.19 ~~progress toward improving the quality of care and patient outcomes for ST elevation~~
107.20 ~~myocardial infarctions; and~~

107.21 ~~(4)~~ (2) coordinate to the extent possible with national voluntary health organizations
107.22 involved in ST elevation myocardial infarction heart attack quality improvement to encourage
107.23 ST elevation myocardial infarction receiving centers to report data consistent with nationally
107.24 recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial
107.25 infarction heart attacks within the state and encourage sharing of information among health
107.26 care providers on ways to improve the quality of care of ST elevation myocardial infarction
107.27 patients in Minnesota.

107.28 Sec. 6. Minnesota Statutes 2021 Supplement, section 144.551, subdivision 1, is amended
107.29 to read:

107.30 Subdivision 1. **Restricted construction or modification.** (a) The following construction
107.31 or modification may not be commenced:

108.1 (1) any erection, building, alteration, reconstruction, modernization, improvement,
108.2 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
108.3 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
108.4 to another, or otherwise results in an increase or redistribution of hospital beds within the
108.5 state; and

108.6 (2) the establishment of a new hospital.

108.7 (b) This section does not apply to:

108.8 (1) construction or relocation within a county by a hospital, clinic, or other health care
108.9 facility that is a national referral center engaged in substantial programs of patient care,
108.10 medical research, and medical education meeting state and national needs that receives more
108.11 than 40 percent of its patients from outside the state of Minnesota;

108.12 (2) a project for construction or modification for which a health care facility held an
108.13 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
108.14 certificate;

108.15 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
108.16 appeal results in an order reversing the denial;

108.17 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
108.18 section 2;

108.19 (5) a project involving consolidation of pediatric specialty hospital services within the
108.20 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
108.21 of pediatric specialty hospital beds among the hospitals being consolidated;

108.22 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
108.23 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
108.24 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
108.25 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
108.26 hospitals must be reinstated at the capacity that existed on each site before the relocation;

108.27 (7) the relocation or redistribution of hospital beds within a hospital building or
108.28 identifiable complex of buildings provided the relocation or redistribution does not result
108.29 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
108.30 one physical site or complex to another; or (iii) redistribution of hospital beds within the
108.31 state or a region of the state;

108.32 (8) relocation or redistribution of hospital beds within a hospital corporate system that
108.33 involves the transfer of beds from a closed facility site or complex to an existing site or

109.1 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
109.2 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
109.3 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
109.4 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution
109.5 does not involve the construction of a new hospital building; and (v) the transferred beds
109.6 are used first to replace within the hospital corporate system the total number of beds
109.7 previously used in the closed facility site or complex for mental health services and substance
109.8 use disorder services. Only after the hospital corporate system has fulfilled the requirements
109.9 of this item may the remainder of the available capacity of the closed facility site or complex
109.10 be transferred for any other purpose;

109.11 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
109.12 County that primarily serves adolescents and that receives more than 70 percent of its
109.13 patients from outside the state of Minnesota;

109.14 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
109.15 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
109.16 and (ii) the total licensed capacity of the replacement hospital, either at the time of
109.17 construction of the initial building or as the result of future expansion, will not exceed 70
109.18 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

109.19 (11) the relocation of licensed hospital beds from an existing state facility operated by
109.20 the commissioner of human services to a new or existing facility, building, or complex
109.21 operated by the commissioner of human services; from one regional treatment center site
109.22 to another; or from one building or site to a new or existing building or site on the same
109.23 campus;

109.24 (12) the construction or relocation of hospital beds operated by a hospital having a
109.25 statutory obligation to provide hospital and medical services for the indigent that does not
109.26 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
109.27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
109.28 Medical Center to Regions Hospital under this clause;

109.29 (13) a construction project involving the addition of up to 31 new beds in an existing
109.30 nonfederal hospital in Beltrami County;

109.31 (14) a construction project involving the addition of up to eight new beds in an existing
109.32 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

109.33 (15) a construction project involving the addition of 20 new hospital beds in an existing
109.34 hospital in Carver County serving the southwest suburban metropolitan area;

110.1 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
110.2 of up to two psychiatric facilities or units for children provided that the operation of the
110.3 facilities or units have received the approval of the commissioner of human services;

110.4 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
110.5 services in an existing hospital in Itasca County;

110.6 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
110.7 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
110.8 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
110.9 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

110.10 (19) a critical access hospital established under section 144.1483, clause (9), and section
110.11 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
110.12 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
110.13 to the extent that the critical access hospital does not seek to exceed the maximum number
110.14 of beds permitted such hospital under federal law;

110.15 (20) notwithstanding section 144.552, a project for the construction of a new hospital
110.16 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

110.17 (i) the project, including each hospital or health system that will own or control the entity
110.18 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
110.19 Council as of March 1, 2006;

110.20 (ii) the entity that will hold the new hospital license will be owned or controlled by one
110.21 or more not-for-profit hospitals or health systems that have previously submitted a plan or
110.22 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
110.23 have been found to be in the public interest by the commissioner of health as of April 1,
110.24 2005;

110.25 (iii) the new hospital's initial inpatient services must include, but are not limited to,
110.26 medical and surgical services, obstetrical and gynecological services, intensive care services,
110.27 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
110.28 services, and emergency room services;

110.29 (iv) the new hospital:

110.30 (A) will have the ability to provide and staff sufficient new beds to meet the growing
110.31 needs of the Maple Grove service area and the surrounding communities currently being
110.32 served by the hospital or health system that will own or control the entity that will hold the
110.33 new hospital license;

- 111.1 (B) will provide uncompensated care;
- 111.2 (C) will provide mental health services, including inpatient beds;
- 111.3 (D) will be a site for workforce development for a broad spectrum of health-care-related
111.4 occupations and have a commitment to providing clinical training programs for physicians
111.5 and other health care providers;
- 111.6 (E) will demonstrate a commitment to quality care and patient safety;
- 111.7 (F) will have an electronic medical records system, including physician order entry;
- 111.8 (G) will provide a broad range of senior services;
- 111.9 (H) will provide emergency medical services that will coordinate care with regional
111.10 providers of trauma services and licensed emergency ambulance services in order to enhance
111.11 the continuity of care for emergency medical patients; and
- 111.12 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
111.13 the control of the entity holding the new hospital license; and
- 111.14 (v) as of 30 days following submission of a written plan, the commissioner of health
111.15 has not determined that the hospitals or health systems that will own or control the entity
111.16 that will hold the new hospital license are unable to meet the criteria of this clause;
- 111.17 (21) a project approved under section 144.553;
- 111.18 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
111.19 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
111.20 is approved by the Cass County Board;
- 111.21 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
111.22 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
111.23 a separately licensed 13-bed skilled nursing facility;
- 111.24 (24) notwithstanding section 144.552, a project for the construction and expansion of a
111.25 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
111.26 who are under 21 years of age on the date of admission. The commissioner conducted a
111.27 public interest review of the mental health needs of Minnesota and the Twin Cities
111.28 metropolitan area in 2008. No further public interest review shall be conducted for the
111.29 construction or expansion project under this clause;
- 111.30 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
111.31 commissioner finds the project is in the public interest after the public interest review
111.32 conducted under section 144.552 is complete;

112.1 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
112.2 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
112.3 admission, if the commissioner finds the project is in the public interest after the public
112.4 interest review conducted under section 144.552 is complete;

112.5 (ii) this project shall serve patients in the continuing care benefit program under section
112.6 256.9693. The project may also serve patients not in the continuing care benefit program;
112.7 and

112.8 (iii) if the project ceases to participate in the continuing care benefit program, the
112.9 commissioner must complete a subsequent public interest review under section 144.552. If
112.10 the project is found not to be in the public interest, the license must be terminated six months
112.11 from the date of that finding. If the commissioner of human services terminates the contract
112.12 without cause or reduces per diem payment rates for patients under the continuing care
112.13 benefit program below the rates in effect for services provided on December 31, 2015, the
112.14 project may cease to participate in the continuing care benefit program and continue to
112.15 operate without a subsequent public interest review;

112.16 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
112.17 in Hennepin County that is exclusively for patients who are under 21 years of age on the
112.18 date of admission;

112.19 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
112.20 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
112.21 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
112.22 In addition, five unlicensed observation mental health beds shall be added;

112.23 (29) upon submission of a plan to the commissioner for public interest review under
112.24 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause
112.25 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I
112.26 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision
112.27 5. Five of the 45 additional beds authorized under this clause must be designated for use
112.28 for inpatient mental health and must be added to the hospital's bed capacity before the
112.29 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed
112.30 beds under this clause prior to completion of the public interest review, provided the hospital
112.31 submits its plan by the 2021 deadline and adheres to the timelines for the public interest
112.32 review described in section 144.552; ~~or~~

112.33 (30) upon submission of a plan to the commissioner for public interest review under
112.34 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital

113.1 in Hennepin County that exclusively provides care to patients who are under 21 years of
 113.2 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital
 113.3 may add licensed beds under this clause prior to completion of the public interest review,
 113.4 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for
 113.5 the public interest review described in section 144.552;

113.6 (31) a project to add licensed beds in a hospital in Cook County that: (i) is designated
 113.7 as a critical access hospital under section 144.1483, clause (9), and United States Code, title
 113.8 42, section 1395i-4; (ii) has a licensed bed capacity of fewer than 25 beds; and (iii) has an
 113.9 attached nursing home, so long as the total number of licensed beds in the hospital after the
 113.10 bed addition does not exceed 25 beds; or

113.11 (32) upon submission of a plan to the commissioner for public interest review under
 113.12 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's
 113.13 hospital in St. Paul that is part of an independent pediatric health system with freestanding
 113.14 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric
 113.15 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add
 113.16 licensed beds under this clause prior to completion of the public interest review, provided
 113.17 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public
 113.18 interest review described in section 144.552.

113.19 Sec. 7. Minnesota Statutes 2020, section 144.565, subdivision 4, is amended to read:

113.20 Subd. 4. **Definitions.** (a) For purposes of this section, the following terms have the
 113.21 meanings given:

113.22 (b) "Diagnostic imaging facility" means a health care facility that is not a hospital or
 113.23 location licensed as a hospital which offers diagnostic imaging services in Minnesota,
 113.24 regardless of whether the equipment used to provide the service is owned or leased. For the
 113.25 purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities
 113.26 such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or
 113.27 surgical center. A dental clinic or office is not considered a diagnostic imaging facility for
 113.28 the purpose of this section when the clinic or office performs diagnostic imaging through
 113.29 dental cone beam computerized tomography.

113.30 (c) "Diagnostic imaging service" means the use of ionizing radiation or other imaging
 113.31 technique on a human patient including, but not limited to, magnetic resonance imaging
 113.32 (MRI) or computerized tomography (CT) other than dental cone beam computerized
 113.33 tomography, positron emission tomography (PET), or single photon emission computerized
 113.34 tomography (SPECT) scans using fixed, portable, or mobile equipment.

114.1 (d) "Financial or economic interest" means a direct or indirect:

114.2 (1) equity or debt security issued by an entity, including, but not limited to, shares of
 114.3 stock in a corporation, membership in a limited liability company, beneficial interest in a
 114.4 trust, units or other interests in a partnership, bonds, debentures, notes or other equity
 114.5 interests or debt instruments, or any contractual arrangements;

114.6 (2) membership, proprietary interest, or co-ownership with an individual, group, or
 114.7 organization to which patients, clients, or customers are referred to; or

114.8 (3) employer-employee or independent contractor relationship, including, but not limited
 114.9 to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar
 114.10 arrangement with any facility to which patients are referred, including any compensation
 114.11 between a facility and a health care provider, the group practice of which the provider is a
 114.12 member or employee or a related party with respect to any of them.

114.13 (e) "Fixed equipment" means a stationary diagnostic imaging machine installed in a
 114.14 permanent location.

114.15 (f) "Mobile equipment" means a diagnostic imaging machine in a self-contained transport
 114.16 vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging
 114.17 services.

114.18 (g) "Portable equipment" means a diagnostic imaging machine designed to be temporarily
 114.19 transported within a permanent location to perform diagnostic imaging services.

114.20 (h) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an
 114.21 entity that offers and bills for diagnostic imaging services at a facility owned or leased by
 114.22 the entity.

114.23 Sec. 8. Minnesota Statutes 2020, section 144.586, is amended by adding a subdivision to
 114.24 read:

114.25 Subd. 4. Screening for eligibility for health coverage or assistance. (a) A hospital
 114.26 must screen a patient who is uninsured or whose insurance coverage status is not known by
 114.27 the hospital, for eligibility for charity care from the hospital, eligibility for state or federal
 114.28 public health care programs using presumptive eligibility or another similar process, and
 114.29 eligibility for a premium tax credit. The hospital must attempt to complete this screening
 114.30 process in person or by telephone within 30 days after the patient's admission to the hospital.

115.1 (b) If the patient is eligible for charity care from the hospital, the hospital must assist
 115.2 the patient in applying for charity care and must refer the patient to the appropriate
 115.3 department in the hospital for follow-up.

115.4 (c) If the patient is presumptively eligible for a public health care program, the hospital
 115.5 must assist the patient in completing an insurance affordability program application, help
 115.6 schedule an appointment for the patient with a navigator organization, or provide the patient
 115.7 with contact information for navigator services. If the patient is eligible for a premium tax
 115.8 credit, the hospital may schedule an appointment for the patient with a navigator organization
 115.9 or provide the patient with contact information for navigator services.

115.10 (d) A patient may decline to participate in the screening process, to apply for charity
 115.11 care, to complete an insurance affordability program application, to schedule an appointment
 115.12 with a navigator organization, or to accept information about navigator services.

115.13 (e) For purposes of this subdivision:

115.14 (1) "hospital" means a private, nonprofit, or municipal hospital licensed under sections
 115.15 144.50 to 144.56;

115.16 (2) "navigator" has the meaning given in section 62V.02, subdivision 9;

115.17 (3) "premium tax credit" means a tax credit or premium subsidy under the federal Patient
 115.18 Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal
 115.19 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any
 115.20 amendments to and federal guidance and regulations issued under these acts; and

115.21 (4) "presumptive eligibility" has the meaning given in section 256B.057, subdivision
 115.22 12.

115.23 **EFFECTIVE DATE.** This section is effective November 1, 2022.

115.24 Sec. 9. Minnesota Statutes 2020, section 144.6502, subdivision 1, is amended to read:

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

115.27 (b) "Commissioner" means the commissioner of health.

115.28 (c) "Department" means the Department of Health.

115.29 (d) "Electronic monitoring" means the placement and use of an electronic monitoring
 115.30 device ~~by a resident~~ in the resident's room or private living unit in accordance with this
 115.31 section.

116.1 (e) "Electronic monitoring device" means a camera or other device that captures, records,
 116.2 or broadcasts audio, video, or both, that is placed in a resident's room or private living unit
 116.3 and is used to monitor the resident or activities in the room or private living unit.

116.4 (f) "Facility" means a facility that is:

116.5 (1) licensed as a nursing home under chapter 144A;

116.6 (2) licensed as a boarding care home under sections 144.50 to 144.56;

116.7 (3) until August 1, 2021, a housing with services establishment registered under chapter
 116.8 144D that is either subject to chapter 144G or has a disclosed special unit under section
 116.9 325F.72; or

116.10 (4) on or after August 1, 2021, an assisted living facility.

116.11 (g) "Resident" means a person 18 years of age or older residing in a facility.

116.12 (h) "Resident representative" means one of the following in the order of priority listed,
 116.13 to the extent the person may reasonably be identified and located:

116.14 (1) a court-appointed guardian;

116.15 (2) a health care agent as defined in section 145C.01, subdivision 2; or

116.16 (3) a person who is not an agent of a facility or of a home care provider designated in
 116.17 writing by the resident and maintained in the resident's records on file with the facility.

116.18 Sec. 10. Minnesota Statutes 2020, section 144.651, is amended by adding a subdivision
 116.19 to read:

116.20 Subd. 10a. Designated support person for pregnant patient. (a) A health care provider
 116.21 and a health care facility must allow, at a minimum, one designated support person of a
 116.22 pregnant patient's choosing to be physically present while the patient is receiving health
 116.23 care services including during a hospital stay.

116.24 (b) For purposes of this subdivision, "designated support person" means any person
 116.25 necessary to provide comfort to the patient including but not limited to the patient's spouse,
 116.26 partner, family member, or another person related by affinity. Certified doulas and traditional
 116.27 midwives may not be counted toward the limit of one designated support person.

117.1 Sec. 11. Minnesota Statutes 2020, section 144.69, is amended to read:

117.2 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

117.3 Subdivision 1. Data collected by the cancer reporting system. Notwithstanding any
117.4 law to the contrary, including section 13.05, subdivision 9, data collected on individuals by
117.5 the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of
117.6 persons required in section 144.68 to report, shall be private and may only be used for the
117.7 purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure
117.8 other than is provided for in this section and sections 144.671, 144.672, and 144.68, is
117.9 declared to be a misdemeanor and punishable as such. Except as provided by rule, and as
117.10 part of an epidemiologic investigation, an officer or employee of the commissioner of health
117.11 may interview patients named in any such report, or relatives of any such patient, only after
117.12 ~~the consent of~~ notifying the attending physician, advanced practice registered nurse, or
117.13 surgeon ~~is obtained~~.

117.14 Subd. 2. Transfers of information to non-Minnesota state and federal government
117.15 agencies. (a) Information containing personal identifiers collected by the cancer reporting
117.16 system may be provided to the statewide cancer registry of other states solely for the purposes
117.17 consistent with this section and sections 144.671, 144.672, and 144.68, provided that the
117.18 other state agrees to maintain the classification of the information as provided under
117.19 subdivision 1.

117.20 (b) Information, excluding direct identifiers such as name, Social Security number,
117.21 telephone number, and street address, collected by the cancer reporting system may be
117.22 provided to the Centers for Disease Control and Prevention's National Program of Cancer
117.23 Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results
117.24 Program registry.

117.25 Sec. 12. Minnesota Statutes 2021 Supplement, section 144.9501, subdivision 17, is amended
117.26 to read:

117.27 Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab
117.28 team services, or interim controls undertaken to make a residence, child care facility, school,
117.29 playground, or other location where lead hazards are identified lead-safe by complying with
117.30 the lead standards and methods adopted under section 144.9508.

117.31 (b) Lead hazard reduction does not include renovation activity that is primarily intended
117.32 to remodel, repair, or restore a given structure or dwelling rather than abate or control
117.33 lead-based paint hazards.

118.1 (c) Lead hazard reduction does not include activities that disturb painted surfaces that
 118.2 total:

118.3 (1) less than 20 square feet (two square meters) on exterior surfaces; or

118.4 (2) less than two square feet (0.2 square meters) in an interior room.

118.5 Sec. 13. Minnesota Statutes 2020, section 144.9501, subdivision 26a, is amended to read:

118.6 Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

118.7 (1) abatement;

118.8 (2) interim controls;

118.9 (3) a clearance inspection;

118.10 (4) a lead hazard screen;

118.11 (5) a lead inspection;

118.12 (6) a lead risk assessment;

118.13 (7) lead project designer services;

118.14 (8) lead sampling technician services;

118.15 (9) swab team services;

118.16 (10) renovation activities; ~~or~~

118.17 (11) lead hazard reduction; or

118.18 ~~(11)~~ (12) activities performed to comply with lead orders issued by a community health
 118.19 ~~board~~ an assessing agency.

118.20 ~~(b) Regulated lead work does not include abatement, interim controls, swab team services,~~
 118.21 ~~or renovation activities that disturb painted surfaces that total no more than:~~

118.22 ~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

118.23 ~~(2) six square feet (0.6 square meters) in an interior room.~~

118.24 Sec. 14. Minnesota Statutes 2020, section 144.9501, subdivision 26b, is amended to read:

118.25 Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978

118.26 affected property for compensation that results in the disturbance of known or presumed

118.27 lead-containing painted surfaces defined under section 144.9508, unless that activity is

118.28 performed as lead hazard reduction. A renovation performed for the purpose of converting

119.1 a building or part of a building into an affected property is a renovation under this
119.2 subdivision.

119.3 (b) Renovation does not include activities that disturb painted surfaces that total:

119.4 (1) less than 20 square feet (two square meters) on exterior surfaces; or

119.5 (2) less than six square feet (0.6 square meters) in an interior room.

119.6 Sec. 15. Minnesota Statutes 2020, section 144.9505, subdivision 1, is amended to read:

119.7 Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this
119.8 section shall be deposited into the state treasury and credited to the state government special
119.9 revenue fund.

119.10 (b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead
119.11 workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers,
119.12 renovation firms, or lead firms unless they have licenses or certificates issued by the
119.13 commissioner under this section.

119.14 (c) The fees required in this section for inspectors, risk assessors, and certified lead firms
119.15 are waived for state or local government employees performing services for or as an assessing
119.16 agency.

119.17 (d) An individual who is the owner of property on which ~~regulated lead work~~ lead hazard
119.18 reduction is to be performed or an adult individual who is related to the property owner, as
119.19 defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain
119.20 a license and pay a fee according to this section.

119.21 (e) A person that employs individuals to perform ~~regulated lead work~~ lead hazard
119.22 reduction, clearance inspections, lead risk assessments, lead inspections, lead hazard screens,
119.23 lead project designer services, lead sampling technician services, and swab team services
119.24 outside of the person's property must obtain certification as a certified lead firm. An
119.25 individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead
119.26 risk assessments, clearance inspections, lead project designer services, lead sampling
119.27 technician services, swab team services, and activities performed to comply with lead orders
119.28 must be employed by a certified lead firm, unless the individual is a sole proprietor and
119.29 does not employ any other individuals; the individual is employed by a person that does
119.30 not perform ~~regulated lead work~~ lead hazard reduction, clearance inspections, lead risk
119.31 assessments, lead inspections, lead hazard screens, lead project designer services, lead
119.32 sampling technician services, and swab team services outside of the person's property; or
119.33 the individual is employed by an assessing agency.

120.1 Sec. 16. Minnesota Statutes 2020, section 144.9505, subdivision 1h, is amended to read:

120.2 Subd. 1h. **Certified renovation firm.** A person who ~~employs individuals to perform~~
 120.3 performs renovation activities ~~outside of the person's property~~ must obtain certification as
 120.4 a renovation firm. The certificate must be in writing, contain an expiration date, be signed
 120.5 by the commissioner, and give the name and address of the person to whom it is issued. A
 120.6 renovation firm certificate is valid for two years. The certification fee is \$100, is
 120.7 nonrefundable, and must be submitted with each application. The renovation firm certificate
 120.8 or a copy of the certificate must be readily available at the worksite for review by the
 120.9 contracting entity, the commissioner, and other public health officials charged with the
 120.10 health, safety, and welfare of the state's citizens.

120.11 Sec. 17. Minnesota Statutes 2020, section 144A.01, is amended to read:

120.12 **144A.01 DEFINITIONS.**

120.13 Subdivision 1. **Scope.** For the purposes of sections 144A.01 to 144A.27, the terms
 120.14 defined in this section have the meanings given them.

120.15 Subd. 2. **Commissioner of health.** "Commissioner of health" means the state
 120.16 commissioner of health established by section 144.011.

120.17 Subd. 3. **Board of Executives for Long Term Services and Supports.** "Board of
 120.18 Executives for Long Term Services and Supports" means the Board of Executives for Long
 120.19 Term Services and Supports established by section 144A.19.

120.20 Subd. 3a. **Certified.** "Certified" means certified for participation as a provider in the
 120.21 Medicare or Medicaid programs under title XVIII or XIX of the Social Security Act.

120.22 Subd. 4. **Controlling ~~person~~ individual.** (a) "Controlling ~~person~~ individual" means ~~any~~
 120.23 ~~public body, governmental agency, business entity, an owner and the following individuals~~
 120.24 and entities, if applicable:

120.25 (1) each officer of the organization, including the chief executive officer and the chief
 120.26 financial officer;

120.27 (2) the nursing home administrator; ~~or director whose responsibilities include the~~
 120.28 ~~direction of the management or policies of a nursing home~~

120.29 (3) any managerial official.

120.30 (b) "Controlling ~~person~~ individual" also means any entity or natural person who, directly
 120.31 ~~or indirectly, beneficially owns any~~ has any direct or indirect ownership interest in:

121.1 (1) any corporation, partnership or other business association which is a controlling
 121.2 ~~person~~ individual;

121.3 (2) any other legal or business entity;

121.4 ~~(2)~~ (3) the land on which a nursing home is located;

121.5 ~~(3)~~ (4) the structure in which a nursing home is located;

121.6 ~~(4)~~ (5) any entity with at least a five percent mortgage, contract for deed, deed of trust,
 121.7 ~~or other obligation secured in whole or part by~~ security interest in the land or structure
 121.8 comprising a nursing home; or

121.9 ~~(5)~~ (6) any lease or sublease of the land, structure, or facilities comprising a nursing
 121.10 home.

121.11 ~~(b)~~ (c) "Controlling ~~person~~ individual" does not include:

121.12 (1) a bank, savings bank, trust company, savings association, credit union, industrial
 121.13 loan and thrift company, investment banking firm, or insurance company unless the entity
 121.14 directly or through a subsidiary operates a nursing home;

121.15 (2) government and government-sponsored entities such as the United States Department
 121.16 of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the
 121.17 Minnesota Housing Finance Agency which provide loans, financing, and insurance products
 121.18 for housing sites;

121.19 ~~(2)~~ (3) an individual who is a state or federal official or, a state or federal employee, or
 121.20 a member or employee of the governing body of a political subdivision of the state which
 121.21 or federal government that operates one or more nursing homes, unless the individual is
 121.22 also an officer or director of a, owner, or managerial official of the nursing home, receives
 121.23 any remuneration from a nursing home, or owns any of the beneficial interests who is a
 121.24 controlling individual not otherwise excluded in this subdivision;

121.25 ~~(3)~~ (4) a natural person who is a member of a tax-exempt organization under section
 121.26 290.05, subdivision 2, unless the individual is also ~~an officer or director of a nursing home,~~
 121.27 ~~or owns any of the beneficial interests~~ a controlling individual not otherwise excluded in
 121.28 this subdivision; and

121.29 ~~(4)~~ (5) a natural person who owns less than five percent of the outstanding common
 121.30 shares of a corporation:

121.31 (i) whose securities are exempt by virtue of section 80A.45, clause (6); or

121.32 (ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

122.1 Subd. 4a. **Emergency.** "Emergency" means a situation or physical condition that creates
122.2 or probably will create an immediate and serious threat to a resident's health or safety.

122.3 Subd. 5. **Nursing home.** "Nursing home" means a facility or that part of a facility which
122.4 provides nursing care to five or more persons. "Nursing home" does not include a facility
122.5 or that part of a facility which is a hospital, a hospital with approved swing beds as defined
122.6 in section 144.562, clinic, doctor's office, diagnostic or treatment center, or a residential
122.7 program licensed pursuant to sections 245A.01 to 245A.16 or 252.28.

122.8 Subd. 6. **Nursing care.** "Nursing care" means health evaluation and treatment of patients
122.9 and residents who are not in need of an acute care facility but who require nursing supervision
122.10 on an inpatient basis. The commissioner of health may by rule establish levels of nursing
122.11 care.

122.12 Subd. 7. **Uncorrected violation.** "Uncorrected violation" means a violation of a statute
122.13 or rule or any other deficiency for which a notice of noncompliance has been issued and
122.14 fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 8.

122.15 Subd. 8. **Managerial ~~employee~~ official.** "Managerial ~~employee~~ official" means an
122.16 ~~employee of a~~ individual who has the decision-making authority related to the operation of
122.17 the nursing home whose duties include and the responsibility for either: (1) the ongoing
122.18 management of the nursing home; or (2) the direction of some or all of the management or
122.19 policies, services, or employees of the nursing home.

122.20 Subd. 9. **Nursing home administrator.** "Nursing home administrator" means a person
122.21 who administers, manages, supervises, or is in general administrative charge of a nursing
122.22 home, whether or not the individual has an ownership interest in the home, and whether or
122.23 not the person's functions and duties are shared with one or more individuals, and who is
122.24 licensed pursuant to section 144A.21.

122.25 Subd. 10. **Repeated violation.** "Repeated violation" means the issuance of two or more
122.26 correction orders, within a 12-month period, for a violation of the same provision of a statute
122.27 or rule.

122.28 Subd. 11. **Change of ownership.** "Change of ownership" means a change in the licensee.

122.29 Subd. 12. **Direct ownership interest.** "Direct ownership interest" means an individual
122.30 or legal entity with the possession of at least five percent equity in capital, stock, or profits
122.31 of the licensee or who is a member of a limited liability company of the licensee.

123.1 Subd. 13. **Indirect ownership interest.** "Indirect ownership interest" means an individual
 123.2 or legal entity with a direct ownership interest in an entity that has a direct or indirect
 123.3 ownership interest of at least five percent in an entity that is a licensee.

123.4 Subd. 14. **Licensee.** "Licensee" means a person or legal entity to whom the commissioner
 123.5 issues a license for a nursing home and who is responsible for the management, control,
 123.6 and operation of the nursing home.

123.7 Subd. 15. **Management agreement.** "Management agreement" means a written, executed
 123.8 agreement between a licensee and manager regarding the provision of certain services on
 123.9 behalf of the licensee.

123.10 Subd. 16. **Manager.** "Manager" means an individual or legal entity designated by the
 123.11 licensee through a management agreement to act on behalf of the licensee in the on-site
 123.12 management of the nursing home.

123.13 Subd. 17. **Managing control.** "Managing control" means any organization that exercises
 123.14 operational or managerial control over the nursing home or conducts the day-to-day
 123.15 operations of the nursing home.

123.16 Subd. 18. **Owner.** "Owner" means: (1) an individual or legal entity that has a direct or
 123.17 indirect ownership interest of five percent or more in a licensee; and (2) for purposes of this
 123.18 chapter, owner of a nonprofit corporation means the president and treasurer of the board of
 123.19 directors; and (3) for an entity owned by an employee stock ownership plan, owner means
 123.20 the president and treasurer of the entity. A government entity that is issued a license under
 123.21 this chapter shall be designated the owner.

123.22 **EFFECTIVE DATE.** This section is effective August 1, 2022.

123.23 Sec. 18. Minnesota Statutes 2020, section 144A.03, subdivision 1, is amended to read:

123.24 Subdivision 1. **Form; requirements.** (a) The commissioner of health by rule shall
 123.25 establish forms and procedures for the processing of nursing home license applications.

123.26 (b) An application for a nursing home license shall include ~~the following information:~~

123.27 (1) ~~the names~~ business name and ~~addresses of all controlling persons and managerial~~
 123.28 ~~employees of the facility to be licensed~~ legal entity name of the licensee;

123.29 (2) ~~the~~ street address, mailing address, and legal property description of the facility;

123.30 (3) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners,
 123.31 controlling individuals, managerial officials, and the nursing home administrator;

- 124.1 (4) the name and e-mail address of the managing agent and manager, if applicable;
- 124.2 (5) the licensed bed capacity;
- 124.3 (6) the license fee in the amount specified in section 144.122;
- 124.4 (7) documentation of compliance with the background study requirements in section
- 124.5 144.057 for the owner, controlling individuals, and managerial officials. Each application
- 124.6 for a new license must include documentation for the applicant and for each individual with
- 124.7 five percent or more direct or indirect ownership in the applicant;
- 124.8 ~~(3)~~ (8) a copy of the architectural and engineering plans and specifications of the facility
- 124.9 as prepared and certified by an architect or engineer registered to practice in this state; and
- 124.10 (9) a copy of the executed lease agreement between the landlord and the licensee, if
- 124.11 applicable;
- 124.12 (10) a copy of the management agreement, if applicable;
- 124.13 (11) a copy of the operations transfer agreement or similar agreement, if applicable;
- 124.14 (12) an organizational chart that identifies all organizations and individuals with an
- 124.15 ownership interest in the licensee of five percent or greater and that specifies their relationship
- 124.16 with the licensee and with each other;
- 124.17 (13) whether the applicant, owner, controlling individual, managerial official, or nursing
- 124.18 home administrator of the facility has ever been convicted of:
- 124.19 (i) a crime or found civilly liable for a federal or state felony-level offense that was
- 124.20 detrimental to the best interests of the facility and its residents within the last ten years
- 124.21 preceding submission of the license application. Offenses include: (A) felony crimes against
- 124.22 persons and other similar crimes for which the individual was convicted, including guilty
- 124.23 pleas and adjudicated pretrial diversions; (B) financial crimes such as extortion,
- 124.24 embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the
- 124.25 individual was convicted, including guilty pleas and adjudicated pretrial diversions; (C)
- 124.26 any felonies involving malpractice that resulted in a conviction of criminal neglect or
- 124.27 misconduct; and (D) any felonies that would result in a mandatory exclusion under section
- 124.28 1128(a) of the Social Security Act;
- 124.29 (ii) any misdemeanor under federal or state law related to the delivery of an item or
- 124.30 service under Medicaid or a state health care program or the abuse or neglect of a patient
- 124.31 in connection with the delivery of a health care item or service;

125.1 (iii) any misdemeanor under federal or state law related to theft, fraud, embezzlement,
125.2 breach of fiduciary duty, or other financial misconduct in connection with the delivery of
125.3 a health care item or service;

125.4 (iv) any felony or misdemeanor under federal or state law relating to the interference
125.5 with or obstruction of any investigation into any criminal offense described in Code of
125.6 Federal Regulations, title 42, section 1001.101 or 1001.201;

125.7 (v) any felony or misdemeanor under federal or state law relating to the unlawful
125.8 manufacture, distribution, prescription, or dispensing of a controlled substance; or

125.9 (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or
125.10 assisted living facility or directly affects resident safety or care during that period;

125.11 (14) whether the applicant, owner, controlling individual, managerial official, or nursing
125.12 home administrator of the facility has had:

125.13 (i) any revocation or suspension of a license to provide health care by any state licensing
125.14 authority. This includes the surrender of the license while a formal disciplinary proceeding
125.15 was pending before a state licensing authority;

125.16 (ii) any revocation or suspension of accreditation; or

125.17 (iii) any suspension or exclusion from participation in, or any sanction imposed by, a
125.18 federal or state health care program or any debarment from participation in any federal
125.19 executive branch procurement or nonprocurement program;

125.20 (15) whether in the preceding three years the applicant or any owner, controlling
125.21 individual, managerial official, or nursing home administrator of the facility has a record
125.22 of defaulting in the payment of money collected for others, including the discharge of debts
125.23 through bankruptcy proceedings;

125.24 (16) the signature of the owner of the licensee or an authorized agent of the licensee;

125.25 (17) identification of all states where the applicant or individual having a five percent
125.26 or more ownership currently or previously has been licensed as an owner or operator of a
125.27 long-term care, community-based, or health care facility or agency where the applicant's or
125.28 individual's license or federal certification has been denied, suspended, restricted, conditioned,
125.29 refused, not renewed, or revoked under a private or state-controlled receivership or where
125.30 these same actions are pending under the laws of any state or federal authority;

125.31 (18) statistical information required by the commissioner; and

126.1 ~~(4)~~ (19) any other relevant information which the commissioner of health by rule or
 126.2 otherwise may determine is necessary to properly evaluate an application for license.

126.3 (c) A controlling person individual which is a corporation shall submit copies of its
 126.4 articles of incorporation and bylaws and any amendments thereto as they occur, together
 126.5 with the names and addresses of its officers and directors. A controlling ~~person~~ individual
 126.6 which is a foreign corporation shall furnish the commissioner of health with a copy of its
 126.7 certificate of authority to do business in this state. ~~An application on behalf of a controlling~~
 126.8 ~~person which is a corporation, association or a governmental unit or instrumentality shall~~
 126.9 ~~be signed by at least two officers or managing agents of that entity.~~

126.10 **EFFECTIVE DATE.** This section is effective August 1, 2022.

126.11 Sec. 19. Minnesota Statutes 2020, section 144A.04, subdivision 4, is amended to read:

126.12 Subd. 4. **Controlling person individual restrictions.** (a) The commissioner has discretion
 126.13 to bar any controlling persons individual of a nursing home ~~may not include any if the~~
 126.14 ~~person who~~ was a controlling person individual of another any other nursing home ~~during~~
 126.15 ~~any period of time,~~ assisted living facility, long-term care or health care facility, or agency
 126.16 in the previous two-year period and:

126.17 (1) ~~during which that period of time of control that other nursing home~~ the facility or
 126.18 agency incurred the following number of uncorrected or repeated violations:

126.19 (i) two or more uncorrected violations or one or more repeated violations which created
 126.20 an imminent risk to direct resident or client care or safety; or

126.21 (ii) four or more uncorrected violations or two or more repeated violations ~~of any nature~~
 126.22 ~~for which the fines are in the four highest daily fine categories prescribed in rule~~ that created
 126.23 an imminent risk to direct resident or client care or safety; or

126.24 (2) ~~who~~ during that period of time, was convicted of a felony or gross misdemeanor that
 126.25 ~~relates~~ related to operation of the ~~nursing home~~ facility or agency or directly ~~affects~~ affected
 126.26 resident safety or care, ~~during that period.~~

126.27 (b) The provisions of this subdivision shall not apply to any controlling ~~person~~ individual
 126.28 who had no legal authority to affect or change decisions related to the operation of the
 126.29 nursing home which incurred the uncorrected violations.

126.30 (c) When the commissioner bars a controlling individual under this subdivision, the
 126.31 controlling individual has the right to appeal under chapter 14.

127.1 Sec. 20. Minnesota Statutes 2020, section 144A.04, subdivision 6, is amended to read:

127.2 Subd. 6. **Managerial ~~employee official~~ or licensed administrator; employment**
 127.3 **prohibitions.** A nursing home may not employ as a managerial ~~employee official~~ or as its
 127.4 licensed administrator any person who was a managerial ~~employee official~~ or the licensed
 127.5 administrator of another facility during any period of time in the previous two-year period:

127.6 (1) during which time of employment that other nursing home incurred the following
 127.7 number of uncorrected violations which were in the jurisdiction and control of the managerial
 127.8 ~~employee official~~ or the administrator:

127.9 (i) two or more uncorrected violations ~~or one or more repeated violations which created~~
 127.10 ~~an imminent risk to direct resident care or safety;~~ or

127.11 (ii) four or more uncorrected violations or two or more repeated violations of any nature
 127.12 for which the fines are in the four highest daily fine categories prescribed in rule; or

127.13 (2) who was convicted of a felony or gross misdemeanor that relates to operation of the
 127.14 nursing home or directly affects resident safety or care, during that period.

127.15 **EFFECTIVE DATE.** This section is effective August 1, 2022.

127.16 Sec. 21. Minnesota Statutes 2020, section 144A.06, is amended to read:

127.17 **144A.06 TRANSFER OF INTERESTS LICENSE PROHIBITED.**

127.18 Subdivision 1. ~~Notice; expiration of license~~ **Transfers prohibited.** ~~Any controlling~~
 127.19 ~~person who makes any transfer of a beneficial interest in a nursing home shall notify the~~
 127.20 ~~commissioner of health of the transfer within 14 days of its occurrence. The notification~~
 127.21 ~~shall identify by name and address the transferor and transferee and shall specify the nature~~
 127.22 ~~and amount of the transferred interest. On determining that the transferred beneficial interest~~
 127.23 ~~exceeds ten percent of the total beneficial interest in the nursing home facility, the structure~~
 127.24 ~~in which the facility is located, or the land upon which the structure is located, the~~
 127.25 ~~commissioner may, and on determining that the transferred beneficial interest exceeds 50~~
 127.26 ~~percent of the total beneficial interest in the facility, the structure in which the facility is~~
 127.27 ~~located, or the land upon which the structure is located, the commissioner shall require that~~
 127.28 ~~the license of the nursing home expire 90 days after the date of transfer. The commissioner~~
 127.29 ~~of health shall notify the nursing home by certified mail of the expiration of the license at~~
 127.30 ~~least 60 days prior to the date of expiration. A nursing home license may not be transferred.~~

127.31 Subd. 2. **Relicensure New license required; change of ownership.** (a) The
 127.32 commissioner of health by rule shall prescribe procedures for ~~relicensure~~ licensure under

128.1 this section. ~~The commissioner of health shall relicense a nursing home if the facility satisfies~~
128.2 ~~the requirements for license renewal established by section 144A.05. A facility shall not be~~
128.3 ~~relicensed by the commissioner if at the time of transfer there are any uncorrected violations.~~
128.4 ~~The commissioner of health may temporarily waive correction of one or more violations if~~
128.5 ~~the commissioner determines that:~~

128.6 ~~(1) temporary noncorrection of the violation will not create an imminent risk of harm~~
128.7 ~~to a nursing home resident; and~~

128.8 ~~(2) a controlling person on behalf of all other controlling persons:~~

128.9 ~~(i) has entered into a contract to obtain the materials or labor necessary to correct the~~
128.10 ~~violation, but the supplier or other contractor has failed to perform the terms of the contract~~
128.11 ~~and the inability of the nursing home to correct the violation is due solely to that failure; or~~

128.12 ~~(ii) is otherwise making a diligent good faith effort to correct the violation.~~

128.13 (b) A new license is required and the prospective licensee must apply for a license prior
128.14 to operating a currently licensed nursing home. The licensee must change whenever one of
128.15 the following events occur:

128.16 (1) the form of the licensee's legal entity structure is converted or changed to a different
128.17 type of legal entity structure;

128.18 (2) the licensee dissolves, consolidates, or merges with another legal organization and
128.19 the licensee's legal organization does not survive;

128.20 (3) within the previous 24 months, 50 percent or more of the licensee's ownership interest
128.21 is transferred, whether by a single transaction or multiple transactions to:

128.22 (i) a different person; or

128.23 (ii) a person who had less than a five percent ownership interest in the facility at the
128.24 time of the first transaction; or

128.25 (4) any other event or combination of events that results in a substitution, elimination,
128.26 or withdrawal of the licensee's responsibility for the facility.

128.27 Subd. 3. **Compliance.** The commissioner must consult with the commissioner of human
128.28 services regarding the history of financial and cost reporting compliance of the prospective
128.29 licensee and prospective licensee's financial operations in any nursing home that the
128.30 prospective licensee or any controlling individual listed in the license application has had
128.31 an interest in.

129.1 Subd. 4. Facility operation. The current licensee remains responsible for the operation
129.2 of the nursing home until the nursing home is licensed to the prospective licensee.

129.3 EFFECTIVE DATE. This section is effective August 1, 2022.

129.4 Sec. 22. [144A.32] CONSIDERATION OF APPLICATIONS.

129.5 (a) Before issuing a provisional license or license or renewing an existing license, the
129.6 commissioner shall consider an applicant's compliance history in providing care in a facility
129.7 that provides care to children, the elderly, ill individuals, or individuals with disabilities.

129.8 (b) The applicant's compliance history shall include repeat violations, rule violations,
129.9 and any license or certification involuntarily suspended or terminated during an enforcement
129.10 process.

129.11 (c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
129.12 or impose conditions if:

129.13 (1) the applicant fails to provide complete and accurate information on the application
129.14 and the commissioner concludes that the missing or corrected information is needed to
129.15 determine if a license is granted;

129.16 (2) the applicant, knowingly or with reason to know, made a false statement of a material
129.17 fact in an application for the license or any data attached to the application or in any matter
129.18 under investigation by the department;

129.19 (3) the applicant refused to allow agents of the commissioner to inspect the applicant's
129.20 books, records, files related to the license application, or any portion of the premises;

129.21 (4) the applicant willfully prevented, interfered with, or attempted to impede in any way:

129.22 (i) the work of any authorized representative of the commissioner, the ombudsman for
129.23 long-term care, or the ombudsman for mental health and developmental disabilities; or

129.24 (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult
129.25 protection, county case managers, or other local government personnel;

129.26 (5) the applicant has a history of noncompliance with federal or state regulations that
129.27 were detrimental to the health, welfare, or safety of a resident or a client; or

129.28 (6) the applicant violates any requirement in this chapter or chapter 256R.

129.29 (d) If a license is denied, the applicant has the reconsideration rights available under
129.30 chapter 14.

129.31 EFFECTIVE DATE. This section is effective August 1, 2022.

130.1 Sec. 23. Minnesota Statutes 2020, section 144A.4799, subdivision 1, is amended to read:

130.2 Subdivision 1. **Membership.** The commissioner of health shall appoint ~~eight~~ 12 persons
130.3 to a home care and assisted living program advisory council consisting of the following:

130.4 (1) ~~three~~ two public members as defined in section 214.02 who shall be persons who
130.5 are currently receiving home care services, persons who have received home care services
130.6 within five years of the application date, persons who have family members receiving home
130.7 care services, or persons who have family members who have received home care services
130.8 within five years of the application date;

130.9 (2) ~~three~~ two Minnesota home care licensees representing basic and comprehensive
130.10 levels of licensure who may be a managerial official, an administrator, a supervising
130.11 registered nurse, or an unlicensed personnel performing home care tasks;

130.12 (3) one member representing the Minnesota Board of Nursing;

130.13 (4) one member representing the Office of Ombudsman for Long-Term Care and the
130.14 Office of Ombudsman for Mental Health and Developmental Disabilities; and

130.15 (5) beginning July 1, 2021, one member of a county health and human services or county
130.16 adult protection office;

130.17 (6) two Minnesota assisted living facility licensees representing assisted living facilities
130.18 and assisted living facilities with dementia care levels of licensure who may be the facility's
130.19 assisted living director, managerial official, or clinical nurse supervisor;

130.20 (7) one organization representing long-term care providers, home care providers, and
130.21 assisted living providers in Minnesota; and

130.22 (8) two public members as defined in section 214.02. One public member shall be a
130.23 person who either is or has been a resident in an assisted living facility and one public
130.24 member shall be a person who has or had a family member living in an assisted living
130.25 facility setting.

130.26 Sec. 24. Minnesota Statutes 2020, section 144A.4799, subdivision 3, is amended to read:

130.27 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
130.28 advice regarding regulations of Department of Health licensed assisted living and home
130.29 care providers in this chapter, including advice on the following:

130.30 (1) community standards for home care practices;

131.1 (2) enforcement of licensing standards and whether certain disciplinary actions are
131.2 appropriate;

131.3 (3) ways of distributing information to licensees and consumers of home care and assisted
131.4 living services defined under chapter 144G;

131.5 (4) training standards;

131.6 (5) identifying emerging issues and opportunities in home care and assisted living services
131.7 defined under chapter 144G;

131.8 (6) identifying the use of technology in home and telehealth capabilities;

131.9 (7) allowable home care licensing modifications and exemptions, including a method
131.10 for an integrated license with an existing license for rural licensed nursing homes to provide
131.11 limited home care services in an adjacent independent living apartment building owned by
131.12 the licensed nursing home; and

131.13 (8) recommendations for studies using the data in section 62U.04, subdivision 4, including
131.14 but not limited to studies concerning costs related to dementia and chronic disease among
131.15 an elderly population over 60 and additional long-term care costs, as described in section
131.16 62U.10, subdivision 6.

131.17 (b) The advisory council shall perform other duties as directed by the commissioner.

131.18 (c) The advisory council shall annually make recommendations to the commissioner for
131.19 the purposes in section 144A.474, subdivision 11, paragraph (i). The recommendations shall
131.20 address ways the commissioner may improve protection of the public under existing statutes
131.21 and laws and include but are not limited to projects that create and administer training of
131.22 licensees and their employees to improve residents' lives, supporting ways that licensees
131.23 can improve and enhance quality care and ways to provide technical assistance to licensees
131.24 to improve compliance; information technology and data projects that analyze and
131.25 communicate information about trends of violations or lead to ways of improving client
131.26 care; communications strategies to licensees and the public; and other projects or pilots that
131.27 benefit clients, families, and the public.

131.28 Sec. 25. Minnesota Statutes 2020, section 144A.75, subdivision 12, is amended to read:

131.29 Subd. 12. **Palliative care.** "Palliative care" means ~~the total active care of patients whose~~
131.30 ~~disease is not responsive to curative treatment. Control of pain, of other symptoms, and of~~
131.31 ~~psychological, social, and spiritual problems is paramount~~ specialized medical care for
131.32 people living with a serious illness or life-limiting condition. This type of care is focused

132.1 on reducing the pain, symptoms, and stress of a serious illness or condition. Palliative care
 132.2 is a team-based approach to care, providing essential support at any age or stage of a serious
 132.3 illness or condition, and is often provided together with curative treatment. The goal of
 132.4 palliative care is ~~the achievement of the best quality of life for patients and their families~~
 132.5 to improve quality of life for both the patient and the patient's family or care partner.

132.6 Sec. 26. Minnesota Statutes 2020, section 144G.08, is amended by adding a subdivision
 132.7 to read:

132.8 Subd. 62a. **Serious injury.** "Serious injury" has the meaning given in section 245.91,
 132.9 subdivision 6.

132.10 Sec. 27. Minnesota Statutes 2020, section 144G.15, is amended to read:

132.11 **144G.15 CONSIDERATION OF APPLICATIONS.**

132.12 (a) Before issuing a provisional license or license or renewing a license, the commissioner
 132.13 shall consider an applicant's compliance history in providing care in this state or any other
 132.14 state in a facility that provides care to children, the elderly, ill individuals, or individuals
 132.15 with disabilities.

132.16 (b) The applicant's compliance history shall include repeat violation, rule violations, and
 132.17 any license or certification involuntarily suspended or terminated during an enforcement
 132.18 process.

132.19 (c) The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license
 132.20 or impose conditions if:

132.21 (1) the applicant fails to provide complete and accurate information on the application
 132.22 and the commissioner concludes that the missing or corrected information is needed to
 132.23 determine if a license shall be granted;

132.24 (2) the applicant, knowingly or with reason to know, made a false statement of a material
 132.25 fact in an application for the license or any data attached to the application or in any matter
 132.26 under investigation by the department;

132.27 (3) the applicant refused to allow agents of the commissioner to inspect its books, records,
 132.28 and files related to the license application, or any portion of the premises;

132.29 (4) the applicant willfully prevented, interfered with, or attempted to impede in any way:
 132.30 (i) the work of any authorized representative of the commissioner, the ombudsman for
 132.31 long-term care, or the ombudsman for mental health and developmental disabilities; or (ii)

133.1 the duties of the commissioner, local law enforcement, city or county attorneys, adult
133.2 protection, county case managers, or other local government personnel;

133.3 (5) the applicant, owner, controlling individual, managerial official, or assisted living
133.4 director for the facility has a history of noncompliance with federal or state regulations that
133.5 were detrimental to the health, welfare, or safety of a resident or a client; or

133.6 (6) the applicant violates any requirement in this chapter.

133.7 (d) If a license is denied, the applicant has the reconsideration rights available under
133.8 section 144G.16, subdivision 4.

133.9 Sec. 28. Minnesota Statutes 2020, section 144G.17, is amended to read:

133.10 **144G.17 LICENSE RENEWAL.**

133.11 A license that is not a provisional license may be renewed for a period of up to one year
133.12 if the licensee:

133.13 (1) submits an application for renewal in the format provided by the commissioner at
133.14 least 60 calendar days before expiration of the license;

133.15 (2) submits the renewal fee under section 144G.12, subdivision 3;

133.16 (3) submits the late fee under section 144G.12, subdivision 4, if the renewal application
133.17 is received less than 30 days before the expiration date of the license or after the expiration
133.18 of the license;

133.19 (4) provides information sufficient to show that the applicant meets the requirements of
133.20 licensure, including items required under section 144G.12, subdivision 1; ~~and~~

133.21 (5) provides information sufficient to show the licensee provided assisted living services
133.22 to at least one resident during the immediately preceding license year and at the assisted
133.23 living facility listed on the license; and

133.24 ~~(5)~~ (6) provides any other information deemed necessary by the commissioner.

133.25 Sec. 29. Minnesota Statutes 2020, section 144G.19, is amended by adding a subdivision
133.26 to read:

133.27 Subd. 4. **Change of licensee.** Notwithstanding any other provision of law, a change of
133.28 licensee under subdivision 2 does not require the facility to meet the design requirements
133.29 of section 144G.45, subdivisions 4 to 6, or 144G.81, subdivision 3.

134.1 Sec. 30. Minnesota Statutes 2020, section 144G.20, subdivision 1, is amended to read:

134.2 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a provisional
134.3 license, refuse to grant a license as a result of a change in ownership, refuse to renew a
134.4 license, suspend or revoke a license, or impose a conditional license if the owner, controlling
134.5 individual, or employee of an assisted living facility:

134.6 (1) is in violation of, or during the term of the license has violated, any of the requirements
134.7 in this chapter or adopted rules;

134.8 (2) permits, aids, or abets the commission of any illegal act in the provision of assisted
134.9 living services;

134.10 (3) performs any act detrimental to the health, safety, and welfare of a resident;

134.11 (4) obtains the license by fraud or misrepresentation;

134.12 (5) knowingly makes a false statement of a material fact in the application for a license
134.13 or in any other record or report required by this chapter;

134.14 (6) denies representatives of the department access to any part of the facility's books,
134.15 records, files, or employees;

134.16 (7) interferes with or impedes a representative of the department in contacting the facility's
134.17 residents;

134.18 (8) interferes with or impedes ombudsman access according to section 256.9742,
134.19 subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental
134.20 Health and Developmental Disabilities according to section 245.94, subdivision 1;

134.21 (9) interferes with or impedes a representative of the department in the enforcement of
134.22 this chapter or fails to fully cooperate with an inspection, survey, or investigation by the
134.23 department;

134.24 (10) destroys or makes unavailable any records or other evidence relating to the assisted
134.25 living facility's compliance with this chapter;

134.26 (11) refuses to initiate a background study under section 144.057 or 245A.04;

134.27 (12) fails to timely pay any fines assessed by the commissioner;

134.28 (13) violates any local, city, or township ordinance relating to housing or assisted living
134.29 services;

134.30 (14) has repeated incidents of personnel performing services beyond their competency
134.31 level; or

135.1 (15) has operated beyond the scope of the assisted living facility's license category.

135.2 (b) A violation by a contractor providing the assisted living services of the facility is a
135.3 violation by the facility.

135.4 Sec. 31. Minnesota Statutes 2020, section 144G.20, subdivision 4, is amended to read:

135.5 Subd. 4. **Mandatory revocation.** Notwithstanding the provisions of subdivision 13,
135.6 paragraph (a), the commissioner must revoke a license if a controlling individual of the
135.7 facility is convicted of a felony or gross misdemeanor that relates to operation of the facility
135.8 or directly affects resident safety or care. The commissioner shall notify the facility and the
135.9 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health
135.10 and Developmental Disabilities 30 calendar days in advance of the date of revocation.

135.11 Sec. 32. Minnesota Statutes 2020, section 144G.20, subdivision 5, is amended to read:

135.12 Subd. 5. **Owners and managerial officials; refusal to grant license.** (a) The owners
135.13 and managerial officials of a facility whose Minnesota license has not been renewed or
135.14 whose ~~Minnesota~~ license in this state or any other state has been revoked because of
135.15 noncompliance with applicable laws or rules shall not be eligible to apply for nor will be
135.16 granted an assisted living facility license under this chapter or a home care provider license
135.17 under chapter 144A, or be given status as an enrolled personal care assistance provider
135.18 agency or personal care assistant by the Department of Human Services under section
135.19 256B.0659, for five years following the effective date of the nonrenewal or revocation. If
135.20 the owners or managerial officials already have enrollment status, the Department of Human
135.21 Services shall terminate that enrollment.

135.22 (b) The commissioner shall not issue a license to a facility for five years following the
135.23 effective date of license nonrenewal or revocation if the owners or managerial officials,
135.24 including any individual who was an owner or managerial official of another licensed
135.25 provider, had a ~~Minnesota~~ license in this state or any other state that was not renewed or
135.26 was revoked as described in paragraph (a).

135.27 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend
135.28 or revoke, the license of a facility that includes any individual as an owner or managerial
135.29 official who was an owner or managerial official of a facility whose ~~Minnesota~~ license in
135.30 this state or any other state was not renewed or was revoked as described in paragraph (a)
135.31 for five years following the effective date of the nonrenewal or revocation.

136.1 (d) The commissioner shall notify the facility 30 calendar days in advance of the date
136.2 of nonrenewal, suspension, or revocation of the license.

136.3 Sec. 33. Minnesota Statutes 2020, section 144G.20, subdivision 8, is amended to read:

136.4 Subd. 8. **Controlling individual restrictions.** (a) The commissioner has discretion to
136.5 bar any controlling individual of a facility if the person was a controlling individual of any
136.6 other nursing home, home care provider licensed under chapter 144A, or given status as an
136.7 enrolled personal care assistance provider agency or personal care assistant by the Department
136.8 of Human Services under section 256B.0659, or assisted living facility in the previous
136.9 two-year period and:

136.10 (1) during that period of time the nursing home, home care provider licensed under
136.11 chapter 144A, or given status as an enrolled personal care assistance provider agency or
136.12 personal care assistant by the Department of Human Services under section 256B.0659, or
136.13 assisted living facility incurred the following number of uncorrected or repeated violations:

136.14 (i) two or more repeated violations that created an imminent risk to direct resident care
136.15 or safety; or

136.16 (ii) four or more uncorrected violations that created an imminent risk to direct resident
136.17 care or safety; or

136.18 (2) during that period of time, was convicted of a felony or gross misdemeanor that
136.19 related to the operation of the nursing home, home care provider licensed under chapter
136.20 144A, or given status as an enrolled personal care assistance provider agency or personal
136.21 care assistant by the Department of Human Services under section 256B.0659, or assisted
136.22 living facility, or directly affected resident safety or care.

136.23 (b) When the commissioner bars a controlling individual under this subdivision, the
136.24 controlling individual may appeal the commissioner's decision under chapter 14.

136.25 Sec. 34. Minnesota Statutes 2020, section 144G.20, subdivision 9, is amended to read:

136.26 Subd. 9. **Exception to controlling individual restrictions.** Subdivision 8 does not apply
136.27 to any controlling individual of the facility who had no legal authority to affect or change
136.28 decisions related to the operation of the nursing home ~~or~~, assisted living facility, or home
136.29 care that incurred the uncorrected or repeated violations.

137.1 Sec. 35. Minnesota Statutes 2020, section 144G.20, subdivision 12, is amended to read:

137.2 Subd. 12. **Notice to residents.** (a) Within five business days after proceedings are initiated
137.3 by the commissioner to revoke or suspend a facility's license, or a decision by the
137.4 commissioner not to renew a living facility's license, the controlling individual of the facility
137.5 or a designee must provide to the commissioner ~~and~~₂ the ombudsman for long-term care,
137.6 and the Office of Ombudsman for Mental Health and Developmental Disabilities the names
137.7 of residents and the names and addresses of the residents' designated representatives and
137.8 legal representatives, and family or other contacts listed in the assisted living contract.

137.9 (b) The controlling individual or designees of the facility must provide updated
137.10 information each month until the proceeding is concluded. If the controlling individual or
137.11 designee of the facility fails to provide the information within this time, the facility is subject
137.12 to the issuance of:

137.13 (1) a correction order; and

137.14 (2) a penalty assessment by the commissioner in rule.

137.15 (c) Notwithstanding subdivisions 21 and 22, any correction order issued under this
137.16 subdivision must require that the facility immediately comply with the request for information
137.17 and that, as of the date of the issuance of the correction order, the facility shall forfeit to the
137.18 state a \$500 fine the first day of noncompliance and an increase in the \$500 fine by \$100
137.19 increments for each day the noncompliance continues.

137.20 (d) Information provided under this subdivision may be used by the commissioner ~~or~~₂
137.21 the ombudsman for long-term care, or the Office of Ombudsman for Mental Health and
137.22 Developmental Disabilities only for the purpose of providing affected consumers information
137.23 about the status of the proceedings.

137.24 (e) Within ten business days after the commissioner initiates proceedings to revoke,
137.25 suspend, or not renew a facility license, the commissioner must send a written notice of the
137.26 action and the process involved to each resident of the facility, legal representatives and
137.27 designated representatives, and at the commissioner's discretion, additional resident contacts.

137.28 (f) The commissioner shall provide the ombudsman for long-term care and the Office
137.29 of Ombudsman for Mental Health and Developmental Disabilities with monthly information
137.30 on the department's actions and the status of the proceedings.

138.1 Sec. 36. Minnesota Statutes 2020, section 144G.20, subdivision 15, is amended to read:

138.2 Subd. 15. **Plan required.** (a) The process of suspending, revoking, or refusing to renew
138.3 a license must include a plan for transferring affected residents' cares to other providers by
138.4 the facility. The commissioner shall monitor the transfer plan. Within three calendar days
138.5 of being notified of the final revocation, refusal to renew, or suspension, the licensee shall
138.6 provide the commissioner, the lead agencies as defined in section 256B.0911, county adult
138.7 protection and case managers, ~~and the ombudsman for long-term care,~~ and the Office of
138.8 Ombudsman for Mental Health and Developmental Disabilities with the following
138.9 information:

138.10 (1) a list of all residents, including full names and all contact information on file;

138.11 (2) a list of the resident's legal representatives and designated representatives and family
138.12 or other contacts listed in the assisted living contract, including full names and all contact
138.13 information on file;

138.14 (3) the location or current residence of each resident;

138.15 (4) the payor sources for each resident, including payor source identification numbers;
138.16 and

138.17 (5) for each resident, a copy of the resident's service plan and a list of the types of services
138.18 being provided.

138.19 (b) The revocation, refusal to renew, or suspension notification requirement is satisfied
138.20 by mailing the notice to the address in the license record. The licensee shall cooperate with
138.21 the commissioner and the lead agencies, county adult protection and case managers, ~~and~~
138.22 the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and
138.23 Developmental Disabilities during the process of transferring care of residents to qualified
138.24 providers. Within three calendar days of being notified of the final revocation, refusal to
138.25 renew, or suspension action, the facility must notify and disclose to each of the residents,
138.26 or the resident's legal and designated representatives or emergency contact persons, that the
138.27 commissioner is taking action against the facility's license by providing a copy of the
138.28 revocation, refusal to renew, or suspension notice issued by the commissioner. If the facility
138.29 does not comply with the disclosure requirements in this section, the commissioner shall
138.30 notify the residents, legal and designated representatives, or emergency contact persons
138.31 about the actions being taken. Lead agencies, county adult protection and case managers,
138.32 and the Office of Ombudsman for Long-Term Care may also provide this information. The
138.33 revocation, refusal to renew, or suspension notice is public data except for any private data
138.34 contained therein.

139.1 (c) A facility subject to this subdivision may continue operating while residents are being
139.2 transferred to other service providers.

139.3 Sec. 37. Minnesota Statutes 2020, section 144G.30, subdivision 5, is amended to read:

139.4 Subd. 5. **Correction orders.** (a) A correction order may be issued whenever the
139.5 commissioner finds upon survey or during a complaint investigation that a facility, a
139.6 managerial official, an agent of the facility, or an employee of the facility is not in compliance
139.7 with this chapter. The correction order shall cite the specific statute and document areas of
139.8 noncompliance and the time allowed for correction.

139.9 (b) The commissioner shall mail or e-mail copies of any correction order to the facility
139.10 within 30 calendar days after the survey exit date. A copy of each correction order and
139.11 copies of any documentation supplied to the commissioner shall be kept on file by the
139.12 facility and public documents shall be made available for viewing by any person upon
139.13 request. Copies may be kept electronically.

139.14 (c) By the correction order date, the facility must document in the facility's records any
139.15 action taken to comply with the correction order. The commissioner may request a copy of
139.16 this documentation and the facility's action to respond to the correction order in future
139.17 surveys, upon a complaint investigation, and as otherwise needed.

139.18 Sec. 38. Minnesota Statutes 2020, section 144G.31, subdivision 4, is amended to read:

139.19 Subd. 4. **Fine amounts.** (a) Fines and enforcement actions under this subdivision may
139.20 be assessed based on the level and scope of the violations described in subdivisions 2 and
139.21 3 as follows and may be imposed immediately with no opportunity to correct the violation
139.22 prior to imposition:

139.23 (1) Level 1, no fines or enforcement;

139.24 (2) Level 2, a fine of \$500 per violation, in addition to any enforcement mechanism
139.25 authorized in section 144G.20 for widespread violations;

139.26 (3) Level 3, a fine of \$3,000 per violation ~~per incident~~, in addition to any enforcement
139.27 mechanism authorized in section 144G.20;

139.28 (4) Level 4, a fine of \$5,000 per ~~incident~~ violation, in addition to any enforcement
139.29 mechanism authorized in section 144G.20; and

139.30 (5) for maltreatment violations for which the licensee was determined to be responsible
139.31 for the maltreatment under section 626.557, subdivision 9c, paragraph (c), a fine of \$1,000.

140.1 A fine of \$5,000 may be imposed if the commissioner determines the licensee is responsible
140.2 for maltreatment consisting of sexual assault, death, or abuse resulting in serious injury.

140.3 (b) When a fine is assessed against a facility for substantiated maltreatment, the
140.4 commissioner shall not also impose an immediate fine under this chapter for the same
140.5 circumstance.

140.6 Sec. 39. Minnesota Statutes 2020, section 144G.31, subdivision 8, is amended to read:

140.7 Subd. 8. **Deposit of fines.** Fines collected under this section shall be deposited in a
140.8 dedicated special revenue account. On an annual basis, the balance in the special revenue
140.9 account shall be appropriated to the commissioner for special projects to improve ~~home~~
140.10 care resident quality of care and outcomes in assisted living facilities licensed under chapter
140.11 144G in Minnesota as recommended by the advisory council established in section
140.12 144A.4799.

140.13 **EFFECTIVE DATE.** This section is effective retroactively for fines collected on or
140.14 after August 1, 2021.

140.15 Sec. 40. Minnesota Statutes 2020, section 144G.41, subdivision 7, is amended to read:

140.16 Subd. 7. **Resident grievances; reporting maltreatment.** All facilities must post in a
140.17 conspicuous place information about the facilities' grievance procedure, and the name,
140.18 telephone number, and e-mail contact information for the individuals who are responsible
140.19 for handling resident grievances. The notice must also have the contact information for the
140.20 ~~state and applicable regional~~ Office of Ombudsman for Long-Term Care and the Office of
140.21 Ombudsman for Mental Health and Developmental Disabilities, and must have information
140.22 for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The
140.23 notice must also state that if an individual has a complaint about the facility or person
140.24 providing services, the individual may contact the Office of Health Facility Complaints at
140.25 the Minnesota Department of Health.

140.26 Sec. 41. Minnesota Statutes 2020, section 144G.41, subdivision 8, is amended to read:

140.27 Subd. 8. **Protecting resident rights.** All facilities shall ensure that every resident has
140.28 access to consumer advocacy or legal services by:

140.29 (1) providing names and contact information, including telephone numbers and e-mail
140.30 addresses of at least three organizations that provide advocacy or legal services to residents,
140.31 one of which must include the designated protection and advocacy organization in Minnesota
140.32 that provides advice and representation to individuals with disabilities;

141.1 (2) providing the name and contact information for the Minnesota Office of Ombudsman
141.2 for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental
141.3 Disabilities, ~~including both the state and regional contact information;~~

141.4 (3) assisting residents in obtaining information on whether Medicare or medical assistance
141.5 under chapter 256B will pay for services;

141.6 (4) making reasonable accommodations for people who have communication disabilities
141.7 and those who speak a language other than English; and

141.8 (5) providing all information and notices in plain language and in terms the residents
141.9 can understand.

141.10 Sec. 42. Minnesota Statutes 2020, section 144G.42, subdivision 10, is amended to read:

141.11 Subd. 10. **Disaster planning and emergency preparedness plan.** (a) The facility must
141.12 meet the following requirements:

141.13 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses
141.14 elements of sheltering in place, identifies temporary relocation sites, and details staff
141.15 assignments in the event of a disaster or an emergency;

141.16 (2) post an emergency disaster plan prominently;

141.17 (3) provide building emergency exit diagrams to all residents;

141.18 (4) post emergency exit diagrams on each floor; and

141.19 (5) have a written policy and procedure regarding missing ~~tenant~~ residents.

141.20 (b) The facility must provide emergency and disaster training to all staff during the initial
141.21 staff orientation and annually thereafter and must make emergency and disaster training
141.22 annually available to all residents. Staff who have not received emergency and disaster
141.23 training are allowed to work only when trained staff are also working on site.

141.24 (c) The facility must meet any additional requirements adopted in rule.

141.25 Sec. 43. Minnesota Statutes 2020, section 144G.50, subdivision 2, is amended to read:

141.26 Subd. 2. **Contract information.** (a) The contract must include in a conspicuous place
141.27 and manner on the contract the legal name and the license number of the facility.

141.28 (b) The contract must include the name, telephone number, and physical mailing address,
141.29 which may not be a public or private post office box, of:

141.30 (1) the facility and contracted service provider when applicable;

- 142.1 (2) the licensee of the facility;
- 142.2 (3) the managing agent of the facility, if applicable; and
- 142.3 (4) the authorized agent for the facility.
- 142.4 (c) The contract must include:
- 142.5 (1) a disclosure of the category of assisted living facility license held by the facility and,
- 142.6 if the facility is not an assisted living facility with dementia care, a disclosure that it does
- 142.7 not hold an assisted living facility with dementia care license;
- 142.8 (2) a description of all the terms and conditions of the contract, including a description
- 142.9 of and any limitations to the housing or assisted living services to be provided for the
- 142.10 contracted amount;
- 142.11 (3) a delineation of the cost and nature of any other services to be provided for an
- 142.12 additional fee;
- 142.13 (4) a delineation and description of any additional fees the resident may be required to
- 142.14 pay if the resident's condition changes during the term of the contract;
- 142.15 (5) a delineation of the grounds under which the resident may be ~~discharged, evicted,~~
- 142.16 ~~or~~ transferred or have housing or services terminated or be subject to an emergency
- 142.17 relocation;
- 142.18 (6) billing and payment procedures and requirements; and
- 142.19 (7) disclosure of the facility's ability to provide specialized diets.
- 142.20 (d) The contract must include a description of the facility's complaint resolution process
- 142.21 available to residents, including the name and contact information of the person representing
- 142.22 the facility who is designated to handle and resolve complaints.
- 142.23 (e) The contract must include a clear and conspicuous notice of:
- 142.24 (1) the right under section 144G.54 to appeal the termination of an assisted living contract;
- 142.25 (2) the facility's policy regarding transfer of residents within the facility, under what
- 142.26 circumstances a transfer may occur, and the circumstances under which resident consent is
- 142.27 required for a transfer;
- 142.28 (3) contact information for the Office of Ombudsman for Long-Term Care, the
- 142.29 Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health
- 142.30 Facility Complaints;
- 142.31 (4) the resident's right to obtain services from an unaffiliated service provider;

143.1 (5) a description of the facility's policies related to medical assistance waivers under
143.2 chapter 256S and section 256B.49 and the housing support program under chapter 256I,
143.3 including:

143.4 (i) whether the facility is enrolled with the commissioner of human services to provide
143.5 customized living services under medical assistance waivers;

143.6 (ii) whether the facility has an agreement to provide housing support under section
143.7 256I.04, subdivision 2, paragraph (b);

143.8 (iii) whether there is a limit on the number of people residing at the facility who can
143.9 receive customized living services or participate in the housing support program at any
143.10 point in time. If so, the limit must be provided;

143.11 (iv) whether the facility requires a resident to pay privately for a period of time prior to
143.12 accepting payment under medical assistance waivers or the housing support program, and
143.13 if so, the length of time that private payment is required;

143.14 (v) a statement that medical assistance waivers provide payment for services, but do not
143.15 cover the cost of rent;

143.16 (vi) a statement that residents may be eligible for assistance with rent through the housing
143.17 support program; and

143.18 (vii) a description of the rent requirements for people who are eligible for medical
143.19 assistance waivers but who are not eligible for assistance through the housing support
143.20 program;

143.21 (6) the contact information to obtain long-term care consulting services under section
143.22 256B.0911; and

143.23 (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.

143.24 Sec. 44. Minnesota Statutes 2020, section 144G.52, subdivision 2, is amended to read:

143.25 Subd. 2. **Prerequisite to termination of a contract.** (a) Before issuing a notice of
143.26 termination of an assisted living contract, a facility must schedule and participate in a meeting
143.27 with the resident and the resident's legal representative and designated representative. The
143.28 purposes of the meeting are to:

143.29 (1) explain in detail the reasons for the proposed termination; and

143.30 (2) identify and offer reasonable accommodations or modifications, interventions, or
143.31 alternatives to avoid the termination or enable the resident to remain in the facility, including

144.1 but not limited to securing services from another provider of the resident's choosing that
 144.2 may allow the resident to avoid the termination. A facility is not required to offer
 144.3 accommodations, modifications, interventions, or alternatives that fundamentally alter the
 144.4 nature of the operation of the facility.

144.5 (b) The meeting must be scheduled to take place at least seven days before a notice of
 144.6 termination is issued. The facility must make reasonable efforts to ensure that the resident,
 144.7 legal representative, and designated representative are able to attend the meeting.

144.8 (c) The facility must notify the resident that the resident may invite family members,
 144.9 relevant health professionals, a representative of the Office of Ombudsman for Long-Term
 144.10 Care, a representative of the Office of Ombudsman for Mental Health and Developmental
 144.11 Disabilities, or other persons of the resident's choosing to participate in the meeting. For
 144.12 residents who receive home and community-based waiver services under chapter 256S and
 144.13 section 256B.49, the facility must notify the resident's case manager of the meeting.

144.14 (d) In the event of an emergency relocation under subdivision 9, where the facility intends
 144.15 to issue a notice of termination and an in-person meeting is impractical or impossible, the
 144.16 facility ~~may attempt to schedule and participate in a meeting under this subdivision via~~ must
 144.17 use telephone, video, or other electronic means to conduct and participate in the meeting
 144.18 required under this subdivision and rules within Minnesota Rules, chapter 4659.

144.19 Sec. 45. Minnesota Statutes 2020, section 144G.52, subdivision 8, is amended to read:

144.20 Subd. 8. **Content of notice of termination.** The notice required under subdivision 7
 144.21 must contain, at a minimum:

144.22 (1) the effective date of the termination of the assisted living contract;

144.23 (2) a detailed explanation of the basis for the termination, including the clinical or other
 144.24 supporting rationale;

144.25 (3) a detailed explanation of the conditions under which a new or amended contract may
 144.26 be executed;

144.27 (4) a statement that the resident has the right to appeal the termination by requesting a
 144.28 hearing, and information concerning the time frame within which the request must be
 144.29 submitted and the contact information for the agency to which the request must be submitted;

144.30 (5) a statement that the facility must participate in a coordinated move to another provider
 144.31 or caregiver, as required under section 144G.55;

145.1 (6) the name and contact information of the person employed by the facility with whom
145.2 the resident may discuss the notice of termination;

145.3 (7) information on how to contact the Office of Ombudsman for Long-Term Care and
145.4 the Office of Ombudsman for Mental Health and Developmental Disabilities to request an
145.5 advocate to assist regarding the termination;

145.6 (8) information on how to contact the Senior LinkAge Line under section 256.975,
145.7 subdivision 7, and an explanation that the Senior LinkAge Line may provide information
145.8 about other available housing or service options; and

145.9 (9) if the termination is only for services, a statement that the resident may remain in
145.10 the facility and may secure any necessary services from another provider of the resident's
145.11 choosing.

145.12 Sec. 46. Minnesota Statutes 2020, section 144G.52, subdivision 9, is amended to read:

145.13 **Subd. 9. Emergency relocation.** (a) A facility may remove a resident from the facility
145.14 in an emergency if necessary due to a resident's urgent medical needs or an imminent risk
145.15 the resident poses to the health or safety of another facility resident or facility staff member.
145.16 An emergency relocation is not a termination.

145.17 (b) In the event of an emergency relocation, the facility must provide a written notice
145.18 that contains, at a minimum:

145.19 (1) the reason for the relocation;

145.20 (2) the name and contact information for the location to which the resident has been
145.21 relocated and any new service provider;

145.22 (3) contact information for the Office of Ombudsman for Long-Term Care and the Office
145.23 of Ombudsman for Mental Health and Developmental Disabilities;

145.24 (4) if known and applicable, the approximate date or range of dates within which the
145.25 resident is expected to return to the facility, or a statement that a return date is not currently
145.26 known; and

145.27 (5) a statement that, if the facility refuses to provide housing or services after a relocation,
145.28 the resident has the right to appeal under section 144G.54. The facility must provide contact
145.29 information for the agency to which the resident may submit an appeal.

145.30 (c) The notice required under paragraph (b) must be delivered as soon as practicable to:

145.31 (1) the resident, legal representative, and designated representative;

146.1 (2) for residents who receive home and community-based waiver services under chapter
146.2 256S and section 256B.49, the resident's case manager; and

146.3 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated
146.4 and has not returned to the facility within four days.

146.5 (d) Following an emergency relocation, a facility's refusal to provide housing or services
146.6 constitutes a termination and triggers the termination process in this section.

146.7 Sec. 47. Minnesota Statutes 2020, section 144G.53, is amended to read:

146.8 **144G.53 NONRENEWAL OF HOUSING.**

146.9 (a) If a facility decides to not renew a resident's housing under a contract, the facility
146.10 must either (1) provide the resident with 60 calendar days' notice of the nonrenewal and
146.11 assistance with relocation planning, or (2) follow the termination procedure under section
146.12 144G.52.

146.13 (b) The notice must include the reason for the nonrenewal and contact information of
146.14 the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental
146.15 Health and Developmental Disabilities.

146.16 (c) A facility must:

146.17 (1) provide notice of the nonrenewal to the Office of Ombudsman for Long-Term Care;

146.18 (2) for residents who receive home and community-based waiver services under chapter
146.19 256S and section 256B.49, provide notice to the resident's case manager;

146.20 (3) ensure a coordinated move to a safe location, as defined in section 144G.55,
146.21 subdivision 2, that is appropriate for the resident;

146.22 (4) ensure a coordinated move to an appropriate service provider identified by the facility,
146.23 if services are still needed and desired by the resident;

146.24 (5) consult and cooperate with the resident, legal representative, designated representative,
146.25 case manager for a resident who receives home and community-based waiver services under
146.26 chapter 256S and section 256B.49, relevant health professionals, and any other persons of
146.27 the resident's choosing to make arrangements to move the resident, including consideration
146.28 of the resident's goals; and

146.29 (6) prepare a written plan to prepare for the move.

146.30 (d) A resident may decline to move to the location the facility identifies or to accept
146.31 services from a service provider the facility identifies, and may instead choose to move to

147.1 a location of the resident's choosing or receive services from a service provider of the
147.2 resident's choosing within the timeline prescribed in the nonrenewal notice.

147.3 Sec. 48. Minnesota Statutes 2020, section 144G.55, subdivision 1, is amended to read:

147.4 Subdivision 1. **Duties of facility.** (a) If a facility terminates an assisted living contract,
147.5 reduces services to the extent that a resident needs to move or obtain a new service provider
147.6 because of a reduction or elimination of services or the facility has its license restricted
147.7 under section 144G.20, or the facility conducts a planned closure under section 144G.57,
147.8 the facility:

147.9 (1) must ensure, subject to paragraph (c), a coordinated move to a safe location that is
147.10 appropriate for the resident and that is identified by the facility prior to any hearing under
147.11 section 144G.54;

147.12 (2) must ensure a coordinated move of the resident to an appropriate service provider
147.13 identified by the facility prior to any hearing under section 144G.54, provided services are
147.14 still needed and desired by the resident; and

147.15 (3) must consult and cooperate with the resident, legal representative, designated
147.16 representative, case manager for a resident who receives home and community-based waiver
147.17 services under chapter 256S and section 256B.49, relevant health professionals, and any
147.18 other persons of the resident's choosing to make arrangements to move the resident, including
147.19 consideration of the resident's goals.

147.20 (b) A facility may satisfy the requirements of paragraph (a), clauses (1) and (2), by
147.21 moving the resident to a different location within the same facility, if appropriate for the
147.22 resident.

147.23 (c) A resident may decline to move to the location the facility identifies or to accept
147.24 services from a service provider the facility identifies, and may choose instead to move to
147.25 a location of the resident's choosing or receive services from a service provider of the
147.26 resident's choosing within the timeline prescribed in the termination notice.

147.27 (d) Sixty days before the facility plans to reduce or eliminate one or more services for
147.28 a particular resident, the facility must provide written notice of the reduction or elimination
147.29 that includes:

147.30 (1) a detailed explanation of the reasons for the reduction or elimination and the date of
147.31 the reduction;

148.1 (2) the contact information for the Office of Ombudsman for Long-Term Care, the Office
 148.2 of Ombudsman for Mental Health and Developmental Disabilities, and the name and contact
 148.3 information of the person employed by the facility with whom the resident may discuss the
 148.4 reduction or elimination of services;

148.5 (3) a statement that if the services being reduced or eliminated are still needed by the
 148.6 resident, the resident may remain in the facility and seek services from another provider;
 148.7 and

148.8 (4) a statement that if the reduction or elimination makes the resident need to move, the
 148.9 facility must participate in a coordinated move of the resident to another provider or
 148.10 caregiver, as required under this section.

148.11 (e) In the event of an unanticipated reduction or elimination in services caused by
 148.12 extraordinary circumstances, the facility must provide the notice required under paragraph
 148.13 (d) as soon as possible.

148.14 (f) If the facility, a resident, a legal representative, or a designated representative
 148.15 determines that a reduction in services will make a resident need to move to a new location,
 148.16 the facility must ensure a coordinated move in accordance with this section, and must provide
 148.17 notice to the Office of Ombudsman for Long-Term Care.

148.18 (g) Nothing in this section affects a resident's right to remain in the facility and seek
 148.19 services from another provider.

148.20 Sec. 49. Minnesota Statutes 2020, section 144G.55, subdivision 3, is amended to read:

148.21 Subd. 3. **Relocation plan required.** The facility must prepare a relocation plan to prepare
 148.22 for the move to ~~the~~ a new safe location or appropriate service provider, as required by this
 148.23 section.

148.24 Sec. 50. Minnesota Statutes 2020, section 144G.56, subdivision 3, is amended to read:

148.25 Subd. 3. **Notice required.** (a) A facility must provide at least 30 calendar days' advance
 148.26 written notice to the resident and the resident's legal and designated representative of a
 148.27 facility-initiated transfer. The notice must include:

148.28 (1) the effective date of the proposed transfer;

148.29 (2) the proposed transfer location;

148.30 (3) a statement that the resident may refuse the proposed transfer, and may discuss any
 148.31 consequences of a refusal with staff of the facility;

149.1 (4) the name and contact information of a person employed by the facility with whom
 149.2 the resident may discuss the notice of transfer; and

149.3 (5) contact information for the Office of Ombudsman for Long-Term Care and the Office
 149.4 of Ombudsman for Mental Health and Developmental Disabilities.

149.5 (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of
 149.6 a resident with less than 30 days' written notice if the transfer is necessary due to:

149.7 (1) conditions that render the resident's room or private living unit uninhabitable;

149.8 (2) the resident's urgent medical needs; or

149.9 (3) a risk to the health or safety of another resident of the facility.

149.10 Sec. 51. Minnesota Statutes 2020, section 144G.56, subdivision 5, is amended to read:

149.11 Subd. 5. **Changes in facility operations.** (a) In situations where there is a curtailment,
 149.12 reduction, or capital improvement within a facility necessitating transfers, the facility must:

149.13 (1) minimize the number of transfers it initiates to complete the project or change in
 149.14 operations;

149.15 (2) consider individual resident needs and preferences;

149.16 (3) provide reasonable accommodations for individual resident requests regarding the
 149.17 transfers; and

149.18 (4) in advance of any notice to any residents, legal representatives, or designated
 149.19 representatives, provide notice to the Office of Ombudsman for Long-Term Care and, ~~when~~
 149.20 ~~appropriate,~~ the Office of Ombudsman for Mental Health and Developmental Disabilities
 149.21 of the curtailment, reduction, or capital improvement and the corresponding needed transfers.

149.22 Sec. 52. Minnesota Statutes 2020, section 144G.57, subdivision 1, is amended to read:

149.23 Subdivision 1. **Closure plan required.** In the event that an assisted living facility elects
 149.24 to voluntarily close the facility, the facility must notify the commissioner ~~and,~~ the Office
 149.25 of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and
 149.26 Developmental Disabilities in writing by submitting a proposed closure plan.

149.27 Sec. 53. Minnesota Statutes 2020, section 144G.57, subdivision 3, is amended to read:

149.28 Subd. 3. **Commissioner's approval required prior to implementation.** (a) The plan
 149.29 shall be subject to the commissioner's approval and subdivision 6. The facility shall take
 149.30 no action to close the residence prior to the commissioner's approval of the plan. The

150.1 commissioner shall approve or otherwise respond to the plan ~~as soon as practicable~~ within
150.2 14 calendar days.

150.3 (b) The commissioner may require the facility to work with a transitional team comprised
150.4 of department staff, staff of the Office of Ombudsman for Long-Term Care, the Office of
150.5 Ombudsman for Mental Health and Developmental Disabilities, and other professionals the
150.6 commissioner deems necessary to assist in the proper relocation of residents.

150.7 Sec. 54. Minnesota Statutes 2020, section 144G.57, subdivision 5, is amended to read:

150.8 Subd. 5. **Notice to residents.** After the commissioner has approved the relocation plan
150.9 and at least 60 calendar days before closing, except as provided under subdivision 6, the
150.10 facility must notify residents, designated representatives, and legal representatives of the
150.11 closure, the proposed date of closure, the contact information of the ombudsman for long-term
150.12 care and the ombudsman for mental health and developmental disabilities, and that the
150.13 facility will follow the termination planning requirements under section 144G.55, and final
150.14 accounting and return requirements under section 144G.42, subdivision 5. For residents
150.15 who receive home and community-based waiver services under chapter 256S and section
150.16 256B.49, the facility must also provide this information to the resident's case manager.

150.17 Sec. 55. Minnesota Statutes 2020, section 144G.70, subdivision 2, is amended to read:

150.18 Subd. 2. **Initial reviews, assessments, and monitoring.** (a) Residents who are not
150.19 receiving any assisted living services shall not be required to undergo an initial nursing
150.20 assessment.

150.21 (b) An assisted living facility shall conduct a nursing assessment by a registered nurse
150.22 of the physical and cognitive needs of the prospective resident and propose a temporary
150.23 service plan prior to the date on which a prospective resident executes a contract with a
150.24 facility or the date on which a prospective resident moves in, whichever is earlier. If
150.25 necessitated by either the geographic distance between the prospective resident and the
150.26 facility, or urgent or unexpected circumstances, the assessment may be conducted using
150.27 telecommunication methods based on practice standards that meet the resident's needs and
150.28 reflect person-centered planning and care delivery.

150.29 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar
150.30 days after initiation of services. Ongoing resident reassessment and monitoring must be
150.31 conducted as needed based on changes in the needs of the resident and cannot exceed 90
150.32 calendar days from the last date of the assessment.

151.1 (d) For residents only receiving assisted living services specified in section 144G.08,
151.2 subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review
151.3 of the resident's needs and preferences. The initial review must be completed within 30
151.4 calendar days of the start of services. Resident monitoring and review must be conducted
151.5 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days
151.6 from the date of the last review.

151.7 (e) A facility must inform the prospective resident of the availability of and contact
151.8 information for long-term care consultation services under section 256B.0911, prior to the
151.9 date on which a prospective resident executes a contract with a facility or the date on which
151.10 a prospective resident moves in, whichever is earlier.

151.11 Sec. 56. Minnesota Statutes 2020, section 144G.70, subdivision 4, is amended to read:

151.12 Subd. 4. **Service plan, implementation, and revisions to service plan.** (a) No later
151.13 than 14 calendar days after the date that services are first provided, an assisted living facility
151.14 shall finalize a current written service plan.

151.15 (b) The service plan and any revisions must include a signature or other authentication
151.16 by the facility and by the resident documenting agreement on the services to be provided.
151.17 The service plan must be revised, if needed, based on resident reassessment under subdivision
151.18 2. The facility must provide information to the resident about changes to the facility's fee
151.19 for services and how to contact the Office of Ombudsman for Long-Term Care and the
151.20 Office of Ombudsman for Mental Health and Developmental Disabilities.

151.21 (c) The facility must implement and provide all services required by the current service
151.22 plan.

151.23 (d) The service plan and the revised service plan must be entered into the resident record,
151.24 including notice of a change in a resident's fees when applicable.

151.25 (e) Staff providing services must be informed of the current written service plan.

151.26 (f) The service plan must include:

151.27 (1) a description of the services to be provided, the fees for services, and the frequency
151.28 of each service, according to the resident's current assessment and resident preferences;

151.29 (2) the identification of staff or categories of staff who will provide the services;

151.30 (3) the schedule and methods of monitoring assessments of the resident;

151.31 (4) the schedule and methods of monitoring staff providing services; and

152.1 (5) a contingency plan that includes:

152.2 (i) the action to be taken if the scheduled service cannot be provided;

152.3 (ii) information and a method to contact the facility;

152.4 (iii) the names and contact information of persons the resident wishes to have notified
152.5 in an emergency or if there is a significant adverse change in the resident's condition,
152.6 including identification of and information as to who has authority to sign for the resident
152.7 in an emergency; and

152.8 (iv) the circumstances in which emergency medical services are not to be summoned
152.9 consistent with chapters 145B and 145C, and declarations made by the resident under those
152.10 chapters.

152.11 Sec. 57. Minnesota Statutes 2020, section 144G.80, subdivision 2, is amended to read:

152.12 Subd. 2. **Demonstrated capacity.** (a) An applicant for licensure as an assisted living
152.13 facility with dementia care must have the ability to provide services in a manner that is
152.14 consistent with the requirements in this section. The commissioner shall consider the
152.15 following criteria, including, but not limited to:

152.16 (1) the experience of the ~~applicant in~~ applicant's assisted living director, managerial
152.17 official, and clinical nurse supervisor managing residents with dementia or previous long-term
152.18 care experience; and

152.19 (2) the compliance history of the applicant in the operation of any care facility licensed,
152.20 certified, or registered under federal or state law.

152.21 (b) If the ~~applicant does~~ applicant's assisted living director, managerial official, and
152.22 clinical nurse supervisor do not have experience in managing residents with dementia, the
152.23 applicant must employ a consultant for at least the first six months of operation. The
152.24 consultant must meet the requirements in paragraph (a), clause (1), and make
152.25 recommendations on providing dementia care services consistent with the requirements of
152.26 this chapter. The consultant must (1) have two years of work experience related to dementia,
152.27 health care, gerontology, or a related field, and (2) have completed at least the minimum
152.28 core training requirements in section 144G.64. The applicant must document an acceptable
152.29 plan to address the consultant's identified concerns and must either implement the
152.30 recommendations or document in the plan any consultant recommendations that the applicant
152.31 chooses not to implement. The commissioner must review the applicant's plan upon request.

153.1 (c) The commissioner shall conduct an on-site inspection prior to the issuance of an
153.2 assisted living facility with dementia care license to ensure compliance with the physical
153.3 environment requirements.

153.4 (d) The label "Assisted Living Facility with Dementia Care" must be identified on the
153.5 license.

153.6 Sec. 58. Minnesota Statutes 2020, section 144G.90, subdivision 1, is amended to read:

153.7 Subdivision 1. **Assisted living bill of rights; notification to resident.** (a) An assisted
153.8 living facility must provide the resident a written notice of the rights under section 144G.91
153.9 before the initiation of services to that resident. The facility shall make all reasonable efforts
153.10 to provide notice of the rights to the resident in a language the resident can understand.

153.11 (b) In addition to the text of the assisted living bill of rights in section 144G.91, the
153.12 notice shall also contain the following statement describing how to file a complaint or report
153.13 suspected abuse:

153.14 "If you want to report suspected abuse, neglect, or financial exploitation, you may contact
153.15 the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about
153.16 the facility or person providing your services, you may contact the Office of Health Facility
153.17 Complaints, Minnesota Department of Health. If you would like to request advocacy services,
153.18 you may ~~also~~ contact the Office of Ombudsman for Long-Term Care or the Office of
153.19 Ombudsman for Mental Health and Developmental Disabilities."

153.20 (c) The statement must include contact information for the Minnesota Adult Abuse
153.21 Reporting Center and the telephone number, website address, e-mail address, mailing
153.22 address, and street address of the Office of Health Facility Complaints at the Minnesota
153.23 Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of
153.24 Ombudsman for Mental Health and Developmental Disabilities. The statement must include
153.25 the facility's name, address, e-mail, telephone number, and name or title of the person at
153.26 the facility to whom problems or complaints may be directed. It must also include a statement
153.27 that the facility will not retaliate because of a complaint.

153.28 (d) A facility must obtain written acknowledgment from the resident of the resident's
153.29 receipt of the assisted living bill of rights or shall document why an acknowledgment cannot
153.30 be obtained. Acknowledgment of receipt shall be retained in the resident's record.

154.1 Sec. 59. Minnesota Statutes 2020, section 144G.91, subdivision 13, is amended to read:

154.2 Subd. 13. **Personal and treatment privacy.** (a) Residents have the right to consideration
154.3 of their privacy, individuality, and cultural identity as related to their social, religious, and
154.4 psychological well-being. Staff must respect the privacy of a resident's space by knocking
154.5 on the door and seeking consent before entering, except in an emergency or ~~where clearly~~
154.6 ~~inadvisable or~~ unless otherwise documented in the resident's service plan.

154.7 (b) Residents have the right to have and use a lockable door to the resident's unit. The
154.8 facility shall provide locks on the resident's unit. Only a staff member with a specific need
154.9 to enter the unit shall have keys. This right may be restricted in certain circumstances if
154.10 necessary for a resident's health and safety and documented in the resident's service plan.

154.11 (c) Residents have the right to respect and privacy regarding the resident's service plan.
154.12 Case discussion, consultation, examination, and treatment are confidential and must be
154.13 conducted discreetly. Privacy must be respected during toileting, bathing, and other activities
154.14 of personal hygiene, except as needed for resident safety or assistance.

154.15 Sec. 60. Minnesota Statutes 2020, section 144G.91, subdivision 21, is amended to read:

154.16 Subd. 21. **Access to counsel and advocacy services.** Residents have the right to the
154.17 immediate access by:

154.18 (1) the resident's legal counsel;

154.19 (2) any representative of the protection and advocacy system designated by the state
154.20 under Code of Federal Regulations, title 45, section 1326.21; or

154.21 (3) any representative of the Office of Ombudsman for Long-Term Care or the Office
154.22 of Ombudsman for Mental Health and Developmental Disabilities.

154.23 Sec. 61. Minnesota Statutes 2020, section 144G.91, is amended by adding a subdivision
154.24 to read:

154.25 Subd. 27. **Restraints.** Residents must be free from any physical or chemical restraints
154.26 imposed for purposes of discipline or convenience.

154.27 Sec. 62. Minnesota Statutes 2020, section 144G.92, subdivision 1, is amended to read:

154.28 Subdivision 1. **Retaliation prohibited.** A facility or agent of a facility may not retaliate
154.29 against a resident or employee if the resident, employee, or any person acting on behalf of
154.30 the resident:

155.1 (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any
155.2 right;

155.3 (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or
155.4 assert any right;

155.5 (3) files, in good faith, or indicates an intention to file a maltreatment report, whether
155.6 mandatory or voluntary, under section 626.557;

155.7 (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic
155.8 problems or concerns to the director or manager of the facility, the Office of Ombudsman
155.9 for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental
155.10 Disabilities, a regulatory or other government agency, or a legal or advocacy organization;

155.11 (5) advocates or seeks advocacy assistance for necessary or improved care or services
155.12 or enforcement of rights under this section or other law;

155.13 (6) takes or indicates an intention to take civil action;

155.14 (7) participates or indicates an intention to participate in any investigation or
155.15 administrative or judicial proceeding;

155.16 (8) contracts or indicates an intention to contract to receive services from a service
155.17 provider of the resident's choice other than the facility; or

155.18 (9) places or indicates an intention to place a camera or electronic monitoring device in
155.19 the resident's private space as provided under section 144.6502.

155.20 Sec. 63. Minnesota Statutes 2020, section 144G.93, is amended to read:

155.21 **144G.93 CONSUMER ADVOCACY AND LEGAL SERVICES.**

155.22 Upon execution of an assisted living contract, every facility must provide the resident
155.23 with the names and contact information, including telephone numbers and e-mail addresses,
155.24 of:

155.25 (1) nonprofit organizations that provide advocacy or legal services to residents including
155.26 but not limited to the designated protection and advocacy organization in Minnesota that
155.27 provides advice and representation to individuals with disabilities; and

155.28 (2) the Office of Ombudsman for Long-Term Care, ~~including both the state and regional~~
155.29 ~~contact information~~ and the Office of Ombudsman for Mental Health and Developmental
155.30 Disabilities.

156.1 Sec. 64. Minnesota Statutes 2020, section 144G.95, is amended to read:

156.2 **144G.95 OFFICE OF OMBUDSMAN FOR LONG-TERM CARE AND OFFICE**
 156.3 **OF OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL**
 156.4 **DISABILITIES.**

156.5 Subdivision 1. **Immunity from liability.** (a) The Office of Ombudsman for Long-Term
 156.6 Care and representatives of the office are immune from liability for conduct described in
 156.7 section 256.9742, subdivision 2.

156.8 (b) The Office of Ombudsman for Mental Health and Developmental Disabilities and
 156.9 representatives of the office are immune from liability for conduct described in section
 156.10 245.96.

156.11 Subd. 2. **Data classification.** (a) All forms and notices received by the Office of
 156.12 Ombudsman for Long-Term Care under this chapter are classified under section 256.9744.

156.13 (b) All data collected or received by the Office of Ombudsman for Mental Health and
 156.14 Developmental Disabilities are classified under section 245.94.

156.15 Sec. 65. **[145.9231] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)**
 156.16 **COUNCIL.**

156.17 Subdivision 1. **Establishment; composition of advisory council.** (a) The commissioner
 156.18 shall establish and appoint a Health Equity Advisory and Leadership (HEAL) Council to
 156.19 provide guidance to the commissioner of health regarding strengthening and improving the
 156.20 health of communities most impacted by health inequities across the state. The council shall
 156.21 consist of 18 members who will provide representation from the following groups:

156.22 (1) African American and African heritage communities;

156.23 (2) Asian American and Pacific Islander communities;

156.24 (3) Latina/o/x communities;

156.25 (4) American Indian communities and Tribal Government/Nations;

156.26 (5) disability communities;

156.27 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

156.28 (7) representatives who reside outside the seven-county metropolitan area.

156.29 (b) No members shall be employees of the Minnesota Department of Health.

157.1 Subd. 2. **Organization and meetings.** The advisory council shall be organized and
157.2 administered under section 15.059, except that the members do not receive per diem
157.3 compensation. Meetings shall be held at least quarterly and hosted by the department.
157.4 Subcommittees may be developed as necessary. Advisory council meetings are subject to
157.5 Open Meeting Law under chapter 13D.

157.6 Subd. 3. **Duties.** The advisory council shall:

157.7 (1) advise the commissioner on health equity issues and the health equity priorities and
157.8 concerns of the populations specified in subdivision 1;

157.9 (2) assist the agency in efforts to advance health equity, including consulting in specific
157.10 agency policies and programs, providing ideas and input about potential budget and policy
157.11 proposals, and recommending review of particular agency policies, standards, or procedures
157.12 that may create or perpetuate health inequities; and

157.13 (3) assist the agency in developing and monitoring meaningful performance measures
157.14 related to advancing health equity.

157.15 Subd. 4. **Expiration.** Notwithstanding section 15.059, subdivision 6, the advisory council
157.16 shall remain in existence until health inequities in the state are eliminated. Health inequities
157.17 will be considered eliminated when race, ethnicity, income, gender, gender identity,
157.18 geographic location, or other identity or social marker will no longer be predictors of health
157.19 outcomes in the state. Section 145.928 describes nine health disparities that must be
157.20 considered when determining whether health inequities have been eliminated in the state.

157.21 Sec. 66. Minnesota Statutes 2020, section 146B.04, subdivision 1, is amended to read:

157.22 Subdivision 1. **General.** Before an individual may work as a guest artist, the
157.23 commissioner shall issue a temporary license to the guest artist. The guest artist shall submit
157.24 an application to the commissioner on a form provided by the commissioner. The
157.25 commissioner must receive the application at least 14 calendar days before the guest artist
157.26 applicant conducts a body art procedure. The form must include:

157.27 (1) the name, home address, and date of birth of the guest artist;

157.28 (2) the name of the licensed technician sponsoring the guest artist;

157.29 (3) proof of having satisfactorily completed coursework within the year preceding
157.30 application and approved by the commissioner on bloodborne pathogens, the prevention of
157.31 disease transmission, infection control, and aseptic technique;

157.32 (4) the starting and anticipated completion dates the guest artist will be working; and

158.1 (5) a copy of any current body art credential or licensure issued by another local or state
158.2 jurisdiction.

158.3 Sec. 67. Minnesota Statutes 2020, section 152.22, subdivision 8, is amended to read:

158.4 Subd. 8. **Medical cannabis product paraphernalia.** "Medical cannabis ~~product~~
158.5 paraphernalia" means any delivery device or related supplies and educational materials used
158.6 in the administration of medical cannabis for a patient with a qualifying medical condition
158.7 enrolled in the registry program.

158.8 Sec. 68. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

158.9 Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner
158.10 shall register two in-state manufacturers for the production of all medical cannabis within
158.11 the state. A registration agreement between the commissioner and a manufacturer is
158.12 nontransferable. The commissioner shall register new manufacturers or reregister the existing
158.13 manufacturers by December 1 every two years, using the factors described in this subdivision.
158.14 The commissioner shall accept applications after December 1, 2014, if one of the
158.15 manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer.
158.16 The commissioner's determination that no manufacturer exists to fulfill the duties under
158.17 sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court.
158.18 Data submitted during the application process are private data on individuals or nonpublic
158.19 data as defined in section 13.02 until the manufacturer is registered under this section. Data
158.20 on a manufacturer that is registered are public data, unless the data are trade secret or security
158.21 information under section 13.37.

158.22 (b) As a condition for registration, a manufacturer must agree to:

158.23 (1) begin supplying medical cannabis to patients ~~by July 1, 2015~~ within eight months
158.24 of its initial registration; and

158.25 (2) comply with all requirements under sections 152.22 to 152.37.

158.26 (c) The commissioner shall consider the following factors when determining which
158.27 manufacturer to register:

158.28 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
158.29 converting the medical cannabis into an acceptable delivery method under section 152.22,
158.30 subdivision 6;

158.31 (2) the qualifications of the manufacturer's employees;

159.1 (3) the long-term financial stability of the manufacturer;

159.2 (4) the ability to provide appropriate security measures on the premises of the
159.3 manufacturer;

159.4 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
159.5 production needs required by sections 152.22 to 152.37; and

159.6 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
159.7 qualifying medical condition.

159.8 (d) If an officer, director, or controlling person of the manufacturer pleads or is found
159.9 guilty of intentionally diverting medical cannabis to a person other than allowed by law
159.10 under section 152.33, subdivision 1, the commissioner may decide not to renew the
159.11 registration of the manufacturer, provided the violation occurred while the person was an
159.12 officer, director, or controlling person of the manufacturer.

159.13 (e) The commissioner shall require each medical cannabis manufacturer to contract with
159.14 an independent laboratory to test medical cannabis produced by the manufacturer. The
159.15 commissioner shall approve the laboratory chosen by each manufacturer and require that
159.16 the laboratory report testing results to the manufacturer in a manner determined by the
159.17 commissioner.

159.18 (f) The commissioner shall implement a state-centralized medical cannabis electronic
159.19 database to monitor and track the manufacturers' medical cannabis inventories from the
159.20 seed or clone source through cultivation, processing, testing, and distribution or disposal.
159.21 The inventory tracking database must allow for information regarding medical cannabis to
159.22 be updated instantaneously. Any manufacturer or third-party laboratory licensed under this
159.23 chapter must submit to the commissioner any information the commissioner deems necessary
159.24 for maintaining the inventory tracking database. The commissioner may contract with a
159.25 separate entity to establish and maintain all or any part of the inventory tracking database.
159.26 The provisions of section 13.05, subdivision 11, apply to a contract entered between the
159.27 commissioner and a third party under this paragraph.

159.28 Sec. 69. Minnesota Statutes 2021 Supplement, section 152.27, subdivision 2, is amended
159.29 to read:

159.30 Subd. 2. **Commissioner duties.** (a) The commissioner shall:

159.31 (1) give notice of the program to health care practitioners in the state who are eligible
159.32 to serve as health care practitioners and explain the purposes and requirements of the
159.33 program;

160.1 (2) allow each health care practitioner who meets or agrees to meet the program's
160.2 requirements and who requests to participate, to be included in the registry program to
160.3 collect data for the patient registry;

160.4 (3) provide explanatory information and assistance to each health care practitioner in
160.5 understanding the nature of therapeutic use of medical cannabis within program requirements;

160.6 (4) create and provide a certification to be used by a health care practitioner for the
160.7 practitioner to certify whether a patient has been diagnosed with a qualifying medical
160.8 condition ~~and include in the certification an option for the practitioner to certify whether~~
160.9 ~~the patient, in the health care practitioner's medical opinion, is developmentally or physically~~
160.10 ~~disabled and, as a result of that disability, the patient requires assistance in administering~~
160.11 ~~medical cannabis or obtaining medical cannabis from a distribution facility;~~

160.12 (5) supervise the participation of the health care practitioner in conducting patient
160.13 treatment and health records reporting in a manner that ensures stringent security and
160.14 record-keeping requirements and that prevents the unauthorized release of private data on
160.15 individuals as defined by section 13.02;

160.16 (6) develop safety criteria for patients with a qualifying medical condition as a
160.17 requirement of the patient's participation in the program, to prevent the patient from
160.18 undertaking any task under the influence of medical cannabis that would constitute negligence
160.19 or professional malpractice on the part of the patient; and

160.20 (7) conduct research and studies based on data from health records submitted to the
160.21 registry program and submit reports on intermediate or final research results to the legislature
160.22 and major scientific journals. The commissioner may contract with a third party to complete
160.23 the requirements of this clause. Any reports submitted must comply with section 152.28,
160.24 subdivision 2.

160.25 (b) The commissioner may add a delivery method under section 152.22, subdivision 6,
160.26 or add, remove, or modify a qualifying medical condition under section 152.22, subdivision
160.27 14, upon a petition from a member of the public or the task force on medical cannabis
160.28 therapeutic research or as directed by law. The commissioner shall evaluate all petitions to
160.29 add a qualifying medical condition or to remove or modify an existing qualifying medical
160.30 condition submitted by the task force on medical cannabis therapeutic research or as directed
160.31 by law and may make the addition, removal, or modification if the commissioner determines
160.32 the addition, removal, or modification is warranted based on the best available evidence
160.33 and research. If the commissioner wishes to add a delivery method under section 152.22,
160.34 subdivision 6, or add or remove a qualifying medical condition under section 152.22,

161.1 subdivision 14, the commissioner must notify the chairs and ranking minority members of
161.2 the legislative policy committees having jurisdiction over health and public safety of the
161.3 addition or removal and the reasons for its addition or removal, including any written
161.4 comments received by the commissioner from the public and any guidance received from
161.5 the task force on medical cannabis research, by January 15 of the year in which the
161.6 commissioner wishes to make the change. The change shall be effective on August 1 of that
161.7 year, unless the legislature by law provides otherwise.

161.8 Sec. 70. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 1, is amended
161.9 to read:

161.10 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight
161.11 distribution facilities, which may include the manufacturer's single location for cultivation,
161.12 harvesting, manufacturing, packaging, and processing but is not required to include that
161.13 location. The commissioner shall designate the geographical service areas to be served by
161.14 each manufacturer based on geographical need throughout the state to improve patient
161.15 access. A manufacturer shall not have more than two distribution facilities in each
161.16 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
161.17 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
161.18 and processing of medical cannabis shall be conducted. This location may be one of the
161.19 manufacturer's distribution facility sites. The additional distribution facilities may dispense
161.20 medical cannabis and medical cannabis ~~products~~ paraphernalia but may not contain any
161.21 medical cannabis in a form other than those forms allowed under section 152.22, subdivision
161.22 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing,
161.23 packaging, or processing at the other distribution facility sites. Any distribution facility
161.24 operated by the manufacturer is subject to all of the requirements applying to the
161.25 manufacturer under sections 152.22 to 152.37, including, but not limited to, security and
161.26 distribution requirements.

161.27 (b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may
161.28 acquire hemp products produced by a hemp processor. A manufacturer may manufacture
161.29 or process hemp and hemp products into an allowable form of medical cannabis under
161.30 section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under
161.31 this paragraph are subject to the same quality control program, security and testing
161.32 requirements, and other requirements that apply to medical cannabis under sections 152.22
161.33 to 152.37 and Minnesota Rules, chapter 4770.

162.1 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
162.2 commissioner, subject to any additional requirements set by the commissioner, for purposes
162.3 of testing medical cannabis manufactured or hemp or hemp products acquired by the medical
162.4 cannabis manufacturer as to content, contamination, and consistency to verify the medical
162.5 cannabis meets the requirements of section 152.22, subdivision 6. The laboratory must
162.6 collect, or contract with a third party that is not a manufacturer to collect, from the
162.7 manufacturer's production facility the medical cannabis samples it will test. The cost of
162.8 collecting samples and laboratory testing shall be paid by the manufacturer.

162.9 (d) The operating documents of a manufacturer must include:

162.10 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
162.11 record keeping;

162.12 (2) procedures for the implementation of appropriate security measures to deter and
162.13 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
162.14 cannabis; and

162.15 (3) procedures for the delivery and transportation of hemp between hemp growers and
162.16 manufacturers and for the delivery and transportation of hemp products between hemp
162.17 processors and manufacturers.

162.18 (e) A manufacturer shall implement security requirements, including requirements for
162.19 the delivery and transportation of hemp and hemp products, protection of each location by
162.20 a fully operational security alarm system, facility access controls, perimeter intrusion
162.21 detection systems, and a personnel identification system.

162.22 (f) A manufacturer shall not share office space with, refer patients to a health care
162.23 practitioner, or have any financial relationship with a health care practitioner.

162.24 (g) A manufacturer shall not permit any person to consume medical cannabis on the
162.25 property of the manufacturer.

162.26 (h) A manufacturer is subject to reasonable inspection by the commissioner.

162.27 (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not
162.28 subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

162.29 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
162.30 of age or who has been convicted of a disqualifying felony offense. An employee of a
162.31 medical cannabis manufacturer must submit a completed criminal history records check
162.32 consent form, a full set of classifiable fingerprints, and the required fees for submission to
162.33 the Bureau of Criminal Apprehension before an employee may begin working with the

163.1 manufacturer. The bureau must conduct a Minnesota criminal history records check and
 163.2 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
 163.3 Investigation to obtain the applicant's national criminal history record information. The
 163.4 bureau shall return the results of the Minnesota and federal criminal history records checks
 163.5 to the commissioner.

163.6 (k) A manufacturer may not operate in any location, whether for distribution or
 163.7 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
 163.8 public or private school existing before the date of the manufacturer's registration with the
 163.9 commissioner.

163.10 (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
 163.11 relating to signage, marketing, display, and advertising of medical cannabis.

163.12 (m) Before a manufacturer acquires hemp from a hemp grower or hemp products from
 163.13 a hemp processor, the manufacturer must verify that the hemp grower or hemp processor
 163.14 has a valid license issued by the commissioner of agriculture under chapter 18K.

163.15 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
 163.16 medical cannabis plant from cultivation through testing and point of sale, the commissioner
 163.17 shall conduct at least one unannounced inspection per year of each manufacturer that includes
 163.18 inspection of:

163.19 (1) business operations;

163.20 (2) physical locations of the manufacturer's manufacturing facility and distribution
 163.21 facilities;

163.22 (3) financial information and inventory documentation, including laboratory testing
 163.23 results; and

163.24 (4) physical and electronic security alarm systems.

163.25 Sec. 71. Minnesota Statutes 2021 Supplement, section 152.29, subdivision 3, is amended
 163.26 to read:

163.27 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
 163.28 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
 163.29 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
 163.30 cannabis or medical cannabis ~~products~~ paraphernalia that have been cultivated, harvested,
 163.31 manufactured, packaged, and processed by that manufacturer to another registered
 163.32 manufacturer for the other manufacturer to distribute.

164.1 (b) A manufacturer may distribute medical cannabis ~~products~~ paraphernalia, whether
164.2 or not the ~~products~~ medical cannabis paraphernalia have been manufactured by that
164.3 manufacturer.

164.4 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

164.5 (1) verify that the manufacturer has received the registry verification from the
164.6 commissioner for that individual patient;

164.7 (2) verify that the person requesting the distribution of medical cannabis is the patient,
164.8 the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse
164.9 listed in the registry verification using the procedures described in section 152.11, subdivision
164.10 2d;

164.11 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

164.12 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
164.13 chapter 151 has consulted with the patient to determine the proper dosage for the individual
164.14 patient after reviewing the ranges of chemical compositions of the medical cannabis and
164.15 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
164.16 consultation may be conducted remotely by secure videoconference, telephone, or other
164.17 remote means, so long as the employee providing the consultation is able to confirm the
164.18 identity of the patient and the consultation adheres to patient privacy requirements that apply
164.19 to health care services delivered through telehealth. A pharmacist consultation under this
164.20 clause is not required when a manufacturer is distributing medical cannabis to a patient
164.21 according to a patient-specific dosage plan established with that manufacturer and is not
164.22 modifying the dosage or product being distributed under that plan and the medical cannabis
164.23 is distributed by a pharmacy technician;

164.24 (5) properly package medical cannabis in compliance with the United States Poison
164.25 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
164.26 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
164.27 and individually identifying information, including:

164.28 (i) the patient's name and date of birth;

164.29 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
164.30 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

164.31 (iii) the patient's registry identification number;

164.32 (iv) the chemical composition of the medical cannabis; and

165.1 (v) the dosage; and

165.2 (6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply
165.3 of the dosage determined for that patient.

165.4 (d) A manufacturer shall require any employee of the manufacturer who is transporting
165.5 medical cannabis or medical cannabis ~~products~~ paraphernalia to a distribution facility or to
165.6 another registered manufacturer to carry identification showing that the person is an employee
165.7 of the manufacturer.

165.8 (e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only
165.9 to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian,
165.10 or spouse of a patient age 21 or older.

165.11 Sec. 72. Minnesota Statutes 2020, section 152.29, subdivision 3a, is amended to read:

165.12 Subd. 3a. **Transportation of medical cannabis; transport staffing.** (a) A medical
165.13 cannabis manufacturer may staff a transport motor vehicle with only one employee if the
165.14 medical cannabis manufacturer is transporting medical cannabis to ~~either a certified~~
165.15 ~~laboratory for the purpose of testing or~~ a facility for the purpose of disposal. If the medical
165.16 cannabis manufacturer is transporting medical cannabis for any other purpose or destination,
165.17 the transport motor vehicle must be staffed with a minimum of two employees as required
165.18 by rules adopted by the commissioner.

165.19 (b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only
165.20 transporting hemp for any purpose may staff the transport motor vehicle with only one
165.21 employee.

165.22 (c) A medical cannabis manufacturer may contract with a third party for armored car
165.23 services for deliveries of medical cannabis from its production facility to distribution
165.24 facilities. A medical cannabis manufacturer that contracts for armored car services remains
165.25 responsible for compliance with transportation manifest and inventory tracking requirements
165.26 in rules adopted by the commissioner.

165.27 (d) A third-party testing laboratory may staff a transport motor vehicle with one or more
165.28 employees when transporting medical cannabis from a manufacturer's production facility
165.29 to the testing laboratory for the purpose of testing samples.

165.30 (e) Department of Health staff may transport medical cannabis for the purposes of
165.31 delivering medical cannabis and other samples to a laboratory for testing under rules adopted
165.32 by the commissioner and in cases of special investigations when the commissioner has
165.33 determined there is a potential threat to public health. The transport motor vehicle must be

166.1 staffed by a minimum of two Department of Health employees. The employees must carry
166.2 their Department of Health identification cards and a transport manifest that meets the
166.3 requirements in Minnesota Rules, part 4770.1100, subpart 2.

166.4 (f) A Tribal medical cannabis program operated by a federally recognized Indian Tribe
166.5 located within the state of Minnesota may transport samples of medical cannabis to testing
166.6 laboratories in the state. Transport vehicles must be staffed by at least two employees of
166.7 the Tribal medical cannabis program. Transporters must carry identification identifying
166.8 them as employees of the Tribal medical cannabis program and a detailed transportation
166.9 manifest that includes the place and time of departure, the address of the testing laboratory
166.10 destination, and a description and count of the medical cannabis being transported.

166.11 Sec. 73. Minnesota Statutes 2020, section 152.30, is amended to read:

166.12 **152.30 PATIENT DUTIES.**

166.13 (a) A patient shall apply to the commissioner for enrollment in the registry program by
166.14 submitting an application as required in section 152.27 and an annual registration fee as
166.15 determined under section 152.35.

166.16 (b) As a condition of continued enrollment, patients shall agree to:

166.17 (1) continue to receive regularly scheduled treatment for their qualifying medical
166.18 condition from their health care practitioner; and

166.19 (2) report changes in their qualifying medical condition to their health care practitioner.

166.20 (c) A patient shall only receive medical cannabis from a registered manufacturer but is
166.21 not required to receive medical cannabis ~~products~~ paraphernalia from only a registered
166.22 manufacturer.

166.23 Sec. 74. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

166.24 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
166.25 are not violations under this chapter:

166.26 (1) use or possession of medical cannabis or medical cannabis products by a patient
166.27 enrolled in the registry program, or possession by a registered designated caregiver or the
166.28 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
166.29 on the registry verification;

167.1 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
167.2 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
167.3 conducting testing on medical cannabis, or employees of the laboratory; and

167.4 (3) possession of medical cannabis or medical cannabis ~~products~~ paraphernalia by any
167.5 person while carrying out the duties required under sections 152.22 to 152.37.

167.6 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
167.7 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

167.8 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
167.9 and any health care practitioner are not subject to any civil or disciplinary penalties by the
167.10 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
167.11 professional licensing board or entity, solely for the participation in the registry program
167.12 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
167.13 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
167.14 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
167.15 licensing board from taking action in response to violations of any other section of law.

167.16 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
167.17 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
167.18 for any injury, loss of property, personal injury, or death caused by any act or omission
167.19 while acting within the scope of office or employment under sections 152.22 to 152.37.

167.20 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
167.21 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
167.22 search warrant.

167.23 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
167.24 employee may release data or information about an individual contained in any report,
167.25 document, or registry created under sections 152.22 to 152.37 or any information obtained
167.26 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

167.27 (g) No information contained in a report, document, or registry or obtained from a patient
167.28 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
167.29 unless independently obtained or in connection with a proceeding involving a violation of
167.30 sections 152.22 to 152.37.

167.31 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
167.32 of a gross misdemeanor.

168.1 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
168.2 Court or professional responsibility board for providing legal assistance to prospective or
168.3 registered manufacturers or others related to activity that is no longer subject to criminal
168.4 penalties under state law pursuant to sections 152.22 to 152.37.

168.5 (j) Possession of a registry verification or application for enrollment in the program by
168.6 a person entitled to possess or apply for enrollment in the registry program does not constitute
168.7 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
168.8 or property of the person possessing or applying for the registry verification, or otherwise
168.9 subject the person or property of the person to inspection by any governmental agency.

168.10 Sec. 75. Minnesota Statutes 2020, section 152.36, is amended to read:

168.11 **152.36 IMPACT ASSESSMENT OF MEDICAL CANNABIS THERAPEUTIC**
168.12 **RESEARCH.**

168.13 Subdivision 1. **Task force on medical cannabis therapeutic research.** (a) A 23-member
168.14 task force on medical cannabis therapeutic research is created to conduct an impact
168.15 assessment of medical cannabis therapeutic research. The task force shall consist of the
168.16 following members:

168.17 (1) two members of the house of representatives, one selected by the speaker of the
168.18 house, the other selected by the minority leader;

168.19 (2) two members of the senate, one selected by the majority leader, the other selected
168.20 by the minority leader;

168.21 (3) four members representing consumers or patients enrolled in the registry program,
168.22 including at least two parents of patients under age 18;

168.23 (4) four members representing health care providers, including one licensed pharmacist;

168.24 (5) four members representing law enforcement, one from the Minnesota Chiefs of
168.25 Police Association, one from the Minnesota Sheriff's Association, one from the Minnesota
168.26 Police and Peace Officers Association, and one from the Minnesota County Attorneys
168.27 Association;

168.28 (6) four members representing substance use disorder treatment providers; and

168.29 (7) the commissioners of health, human services, and public safety.

168.30 (b) Task force members listed under paragraph (a), clauses (3), (4), (5), and (6), shall
168.31 be appointed by the governor under the appointment process in section 15.0597. Members
168.32 shall serve on the task force at the pleasure of the appointing authority. ~~All members must~~

169.1 ~~be appointed by July 15, 2014, and the commissioner of health shall convene the first meeting~~
 169.2 ~~of the task force by August 1, 2014.~~

169.3 (c) There shall be two cochair of the task force chosen from the members listed under
 169.4 paragraph (a). One cochair shall be selected by the speaker of the house and the other cochair
 169.5 shall be selected by the majority leader of the senate. The authority to convene meetings
 169.6 shall alternate between the cochair.

169.7 (d) Members of the task force other than those in paragraph (a), clauses (1), (2), and (7),
 169.8 shall receive expenses as provided in section 15.059, subdivision 6.

169.9 Subd. 1a. **Administration.** The commissioner of health shall provide administrative and
 169.10 technical support to the task force.

169.11 Subd. 2. **Impact assessment.** The task force shall hold hearings to evaluate the impact
 169.12 of the use of medical cannabis and hemp and Minnesota's activities involving medical
 169.13 cannabis and hemp, including, but not limited to:

169.14 (1) program design and implementation;

169.15 (2) the impact on the health care provider community;

169.16 (3) patient experiences;

169.17 (4) the impact on the incidence of substance abuse;

169.18 (5) access to and quality of medical cannabis, hemp, and medical cannabis ~~products~~
 169.19 paraphernalia;

169.20 (6) the impact on law enforcement and prosecutions;

169.21 (7) public awareness and perception; and

169.22 (8) any unintended consequences.

169.23 ~~Subd. 3. **Cost assessment.** By January 15 of each year, beginning January 15, 2015,~~
 169.24 ~~and ending January 15, 2019, the commissioners of state departments impacted by the~~
 169.25 ~~medical cannabis therapeutic research study shall report to the cochair of the task force on~~
 169.26 ~~the costs incurred by each department on implementing sections 152.22 to 152.37. The~~
 169.27 ~~reports must compare actual costs to the estimated costs of implementing these sections and~~
 169.28 ~~must be submitted to the task force on medical cannabis therapeutic research.~~

169.29 Subd. 4. **Reports to the legislature.** (a) The cochair of the task force shall submit ~~the~~
 169.30 ~~following reports~~ an impact assessment report to the chair and ranking minority members

170.1 of the legislative committees and divisions with jurisdiction over health and human services,
 170.2 public safety, judiciary, and civil law:

170.3 ~~(1) by February 1, 2015, a report on the design and implementation of the registry~~
 170.4 ~~program; and every two years thereafter, a complete impact assessment report; and.~~

170.5 ~~(2) upon receipt of a cost assessment from a commissioner of a state agency, the~~
 170.6 ~~completed cost assessment.~~

170.7 (b) The task force may make recommendations to the legislature on whether to add or
 170.8 remove conditions from the list of qualifying medical conditions.

170.9 Subd. 5. **No expiration.** The task force on medical cannabis therapeutic research does
 170.10 not expire.

170.11 Sec. 76. **COMMISSIONER OF HEALTH; RECOMMENDATION REGARDING**
 170.12 **EXCEPTION TO HOSPITAL CONSTRUCTION MORATORIUM.**

170.13 By February 1, 2023, the commissioner of health, in consultation with the commissioner
 170.14 of human services, shall make a recommendation to the chairs and ranking minority members
 170.15 of the legislative committees with jurisdiction over health and human services finance as
 170.16 to whether Minnesota Statutes, section 144.551, subdivision 1, should be amended to
 170.17 authorize exceptions, for hospitals in other counties and without a public interest review,
 170.18 that are substantially similar to the exception in Minnesota Statutes, section 144.551,
 170.19 subdivision 1, paragraph (b), clause (31).

170.20 Sec. 77. **REVISOR INSTRUCTION.**

170.21 (a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer
 170.22 reporting system" wherever it appears in Minnesota Statutes and Minnesota Rules.

170.23 (b) The revisor of statutes shall make any necessary cross-reference changes required
 170.24 as a result of the amendments in sections 17 to 22.

170.25 **ARTICLE 3**
 170.26 **HEALTH CARE FINANCE**

170.27 Section 1. **[62J.86] DEFINITIONS.**

170.28 Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following
 170.29 terms have the meanings given.

171.1 Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability
171.2 Advisory Council established under section 62J.88.

171.3 Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under
171.4 section 62J.87.

171.5 Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

171.6 Subdivision 1. **Establishment.** The Health Care Affordability Board is established and
171.7 shall be governed as a board under section 15.012, paragraph (a), to protect consumers,
171.8 state and local governments, health plan companies, providers, and other health care system
171.9 stakeholders from unaffordable health care costs. The board must be operational by January
171.10 1, 2023.

171.11 Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members,
171.12 appointed as follows:

171.13 (1) five members appointed by the governor;

171.14 (2) two members appointed by the majority leader of the senate;

171.15 (3) two members appointed by the minority leader of the senate;

171.16 (4) two members appointed by the speaker of the house; and

171.17 (5) two members appointed by the minority leader of the house of representatives.

171.18 (b) All appointed members must have knowledge and demonstrated expertise in one or
171.19 more of the following areas: health care finance, health economics, health care management
171.20 or administration at a senior level, health care consumer advocacy, representing the health
171.21 care workforce as a leader in a labor organization, purchasing health care insurance as a
171.22 health benefits administrator, delivery of primary care, health plan company administration,
171.23 public or population health, and addressing health disparities and structural inequities.

171.24 (c) A member may not participate in board proceedings involving an organization,
171.25 activity, or transaction in which the member has either a direct or indirect financial interest,
171.26 other than as an individual consumer of health services.

171.27 (d) The Legislative Coordinating Commission shall coordinate appointments under this
171.28 subdivision to ensure that board members are appointed by August 1, 2022, and that board
171.29 members as a whole meet all of the criteria related to the knowledge and expertise specified
171.30 in paragraph (b).

172.1 Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall
172.2 not serve more than three consecutive terms.

172.3 (b) A board member may resign at any time by giving written notice to the board.

172.4 Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from
172.5 the members appointed by the governor.

172.6 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
172.7 board by a majority of the members. The chair shall serve for two years.

172.8 (c) The board shall elect a vice-chair and other officers from its membership as it deems
172.9 necessary.

172.10 Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time
172.11 executive director and other staff, who shall serve in the unclassified service. The executive
172.12 director must have significant knowledge and expertise in health economics and demonstrated
172.13 experience in health policy.

172.14 (b) The attorney general shall provide legal services to the board.

172.15 (c) The Health Economics Program within the Department of Health shall provide
172.16 technical assistance to the board in analyzing health care trends and costs and in setting
172.17 health care spending growth targets.

172.18 (d) The board may employ or contract for professional and technical assistance, including
172.19 actuarial assistance, as the board deems necessary to perform the board's duties.

172.20 Subd. 6. **Access to information.** (a) The board may request that a state agency provide
172.21 the board with any publicly available information in a usable format as requested by the
172.22 board, at no cost to the board.

172.23 (b) The board may request from a state agency unique or custom data sets, and the agency
172.24 may charge the board for providing the data at the same rate the agency would charge any
172.25 other public or private entity.

172.26 (c) Any information provided to the board by a state agency must be de-identified. For
172.27 purposes of this subdivision, "de-identification" means the process used to prevent the
172.28 identity of a person or business from being connected with the information and ensuring
172.29 all identifiable information has been removed.

172.30 (d) Any data submitted to the board retains its original classification under the Minnesota
172.31 Data Practices Act in chapter 13.

173.1 Subd. 7. **Compensation.** Board members shall not receive compensation but may receive
 173.2 reimbursement for expenses as authorized under section 15.059, subdivision 3.

173.3 Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall
 173.4 meet publicly at least quarterly. The board may meet in closed session when reviewing
 173.5 proprietary information as specified in section 62J.71, subdivision 4.

173.6 (b) The board shall announce each public meeting at least two weeks prior to the
 173.7 scheduled date of the meeting. Any materials for the meeting must be made public at least
 173.8 one week prior to the scheduled date of the meeting.

173.9 (c) At each public meeting, the board shall provide the opportunity for comments from
 173.10 the public, including the opportunity for written comments to be submitted to the board
 173.11 prior to a decision by the board.

173.12 Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

173.13 Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability
 173.14 Advisory Council of up to 15 members to provide advice to the board on health care costs
 173.15 and access issues and to represent the views of patients and other stakeholders. Members
 173.16 of the advisory council must be appointed based on their knowledge and demonstrated
 173.17 expertise in one or more of the following areas: health care delivery, ensuring health care
 173.18 access for diverse populations, public and population health, patient perspectives, health
 173.19 care cost trends and drivers, clinical and health services research, innovation in health care
 173.20 delivery, and health care benefits management.

173.21 Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to
 173.22 the board on:

173.23 (1) the identification of economic indicators and other metrics related to the development
 173.24 and setting of health care spending growth targets;

173.25 (2) data sources for measuring health care spending; and

173.26 (3) measurement of the impact of health care spending growth targets on diverse
 173.27 communities and populations, including but not limited to those communities and populations
 173.28 adversely affected by health disparities.

173.29 (b) The council shall report technical recommendations and a summary of its activities
 173.30 to the board at least annually, and shall submit additional reports on its activities and
 173.31 recommendations to the board, as requested by the board or at the discretion of the council.

174.1 Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered
 174.2 terms of two, three, or four years determined by lot by the secretary of state. Following the
 174.3 initial appointments, advisory council members shall serve four-year terms.

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

174.5 Subd. 4. **Compensation.** Advisory council members may be compensated according to
 174.6 section 15.059.

174.7 Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the
 174.8 advisory council are subject to chapter 13D.

174.9 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not
 174.10 expire.

174.11 **Sec. 4. [62J.89] DUTIES OF THE BOARD.**

174.12 Subdivision 1. **General.** (a) The board shall monitor the administration and reform of
 174.13 the health care delivery and payment systems in the state. The board shall:

174.14 (1) set health care spending growth targets for the state, as specified under section 62J.90;

174.15 (2) enhance the transparency of provider organizations;

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

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

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

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

174.21 (b) The board shall establish goals to reduce health care disparities in racial and ethnic
 174.22 communities and to ensure access to quality care for persons with disabilities or with chronic
 174.23 or complex health conditions.

174.24 Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care
 174.25 delivery and payment system in Minnesota to understand emerging trends in the commercial
 174.26 health insurance market, including large self-insured employers and the state's public health
 174.27 care programs, in order to identify opportunities for state action to achieve:

174.28 (1) improved patient experience of care, including quality and satisfaction;

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

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

175.1 Subd. 3. **Recommendations for reform.** The board shall recommend legislative policy,
175.2 market, or any other reforms to:

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

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

175.7 (3) improve the quality and value of care for all Minnesotans, and for specific populations
175.8 adversely affected by health inequities.

175.9 Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient
175.10 Protection, to be operational by January 1, 2024. The office shall assist consumers with
175.11 issues related to access and quality of health care, and advise the legislature on ways to
175.12 reduce consumer health care spending and improve consumer experiences by reducing
175.13 complexity for consumers.

175.14 Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

175.15 Subdivision 1. **Establishment and administration.** The board shall establish and
175.16 administer the health care spending growth target program to limit health care spending
175.17 growth in the state, and shall report regularly to the legislature and the public on progress
175.18 toward these targets.

175.19 Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual
175.20 health care spending growth targets and the economic indicators to be used in establishing
175.21 the initial and subsequent target levels.

175.22 (b) The health care spending growth target must:

175.23 (1) use a clear and operational definition of total state health care spending;

175.24 (2) promote a predictable and sustainable rate of growth for total health care spending
175.25 as measured by an established economic indicator, such as the rate of increase of the state's
175.26 economy or of the personal income of residents of this state, or a combination;

175.27 (3) define the health care markets and the entities to which the targets apply;

175.28 (4) take into consideration the potential for variability in targets across public and private
175.29 payers;

175.30 (5) account for the health status of patients; and

175.31 (6) incorporate specific benchmarks related to health equity.

176.1 (c) In developing, implementing, and evaluating the growth target program, the board
176.2 shall:

176.3 (1) consider the incorporation of quality of care and primary care spending goals;

176.4 (2) ensure that the program does not place a disproportionate burden on communities
176.5 most impacted by health disparities, the providers who primarily serve communities most
176.6 impacted by health disparities, or individuals who reside in rural areas or have high health
176.7 care needs;

176.8 (3) explicitly consider payment models that help ensure financial sustainability of rural
176.9 health care delivery systems and the ability to provide population health;

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

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

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

176.15 (5) ensure that growth targets:

176.16 (i) do not constrain the Minnesota health care workforce, including the need to provide
176.17 competitive wages and benefits;

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

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

176.21 (6) consult with the advisory council and other stakeholders.

176.22 Subd. 3. **Data.** The board shall identify data to be used for tracking performance in
176.23 meeting the growth target and identify methods of data collection necessary for efficient
176.24 implementation by the board. In identifying data and methods, the board shall:

176.25 (1) consider the availability, timeliness, quality, and usefulness of existing data, including
176.26 the data collected under section 62U.04;

176.27 (2) assess the need for additional investments in data collection, data validation, or data
176.28 analysis capacity to support the board in performing its duties; and

176.29 (3) minimize the reporting burden to the extent possible.

176.30 Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2023, and
176.31 by June 15 of each succeeding calendar year through June 15, 2027, shall establish annual

177.1 health care spending growth targets for the next calendar year consistent with the
177.2 requirements of this section. The board shall set annual health care spending growth targets
177.3 for the five-year period from January 1, 2024, through December 31, 2028.

177.4 (b) The board shall periodically review all components of the health care spending
177.5 growth target program methodology, economic indicators, and other factors. The board may
177.6 revise the annual spending growth targets after a public hearing, as appropriate. If the board
177.7 revises a spending growth target, the board must provide public notice at least 60 days
177.8 before the start of the calendar year to which the revised growth target will apply.

177.9 (c) The board, based on an analysis of drivers of health care spending and evidence from
177.10 public testimony, shall evaluate strategies and new policies, including the establishment of
177.11 accountability mechanisms, that are able to contribute to meeting growth targets and limiting
177.12 health care spending growth without increasing disparities in access to health care.

177.13 Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present
177.14 findings from spending growth target monitoring. The board shall also regularly hold public
177.15 hearings to take testimony from stakeholders on health care spending growth, setting and
177.16 revising health care spending growth targets, the impact of spending growth and growth
177.17 targets on health care access and quality, and as needed to perform the duties assigned under
177.18 section 62J.89, subdivisions 1, 2, and 3.

177.19 Sec. 6. **[62J.91] NOTICE TO HEALTH CARE ENTITIES.**

177.20 Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that
177.21 have been identified by the board as exceeding the spending growth target for any given
177.22 year.

177.23 (b) For purposes of this section, "health care entity" must be defined by the board during
177.24 the development of the health care spending growth methodology. When developing this
177.25 methodology, the board shall consider a definition of health care entity that includes clinics,
177.26 hospitals, ambulatory surgical centers, physician organizations, accountable care
177.27 organizations, integrated provider and plan systems, and other entities defined by the board,
177.28 provided that physician organizations with a patient panel of 15,000 or fewer, or which
177.29 represent providers who collectively receive less than \$25,000,000 in annual net patient
177.30 service revenue from health plan companies and other payers, are exempt.

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

178.1 implement a performance improvement plan. The board shall provide written notice of this
178.2 requirement to health care entities.

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

178.5 (1) file a performance improvement plan with the board; or

178.6 (2) file an application with the board to waive the requirement to file a performance
178.7 improvement plan or extend the timeline for filing a performance improvement plan.

178.8 (c) The health care entity may file any documentation or supporting evidence with the
178.9 board to support the health care entity's application to waive or extend the timeline to file
178.10 a performance improvement plan. The board shall require the health care entity to submit
178.11 any other relevant information it deems necessary in considering the waiver or extension
178.12 application, provided that this information must be made public at the discretion of the
178.13 board. The board may waive or delay the requirement for a health care entity to file a
178.14 performance improvement plan in response to a waiver or extension request in light of all
178.15 information received from the health care entity, based on a consideration of the following
178.16 factors:

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

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

178.22 (3) whether the factors that led to increased costs for the health care entity can reasonably
178.23 be considered to be unanticipated and outside of the control of the entity. These factors may
178.24 include but are not limited to age and other health status adjusted factors and other cost
178.25 inputs such as pharmaceutical expenses and medical device expenses;

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

178.27 (5) any other factors the board considers relevant. If the board declines to waive or
178.28 extend the requirement for the health care entity to file a performance improvement plan,
178.29 the board shall provide written notice to the health care entity that its application for a waiver
178.30 or extension was denied and the health care entity shall file a performance improvement
178.31 plan.

178.32 (d) A health care entity shall file a performance improvement plan with the board:

- 179.1 (1) within 45 days of receipt of an initial notice;
- 179.2 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt
- 179.3 of a notice that such waiver or extension has been denied; or
- 179.4 (3) if the health care entity is granted an extension, on the date given on the extension.
- 179.5 (e) The performance improvement plan must identify the causes of the entity's cost
- 179.6 growth and include but not be limited to specific strategies, adjustments, and action steps
- 179.7 the entity proposes to implement to improve cost performance. The proposed performance
- 179.8 improvement plan must include specific identifiable and measurable expected outcomes
- 179.9 and a timetable for implementation. The timetable for a performance improvement plan
- 179.10 must not exceed 18 months.
- 179.11 (f) The board shall approve any performance improvement plan it determines is
- 179.12 reasonably likely to address the underlying cause of the entity's cost growth and has a
- 179.13 reasonable expectation for successful implementation. If the board determines that the
- 179.14 performance improvement plan is unacceptable or incomplete, the board may provide
- 179.15 consultation on the criteria that have not been met and may allow an additional time period
- 179.16 of up to 30 calendar days for resubmission. Upon approval of the proposed performance
- 179.17 improvement plan, the board shall notify the health care entity to begin immediate
- 179.18 implementation of the performance improvement plan. The board shall provide public notice
- 179.19 on its website identifying that the health care entity is implementing a performance
- 179.20 improvement plan. All health care entities implementing an approved performance
- 179.21 improvement plan shall be subject to additional reporting requirements and compliance
- 179.22 monitoring, as determined by the board. The board shall provide assistance to the health
- 179.23 care entity in the successful implementation of the performance improvement plan.
- 179.24 (g) All health care entities shall in good faith work to implement the performance
- 179.25 improvement plan. At any point during the implementation of the performance improvement
- 179.26 plan, the health care entity may file amendments to the performance improvement plan,
- 179.27 subject to approval of the board. At the conclusion of the timetable established in the
- 179.28 performance improvement plan, the health care entity shall report to the board regarding
- 179.29 the outcome of the performance improvement plan. If the board determines the performance
- 179.30 improvement plan was not implemented successfully, the board shall:
- 179.31 (1) extend the implementation timetable of the existing performance improvement plan;
- 179.32 (2) approve amendments to the performance improvement plan as proposed by the health
- 179.33 care entity;

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

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

180.4 (h) Upon the successful completion of the performance improvement plan, the board
180.5 shall remove the identity of the health care entity from the board's website. The board may
180.6 assist health care entities with implementing the performance improvement plans or otherwise
180.7 ensure compliance with this subdivision.

180.8 (i) If the board determines that a health care entity has:

180.9 (1) willfully neglected to file a performance improvement plan with the board within
180.10 45 days as required;

180.11 (2) failed to file an acceptable performance improvement plan in good faith with the
180.12 board;

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

180.14 (4) knowingly failed to provide information required by this subdivision to the board or
180.15 knowingly provided false information, the board may assess a civil penalty to the health
180.16 care entity of not more than \$500,000. The board must only impose a civil penalty as a last
180.17 resort.

180.18 **Sec. 7. [62J.92] REPORTING REQUIREMENTS.**

180.19 Subdivision 1. **General requirement.** (a) The board shall present the reports required
180.20 by this section to the chairs and ranking members of the legislative committees with primary
180.21 jurisdiction over health care finance and policy. The board shall also make these reports
180.22 available to the public on the board's website.

180.23 (b) The board may contract with a third-party vendor for technical assistance in preparing
180.24 the reports.

180.25 Subd. 2. **Progress reports.** The board shall submit written progress updates about the
180.26 development and implementation of the health care spending growth target program by
180.27 February 15, 2024, and February 15, 2025. The updates must include reporting on board
180.28 membership and activities, program design decisions, planned timelines for implementation
180.29 of the program, and the progress of implementation. The reports must include the
180.30 methodological details underlying program design decisions.

181.1 Subd. 3. Health care spending trends. By December 15, 2024, and every December
181.2 15 thereafter, the board shall submit a report on health care spending trends and the health
181.3 care spending growth target program that includes:

181.4 (1) spending growth in aggregate and for entities subject to health care spending growth
181.5 targets relative to established target levels;

181.6 (2) findings from analyses of drivers of health care spending growth;

181.7 (3) estimates of the impact of health care spending growth on Minnesota residents,
181.8 including for communities most impacted by health disparities, related to their access to
181.9 insurance and care, value of health care, and the ability to pursue other spending priorities;

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

181.12 (5) changes under consideration for revising the methodology to monitor or set growth
181.13 targets;

181.14 (6) recommendations for initiatives to assist health care entities in meeting health care
181.15 spending growth targets, including broader and more transparent adoption of value-based
181.16 payment arrangements; and

181.17 (7) the number of health care entities whose spending growth exceeded growth targets,
181.18 information on performance improvement plans and the extent to which the plans were
181.19 completed, and any civil penalties imposed on health care entities related to noncompliance
181.20 with performance improvement plans and related requirements.

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

181.22 **Subd. 11. Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
181.23 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
181.24 designee shall only use the data submitted under subdivisions 4 and 5 for the following
181.25 purposes:

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

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

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

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

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

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

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

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

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

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

182.15 (6) to provide technical assistance to the Health Care Affordability Board to implement
182.16 sections 62J.86 to 62J.92.

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

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

182.23 (d) The commissioner or the commissioner's designee may use the data submitted under
182.24 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
182.25 2023.

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

182.29 Sec. 9. Minnesota Statutes 2020, section 256B.021, subdivision 4, is amended to read:

182.30 Subd. 4. **Projects.** The commissioner shall request permission and funding to further
182.31 the following initiatives.

183.1 (a) Health care delivery demonstration projects. This project involves testing alternative
183.2 payment and service delivery models in accordance with sections 256B.0755 and 256B.0756.
183.3 These demonstrations will allow the Minnesota Department of Human Services to engage
183.4 in alternative payment arrangements with provider organizations that provide services to a
183.5 specified patient population for an agreed upon total cost of care or risk/gain sharing payment
183.6 arrangement, but are not limited to these models of care delivery or payment. Quality of
183.7 care and patient experience will be measured and incorporated into payment models alongside
183.8 the cost of care. Demonstration sites should include Minnesota health care programs
183.9 fee-for-services recipients and managed care enrollees and support a robust primary care
183.10 model and improved care coordination for recipients.

183.11 (b) Promote personal responsibility and encourage and reward healthy outcomes. This
183.12 project provides Medicaid funding to provide individual and group incentives to encourage
183.13 healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus
183.14 areas may include diabetes prevention and management, tobacco cessation, reducing weight,
183.15 lowering cholesterol, and lowering blood pressure.

183.16 (c) Encourage utilization of high quality, cost-effective care. This project creates
183.17 incentives ~~through Medicaid and MinnesotaCare enrollee cost-sharing and other means to~~
183.18 encourage the utilization of high-quality, low-cost, high-value providers, as determined by
183.19 the state's provider peer grouping initiative under section 62U.04.

183.20 (d) Adults without children. This proposal includes requesting federal authority to impose
183.21 a limit on assets for adults without children in medical assistance, as defined in section
183.22 256B.055, subdivision 15, who have a household income equal to or less than 75 percent
183.23 of the federal poverty limit, and to impose a 180-day durational residency requirement in
183.24 MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children,
183.25 regardless of income.

183.26 (e) Empower and encourage work, housing, and independence. This project provides
183.27 services and supports for individuals who have an identified health or disabling condition
183.28 but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce
183.29 the need for intensive health care and long-term care services and supports, and to help
183.30 maintain or obtain employment or assist in return to work. Benefits may include:

183.31 (1) coordination with health care homes or health care coordinators;

183.32 (2) assessment for wellness, housing needs, employment, planning, and goal setting;

183.33 (3) training services;

- 184.1 (4) job placement services;
- 184.2 (5) career counseling;
- 184.3 (6) benefit counseling;
- 184.4 (7) worker supports and coaching;
- 184.5 (8) assessment of workplace accommodations;
- 184.6 (9) transitional housing services; and
- 184.7 (10) assistance in maintaining housing.
- 184.8 (f) Redesign home and community-based services. This project realigns existing funding,
184.9 services, and supports for people with disabilities and older Minnesotans to ensure community
184.10 integration and a more sustainable service system. This may involve changes that promote
184.11 a range of services to flexibly respond to the following needs:
- 184.12 (1) provide people less expensive alternatives to medical assistance services;
- 184.13 (2) offer more flexible and updated community support services under the Medicaid
184.14 state plan;
- 184.15 (3) provide an individual budget and increased opportunity for self-direction;
- 184.16 (4) strengthen family and caregiver support services;
- 184.17 (5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected
184.18 needs or foster development of needed services;
- 184.19 (6) use of home and community-based waiver programs for people whose needs cannot
184.20 be met with the expanded Medicaid state plan community support service options;
- 184.21 (7) target access to residential care for those with higher needs;
- 184.22 (8) develop capacity within the community for crisis intervention and prevention;
- 184.23 (9) redesign case management;
- 184.24 (10) offer life planning services for families to plan for the future of their child with a
184.25 disability;
- 184.26 (11) enhance self-advocacy and life planning for people with disabilities;
- 184.27 (12) improve information and assistance to inform long-term care decisions; and
- 184.28 (13) increase quality assurance, performance measurement, and outcome-based
184.29 reimbursement.

185.1 This project may include different levels of long-term supports that allow seniors to remain
185.2 in their homes and communities, and expand care transitions from acute care to community
185.3 care to prevent hospitalizations and nursing home placement. The levels of support for
185.4 seniors may range from basic community services for those with lower needs, access to
185.5 residential services if a person has higher needs, and targets access to nursing home care to
185.6 those with rehabilitation or high medical needs. This may involve the establishment of
185.7 medical need thresholds to accommodate the level of support needed; provision of a
185.8 long-term care consultation to persons seeking residential services, regardless of payer
185.9 source; adjustment of incentives to providers and care coordination organizations to achieve
185.10 desired outcomes; and a required coordination with medical assistance basic care benefit
185.11 and Medicare/Medigap benefit. This proposal will improve access to housing and improve
185.12 capacity to maintain individuals in their existing home; adjust screening and assessment
185.13 tools, as needed; improve transition and relocation efforts; seek federal financial participation
185.14 for alternative care and essential community supports; and provide Medigap coverage for
185.15 people having lower needs.

185.16 (g) Coordinate and streamline services for people with complex needs, including those
185.17 with multiple diagnoses of physical, mental, and developmental conditions. This project
185.18 will coordinate and streamline medical assistance benefits for people with complex needs
185.19 and multiple diagnoses. It would include changes that:

185.20 (1) develop community-based service provider capacity to serve the needs of this group;

185.21 (2) build assessment and care coordination expertise specific to people with multiple
185.22 diagnoses;

185.23 (3) adopt service delivery models that allow coordinated access to a range of services
185.24 for people with complex needs;

185.25 (4) reduce administrative complexity;

185.26 (5) measure the improvements in the state's ability to respond to the needs of this
185.27 population; and

185.28 (6) increase the cost-effectiveness for the state budget.

185.29 (h) Implement nursing home level of care criteria. This project involves obtaining any
185.30 necessary federal approval in order to implement the changes to the level of care criteria in
185.31 section 144.0724, subdivision 11, and implement further changes necessary to achieve
185.32 reform of the home and community-based service system.

186.1 (i) Improve integration of Medicare and Medicaid. This project involves reducing
186.2 fragmentation in the health care delivery system to improve care for people eligible for both
186.3 Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term
186.4 care. The proposal may include:

186.5 (1) requesting an exception to the new Medicare methodology for payment adjustment
186.6 for fully integrated special needs plans for dual eligible individuals;

186.7 (2) testing risk adjustment models that may be more favorable to capturing the needs of
186.8 frail dually eligible individuals;

186.9 (3) requesting an exemption from the Medicare bidding process for fully integrated
186.10 special needs plans for the dually eligible;

186.11 (4) modifying the Medicare bid process to recognize additional costs of health home
186.12 services; and

186.13 (5) requesting permission for risk-sharing and gain-sharing.

186.14 (j) Intensive residential treatment services. This project would involve providing intensive
186.15 residential treatment services for individuals who have serious mental illness and who have
186.16 other complex needs. This proposal would allow such individuals to remain in these settings
186.17 after mental health symptoms have stabilized, in order to maintain their mental health and
186.18 avoid more costly or unnecessary hospital or other residential care due to their other complex
186.19 conditions. The commissioner may pursue a specialized rate for projects created under this
186.20 section.

186.21 (k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center
186.22 (AMRTC). This project involves seeking Medicaid reimbursement for medical services
186.23 provided to patients to AMRTC, including requesting a waiver of United States Code, title
186.24 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services
186.25 provided by hospitals with more than 16 beds that are primarily focused on the treatment
186.26 of mental illness. This waiver would allow AMRTC to serve as a statewide resource to
186.27 provide diagnostics and treatment for people with the most complex conditions.

186.28 (l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in
186.29 residential facilities. This proposal would seek Medicaid reimbursement for any
186.30 Medicaid-covered service for children who are placed in residential settings that are
186.31 determined to be "institutions for mental diseases," under United States Code, title 42,
186.32 section 1396d.

186.33 **EFFECTIVE DATE.** This section is effective January 1, 2023.

187.1 Sec. 10. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, is
187.2 amended to read:

187.3 Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report
187.4 beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority
187.5 members of the legislative committees with jurisdiction over health and human services
187.6 policy and finance that includes the percentage for adults and children one through 20 years
187.7 of age for the most recent complete calendar year receiving at least one dental visit for both
187.8 fee-for-service and the prepaid medical assistance program. The report must include:

187.9 (1) statewide utilization for both fee-for-service and for the prepaid medical assistance
187.10 program;

187.11 (2) utilization by county;

187.12 (3) utilization by children receiving dental services through fee-for-service and through
187.13 a managed care plan or county-based purchasing plan;

187.14 (4) utilization by adults receiving dental services through fee-for-service and through a
187.15 managed care plan or county-based purchasing plan.

187.16 (b) The report must also include a description of any corrective action plans required to
187.17 be submitted under subdivision 2.

187.18 (c) The initial report due on March 15, 2022, must include the utilization metrics described
187.19 in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

187.20 (d) In the annual report due on March 15, 2023, and in each report due thereafter, the
187.21 commissioner shall include the following:

187.22 (1) the number of dentists enrolled with the commissioner as a medical assistance dental
187.23 provider and the county or counties in which the dentist provides services;

187.24 (2) the number of enrolled dentists who provided fee-for-service dental services to
187.25 medical assistance or MinnesotaCare patients within the previous calendar year in the
187.26 following increments: one to nine patients, ten to 100 patients, and over 100 patients;

187.27 (3) the number of enrolled dentists who provided dental services to medical assistance
187.28 or MinnesotaCare patients through a managed care plan or county-based purchasing plan
187.29 within the previous calendar year in the following increments: one to nine patients, ten to
187.30 100 patients, and over 100 patients; and

187.31 (4) the number of dentists who provided dental services to a new patient who was enrolled
187.32 in medical assistance or MinnesotaCare within the previous calendar year.

188.1 (e) The report due on March 15, 2023, must include the metrics described in paragraph
 188.2 (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

188.3 Sec. 11. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
 188.4 to read:

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

188.9 (1) eyeglasses;

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

188.13 (3) hearing aids and supplies;

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

188.15 (i) hospital beds;

188.16 (ii) commodes;

188.17 (iii) glide-about chairs;

188.18 (iv) patient lift apparatus;

188.19 (v) wheelchairs and accessories;

188.20 (vi) oxygen administration equipment;

188.21 (vii) respiratory therapy equipment;

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

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

188.25 (5) nonemergency medical transportation level of need determinations, disbursement of
 188.26 public transportation passes and tokens, and volunteer and recipient mileage and parking
 188.27 reimbursements; and

188.28 (6) drugs.

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

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

189.4 **EFFECTIVE DATE.** This section is effective January 1, 2023.

189.5 Sec. 12. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
189.6 to read:

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

189.11 (1) eyeglasses;

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

189.15 (3) hearing aids and supplies;

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

189.17 (i) hospital beds;

189.18 (ii) commodes;

189.19 (iii) glide-about chairs;

189.20 (iv) patient lift apparatus;

189.21 (v) wheelchairs and accessories;

189.22 (vi) oxygen administration equipment;

189.23 (vii) respiratory therapy equipment;

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

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

189.27 (5) nonemergency medical transportation level of need determinations, disbursement of
189.28 public transportation passes and tokens, and volunteer and recipient mileage and parking
189.29 reimbursements; ~~and~~

189.30 (6) drugs; and

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

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

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

190.7 Sec. 13. Minnesota Statutes 2020, section 256B.055, subdivision 17, is amended to read:

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

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

190.18 **EFFECTIVE DATE.** This section is effective January 1, 2023.

190.19 Sec. 14. Minnesota Statutes 2020, section 256B.056, subdivision 3, is amended to read:

190.20 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
190.21 assistance, a person must not individually own more than \$3,000 in assets, or if a member
190.22 of a household with two family members, husband and wife, or parent and child, the
190.23 household must not own more than \$6,000 in assets, plus \$200 for each additional legal
190.24 dependent. In addition to these maximum amounts, an eligible individual or family may
190.25 accrue interest on these amounts, but they must be reduced to the maximum at the time of
190.26 an eligibility redetermination. The accumulation of the clothing and personal needs allowance
190.27 according to section 256B.35 must also be reduced to the maximum at the time of the
190.28 eligibility redetermination. The value of assets that are not considered in determining
190.29 eligibility for medical assistance is the value of those assets excluded under the Supplemental
190.30 Security Income program for aged, blind, and disabled persons, with the following
190.31 exceptions:

190.32 (1) household goods and personal effects are not considered;

191.1 (2) capital and operating assets of a trade or business that the local agency determines
191.2 are necessary to the person's ability to earn an income are not considered;

191.3 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
191.4 Income program;

191.5 (4) assets designated as burial expenses are excluded to the same extent excluded by the
191.6 Supplemental Security Income program. Burial expenses funded by annuity contracts or
191.7 life insurance policies must irrevocably designate the individual's estate as contingent
191.8 beneficiary to the extent proceeds are not used for payment of selected burial expenses;

191.9 (5) for a person who no longer qualifies as an employed person with a disability due to
191.10 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
191.11 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
191.12 as an employed person with a disability, to the extent that the person's total assets remain
191.13 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

191.14 (6) a designated employment incentives asset account is disregarded when determining
191.15 eligibility for medical assistance for a person age 65 years or older under section 256B.055,
191.16 subdivision 7. An employment incentives asset account must only be designated by a person
191.17 who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a
191.18 24-consecutive-month period. A designated employment incentives asset account contains
191.19 qualified assets owned by the person and the person's spouse in the last month of enrollment
191.20 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
191.21 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
191.22 other nonexcluded assets. An employment incentives asset account is no longer designated
191.23 when a person loses medical assistance eligibility for a calendar month or more before
191.24 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
191.25 a new designated employment incentives asset account by establishing a new
191.26 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
191.27 income of a spouse of a person enrolled in medical assistance under section 256B.057,
191.28 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
191.29 must be disregarded when determining eligibility for medical assistance under section
191.30 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
191.31 in section 256B.059; ~~and~~

191.32 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
191.33 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

192.1 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
 192.2 definition of Indian according to Code of Federal Regulations, title 42, section 447.50; and

192.3 (8) for individuals who were enrolled in medical assistance during the COVID-19 federal
 192.4 public health emergency declared by the United States Secretary of Health and Human
 192.5 Services and who are subject to the asset limits established by this subdivision, assets in
 192.6 excess of the limits must be disregarded until 95 days after the individual's first renewal
 192.7 occurring after the expiration of the COVID-19 federal public health emergency declared
 192.8 by the United States Secretary of Health and Human Services.

192.9 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
 192.10 15.

192.11 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
 192.12 whichever is later. The commissioner of human services shall notify the revisor of statutes
 192.13 when federal approval is obtained.

192.14 Sec. 15. Minnesota Statutes 2020, section 256B.056, subdivision 4, is amended to read:

192.15 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
 192.16 256B.055, subdivisions 7, 7a, and 12, may have income up to ~~100~~ percent of the federal
 192.17 poverty guidelines effective July 1, 2024, and up to 133 percent of the federal poverty
 192.18 guidelines effective July 1, 2025. Effective January 1, 2000, and each successive January,
 192.19 recipients of Supplemental Security Income may have an income up to the Supplemental
 192.20 Security Income standard in effect on that date.

192.21 (b) To be eligible for medical assistance under section 256B.055, subdivision 3a, a parent
 192.22 or caretaker relative may have an income up to 133 percent of the federal poverty guidelines
 192.23 for the household size.

192.24 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a
 192.25 person may have an income up to 133 percent of federal poverty guidelines for the household
 192.26 size.

192.27 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child
 192.28 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for
 192.29 the household size.

192.30 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
 192.31 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
 192.32 household size.

193.1 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
 193.2 who are not residents of long-term care facilities, the commissioner shall disregard increases
 193.3 in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons
 193.4 eligible under paragraph (a), veteran aid and attendance benefits and Veterans Administration
 193.5 unusual medical expense payments are considered income to the recipient.

193.6 Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 7, is amended to read:

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

193.10 (b) For a person eligible for an insurance affordability program as defined in section
 193.11 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
 193.12 assistance, eligibility is available for the month the change was reported and for three months
 193.13 prior to the month the change was reported, if the person was eligible in those prior months.

193.14 (c) Once determined eligible for medical assistance, a child under the age of 21 is
 193.15 continuously eligible for a period of up to 12 months, unless:

193.16 (1) the child reaches age 21;

193.17 (2) the child requests voluntary termination of coverage;

193.18 (3) the child ceases to be a resident of Minnesota;

193.19 (4) the child dies; or

193.20 (5) the agency determines the child's eligibility was erroneously granted due to agency
 193.21 error or enrollee fraud, abuse, or perjury.

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

193.25 Sec. 17. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 9, is
 193.26 amended to read:

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

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

- 194.1 ~~(1) comprehensive exams, limited to once every five years;~~
- 194.2 ~~(2) periodic exams, limited to one per year;~~
- 194.3 ~~(3) limited exams;~~
- 194.4 ~~(4) bitewing x-rays, limited to one per year;~~
- 194.5 ~~(5) periapical x-rays;~~
- 194.6 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~
- 194.7 ~~for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once~~
- 194.8 ~~every two years for patients who cannot cooperate for intraoral film due to a developmental~~
- 194.9 ~~disability or medical condition that does not allow for intraoral film placement;~~
- 194.10 ~~(7) prophylaxis, limited to one per year;~~
- 194.11 ~~(8) application of fluoride varnish, limited to one per year;~~
- 194.12 ~~(9) posterior fillings, all at the amalgam rate;~~
- 194.13 ~~(10) anterior fillings;~~
- 194.14 ~~(11) endodontics, limited to root canals on the anterior and premolars only;~~
- 194.15 ~~(12) removable prostheses, each dental arch limited to one every six years;~~
- 194.16 ~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~
- 194.17 ~~(14) palliative treatment and sedative fillings for relief of pain;~~
- 194.18 ~~(15) full-mouth debridement, limited to one every five years; and~~
- 194.19 ~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing~~
- 194.20 ~~once every two years for each quadrant, and routine periodontal maintenance procedures.~~
- 194.21 ~~(c) In addition to the services specified in paragraph (b), medical assistance covers the~~
- 194.22 ~~following services for adults, if provided in an outpatient hospital setting or freestanding~~
- 194.23 ~~ambulatory surgical center as part of outpatient dental surgery:~~
- 194.24 ~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~
- 194.25 ~~(2) general anesthesia; and~~
- 194.26 ~~(3) full-mouth survey once every five years.~~
- 194.27 ~~(d) Medical assistance covers medically necessary dental services for children and~~
- 194.28 ~~pregnant women. The following guidelines apply:~~
- 194.29 (1) posterior fillings are paid at the amalgam rate;

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

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

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

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

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

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

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

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

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

195.19 Sec. 18. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 17, is
 195.20 amended to read:

195.21 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
 195.22 means motor vehicle transportation provided by a public or private person that serves
 195.23 Minnesota health care program beneficiaries who do not require emergency ambulance
 195.24 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

195.25 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
 195.26 emergency medical care or transportation costs incurred by eligible persons in obtaining
 195.27 emergency or nonemergency medical care when paid directly to an ambulance company,
 195.28 nonemergency medical transportation company, or other recognized providers of
 195.29 transportation services. Medical transportation must be provided by:

195.30 (1) nonemergency medical transportation providers who meet the requirements of this
 195.31 subdivision;

196.1 (2) ambulances, as defined in section 144E.001, subdivision 2;

196.2 (3) taxicabs that meet the requirements of this subdivision;

196.3 (4) public transit, as defined in section 174.22, subdivision 7; or

196.4 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
196.5 subdivision 1, paragraph (h).

196.6 (c) Medical assistance covers nonemergency medical transportation provided by
196.7 nonemergency medical transportation providers enrolled in the Minnesota health care
196.8 programs. All nonemergency medical transportation providers must comply with the
196.9 operating standards for special transportation service as defined in sections 174.29 to 174.30
196.10 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
196.11 commissioner and reported on the claim as the individual who provided the service. All
196.12 nonemergency medical transportation providers shall bill for nonemergency medical
196.13 transportation services in accordance with Minnesota health care programs criteria. Publicly
196.14 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
196.15 requirements outlined in this paragraph.

196.16 (d) An organization may be terminated, denied, or suspended from enrollment if:

196.17 (1) the provider has not initiated background studies on the individuals specified in
196.18 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

196.19 (2) the provider has initiated background studies on the individuals specified in section
196.20 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

196.21 (i) the commissioner has sent the provider a notice that the individual has been
196.22 disqualified under section 245C.14; and

196.23 (ii) the individual has not received a disqualification set-aside specific to the special
196.24 transportation services provider under sections 245C.22 and 245C.23.

196.25 (e) The administrative agency of nonemergency medical transportation must:

196.26 (1) adhere to the policies defined by the commissioner in consultation with the
196.27 Nonemergency Medical Transportation Advisory Committee;

196.28 (2) pay nonemergency medical transportation providers for services provided to
196.29 Minnesota health care programs beneficiaries to obtain covered medical services;

196.30 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
196.31 trips, and number of trips by mode; and

197.1 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
197.2 administrative structure assessment tool that meets the technical requirements established
197.3 by the commissioner, reconciles trip information with claims being submitted by providers,
197.4 and ensures prompt payment for nonemergency medical transportation services.

197.5 (f) Until the commissioner implements the single administrative structure and delivery
197.6 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
197.7 commissioner or an entity approved by the commissioner that does not dispatch rides for
197.8 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

197.9 (g) The commissioner may use an order by the recipient's attending physician, advanced
197.10 practice registered nurse, or a medical or mental health professional to certify that the
197.11 recipient requires nonemergency medical transportation services. Nonemergency medical
197.12 transportation providers shall perform driver-assisted services for eligible individuals, when
197.13 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
197.14 residence or place of business, assistance with admittance of the individual to the medical
197.15 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
197.16 or stretchers in the vehicle.

197.17 Nonemergency medical transportation providers must take clients to the health care
197.18 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
197.19 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
197.20 authorization from the local agency.

197.21 Nonemergency medical transportation providers may not bill for separate base rates for
197.22 the continuation of a trip beyond the original destination. Nonemergency medical
197.23 transportation providers must maintain trip logs, which include pickup and drop-off times,
197.24 signed by the medical provider or client, whichever is deemed most appropriate, attesting
197.25 to mileage traveled to obtain covered medical services. Clients requesting client mileage
197.26 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
197.27 services.

197.28 (h) The administrative agency shall use the level of service process established by the
197.29 commissioner in consultation with the Nonemergency Medical Transportation Advisory
197.30 Committee to determine the client's most appropriate mode of transportation. If public transit
197.31 or a certified transportation provider is not available to provide the appropriate service mode
197.32 for the client, the client may receive a onetime service upgrade.

197.33 (i) The covered modes of transportation are:

198.1 (1) client reimbursement, which includes client mileage reimbursement provided to
198.2 clients who have their own transportation, or to family or an acquaintance who provides
198.3 transportation to the client;

198.4 (2) volunteer transport, which includes transportation by volunteers using their own
198.5 vehicle;

198.6 (3) unassisted transport, which includes transportation provided to a client by a taxicab
198.7 or public transit. If a taxicab or public transit is not available, the client can receive
198.8 transportation from another nonemergency medical transportation provider;

198.9 (4) assisted transport, which includes transport provided to clients who require assistance
198.10 by a nonemergency medical transportation provider;

198.11 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
198.12 dependent on a device and requires a nonemergency medical transportation provider with
198.13 a vehicle containing a lift or ramp;

198.14 (6) protected transport, which includes transport provided to a client who has received
198.15 a prescreening that has deemed other forms of transportation inappropriate and who requires
198.16 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
198.17 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
198.18 the vehicle driver; and (ii) who is certified as a protected transport provider; and

198.19 (7) stretcher transport, which includes transport for a client in a prone or supine position
198.20 and requires a nonemergency medical transportation provider with a vehicle that can transport
198.21 a client in a prone or supine position.

198.22 (j) The local agency shall be the single administrative agency and shall administer and
198.23 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
198.24 commissioner has developed, made available, and funded the web-based single administrative
198.25 structure, assessment tool, and level of need assessment under subdivision 18e. The local
198.26 agency's financial obligation is limited to funds provided by the state or federal government.

198.27 (k) The commissioner shall:

198.28 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
198.29 verify that the mode and use of nonemergency medical transportation is appropriate;

198.30 (2) verify that the client is going to an approved medical appointment; and

198.31 (3) investigate all complaints and appeals.

199.1 (l) The administrative agency shall pay for the services provided in this subdivision and
199.2 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
199.3 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
199.4 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

199.5 (m) Payments for nonemergency medical transportation must be paid based on the client's
199.6 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
199.7 medical assistance reimbursement rates for nonemergency medical transportation services
199.8 that are payable by or on behalf of the commissioner for nonemergency medical
199.9 transportation services are:

199.10 (1) \$0.22 per mile for client reimbursement;

199.11 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
199.12 transport;

199.13 (3) equivalent to the standard fare for unassisted transport when provided by public
199.14 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
199.15 medical transportation provider;

199.16 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

199.17 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

199.18 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

199.19 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
199.20 an additional attendant if deemed medically necessary.

199.21 (n) The base rate for nonemergency medical transportation services in areas defined
199.22 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
199.23 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
199.24 services in areas defined under RUCA to be rural or super rural areas is:

199.25 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
199.26 rate in paragraph (m), clauses (1) to (7); and

199.27 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
199.28 rate in paragraph (m), clauses (1) to (7).

199.29 (o) For purposes of reimbursement rates for nonemergency medical transportation
199.30 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
199.31 shall determine whether the urban, rural, or super rural reimbursement rate applies.

200.1 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
200.2 a census-tract based classification system under which a geographical area is determined
200.3 to be urban, rural, or super rural.

200.4 (q) The commissioner, when determining reimbursement rates for nonemergency medical
200.5 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
200.6 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

200.7 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
200.8 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
200.9 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
200.10 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
200.11 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
200.12 or decrease must be calculated using the average of the most recently available price of all
200.13 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
200.14 Administration.

200.15 **EFFECTIVE DATE.** This section is effective July 1, 2022.

200.16 Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 17a, is amended to
200.17 read:

200.18 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
200.19 services. Providers shall bill ambulance services according to Medicare criteria.
200.20 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
200.21 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
200.22 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
200.23 effect on July 1, 2000, whichever is greater.

200.24 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
200.25 rates for ambulance services identified in this paragraph are increased by five percent.
200.26 Capitation payments made to managed care plans and county-based purchasing plans for
200.27 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
200.28 rate increase. The increased rate described in this paragraph applies to ambulance service
200.29 providers whose base of operations as defined in section 144E.10 is located:

200.30 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
200.31 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

200.32 (2) within a municipality with a population of less than 1,000.

201.1 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
201.2 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
201.3 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one
201.4 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
201.5 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
201.6 increase or decrease must be calculated using the average of the most recently available
201.7 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
201.8 Information Administration.

201.9 **EFFECTIVE DATE.** This section is effective July 1, 2022.

201.10 Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 22, is amended to read:

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

201.17 Sec. 21. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
201.18 to read:

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

201.25 (b) The payment rates for coverage under this subdivision must be 100 percent of the
201.26 Medicare rate for continuous home care hospice services as published in the Centers for
201.27 Medicare and Medicaid Services annual final rule updating payments and policies for hospice
201.28 care. Payment for hospice respite and end-of-life care under this subdivision must be made
201.29 from state funds, though the commissioner shall seek to obtain federal financial participation
201.30 for the payments. Payment for hospice respite and end-of-life care must be paid to the
201.31 residential hospice facility and are not included in any limits or cap amount applicable to
201.32 hospice services payments to the elected hospice services provider.

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

202.4 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 28b, is amended to
202.5 read:

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

202.12 **EFFECTIVE DATE.** This section is effective January 1, 2024, subject to federal
202.13 approval. The commissioner of human services shall notify the revisor of statutes when
202.14 federal approval is obtained.

202.15 Sec. 23. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 30, is
202.16 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

204.30 (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the
204.31 Social Security Act, to obtain federal financial participation at the 100 percent federal
204.32 matching percentage available to facilities of the Indian Health Service or tribal organization
204.33 in accordance with section 1905(b) of the Social Security Act for expenditures made to

205.1 organizations dually certified under Title V of the Indian Health Care Improvement Act,
205.2 Public Law 94-437, and as a federally qualified health center under paragraph (a) that
205.3 provides services to American Indian and Alaskan Native individuals eligible for services
205.4 under this subdivision.

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

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

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

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

205.17 (i) general social services and administrative costs;

205.18 (ii) retail pharmacy;

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

205.20 (iv) external lab and x-ray;

205.21 (v) navigation services;

205.22 (vi) health care taxes;

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

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

205.25 (ix) contributions and donations;

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

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

205.28 (xii) fund-raising, investment management, and associated administrative costs;

205.29 (xiii) research and associated administrative costs;

205.30 (xiv) nonpaid workers;

206.1 (xv) lobbying;

206.2 (xvi) scholarships and student aid; and

206.3 (xvii) nonmedical assistance covered services;

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

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

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

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

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

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

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

206.26 (6) the commissioner shall annually inflate the applicable organization encounter rates
206.27 for FQHCs and rural health clinics from the base year payment rate to the effective date by
206.28 using the CMS FQHC Market Basket inflator established under United States Code, title
206.29 42, section 1395m(o), less productivity;

206.30 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
206.31 under this paragraph shall submit all necessary documentation required by the commissioner
206.32 to compute the rebased organization encounter rates no later than six months following the

207.1 date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid
207.2 Services;

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

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

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

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

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

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

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

208.1 (12) the commissioner, when establishing organization encounter rates for new FQHCs
208.2 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
208.3 health clinics in a 60-mile radius for organizations established outside of the seven-county
208.4 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan
208.5 area. If this information is not available, the commissioner may use Medicare cost reports
208.6 or audited financial statements to establish base rates;

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

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

208.14 (m) Effective July 1, 2022, an enrolled Indian Health Service facility or a Tribal health
208.15 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.
208.16 No requirements that otherwise apply to FQHCs covered in this subdivision apply to Tribal
208.17 FQHCs enrolled under this paragraph, except those necessary to comply with federal
208.18 regulations. The commissioner shall establish an alternative payment method for Tribal
208.19 FQHCs enrolled under this paragraph that uses the same method and rates applicable to a
208.20 Tribal facility or health center that does not enroll as a Tribal FQHC.

208.21 Sec. 24. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 31, is
208.22 amended to read:

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

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

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

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

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

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

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

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

209.16 (1) can withstand repeated use;

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

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

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

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

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

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

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

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

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

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

210.11 (ii) provide data to the health care provider necessary to appropriately diagnose or treat
210.12 the recipient's health condition that causes the seizure activity.

210.13 (j) For purposes of paragraph (i), "seizure detection device" means a United States Food
210.14 and Drug Administration approved monitoring device and any related service or subscription
210.15 supporting the prescribed use of the device, including technology that:

210.16 (1) provides ongoing patient monitoring and alert services that detects nocturnal seizure
210.17 activity and transmits notification of the seizure activity to a caregiver for appropriate
210.18 medical response; or

210.19 (2) collects data of the seizure activity of the recipient that can be used by a health care
210.20 provider to diagnose or appropriately treat a health care condition that causes the seizure
210.21 activity.

210.22 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
210.23 whichever is later. The commissioner of human services shall notify the revisor of statutes
210.24 when federal approval is obtained.

210.25 Sec. 25. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
210.26 to read:

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

- 211.1 (b) Medical assistance must cover in-person individual and group tobacco and nicotine
211.2 cessation education and counseling services if provided by a health care practitioner whose
211.3 scope of practice encompasses tobacco and nicotine cessation education and counseling.
211.4 Service providers include but are not limited to the following:
- 211.5 (1) mental health practitioners under section 245.462, subdivision 17;
211.6 (2) mental health professionals under section 245.462, subdivision 18;
211.7 (3) mental health certified peer specialists under section 256B.0615;
211.8 (4) alcohol and drug counselors licensed under chapter 148F;
211.9 (5) recovery peers as defined in section 245F.02, subdivision 21;
211.10 (6) certified tobacco treatment specialists;
211.11 (7) community health workers;
211.12 (8) physicians;
211.13 (9) physician assistants;
211.14 (10) advanced practice registered nurses; or
211.15 (11) other licensed or nonlicensed professionals or paraprofessionals with training in
211.16 providing tobacco and nicotine cessation education and counseling services.
- 211.17 (c) Medical assistance covers telephone cessation counseling services provided through
211.18 a quitline. Notwithstanding subdivision 3b, quitline services may be provided through
211.19 audio-only communications. The commissioner may use volume purchasing for quitline
211.20 services consistent with section 256B.04, subdivision 14.
- 211.21 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy
211.22 drugs approved by the United States Food and Drug Administration for cessation of tobacco
211.23 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a
211.24 Medicaid drug rebate agreement.
- 211.25 (e) Services covered under this subdivision may be provided by telemedicine.
- 211.26 (f) The commissioner must not:
- 211.27 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation
211.28 services;
- 211.29 (2) prohibit the simultaneous use of multiple cessation services, including but not limited
211.30 to simultaneous use of counseling and drugs;

- 212.1 (3) require counseling prior to receiving drugs or as a condition of receiving drugs;
- 212.2 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of
- 212.3 a medically accepted indication, as defined in United States Code, title 42, section
- 212.4 1396r-8(k)(6); limit dosing frequency; or impose duration limits;
- 212.5 (5) prohibit simultaneous use of multiple drugs, including prescription and
- 212.6 over-the-counter drugs;
- 212.7 (6) require or authorize step therapy; or
- 212.8 (7) require or utilize prior authorization or require a co-payment or deductible for any
- 212.9 tobacco and nicotine cessation services and drugs covered under this subdivision.
- 212.10 (g) The commissioner must require all participating entities under contract with the
- 212.11 commissioner to comply with this subdivision when providing coverage, services, or care
- 212.12 management for medical assistance and MinnesotaCare enrollees. For purposes of this
- 212.13 subdivision, "participating entity" means any of the following:
- 212.14 (1) a health carrier as defined in section 62A.011, subdivision 2;
- 212.15 (2) a county-based purchasing plan established under section 256B.692;
- 212.16 (3) an accountable care organization or other entity participating as an integrated health
- 212.17 partnership under section 256B.0755;
- 212.18 (4) an entity operating a county integrated health care delivery network pilot project
- 212.19 authorized under section 256B.0756;
- 212.20 (5) a network of health care providers established to offer services under medical
- 212.21 assistance or MinnesotaCare; or
- 212.22 (6) any other entity that has a contract with the commissioner to cover, provide, or
- 212.23 manage health care services provided to medical assistance or MinnesotaCare enrollees on
- 212.24 a capitated or risk-based payment arrangement or under a reimbursement methodology with
- 212.25 substantial financial incentives to reduce the total cost of health care for a population of
- 212.26 patients that is enrolled with or assigned or attributed to the entity.

213.1 Sec. 26. Minnesota Statutes 2020, section 256B.0631, as amended by Laws 2021, First
213.2 Special Session chapter 7, article 1, section 17, is amended to read:

213.3 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**

213.4 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
213.5 assistance benefit plan shall include the following cost-sharing for all recipients, effective
213.6 for services provided on or after September 1, 2011, through December 31, 2022:

213.7 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
213.8 subdivision, a visit means an episode of service which is required because of a recipient's
213.9 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
213.10 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
213.11 practice nurse, audiologist, optician, or optometrist;

213.12 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
213.13 co-payment shall be increased to \$20 upon federal approval;

213.14 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
213.15 prescription for a brand-name multisource drug listed in preferred status on the preferred
213.16 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No
213.17 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

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

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

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

213.29 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
213.30 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
213.31 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
213.32 of the family deductible shall not be included in the capitation payment to managed care

214.1 plans and county-based purchasing plans. Managed care plans and county-based purchasing
 214.2 plans shall certify annually to the commissioner the dollar value of the family deductible.

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

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

214.10 (f) Paragraphs (a) to (e) apply only for services provided through December 31, 2022.
 214.11 Effective for services provided on or after January 1, 2023, the medical assistance program
 214.12 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
 214.13 cost-sharing.

214.14 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject, through December
 214.15 31, 2022, to the following exceptions:

214.16 (1) children under the age of 21;

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

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

214.21 (4) recipients receiving hospice care;

214.22 (5) 100 percent federally funded services provided by an Indian health service;

214.23 (6) emergency services;

214.24 (7) family planning services;

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

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

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

215.1 (11) American Indians who meet the requirements in Code of Federal Regulations, title
215.2 42, sections 447.51 and 447.56;

215.3 (12) persons needing treatment for breast or cervical cancer as described under section
215.4 256B.057, subdivision 10; and

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

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

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

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

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

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

215.21 (d) Paragraphs (a) to (c) apply only for services provided through December 31, 2022.

215.22 Sec. 27. Minnesota Statutes 2021 Supplement, section 256B.0631, subdivision 1, is
215.23 amended to read:

215.24 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
215.25 assistance benefit plan ~~shall~~ must include the following cost-sharing for all recipients,
215.26 effective for services provided on or after September 1, 2011:

215.27 (1) \$3 per nonpreventive visit, except as provided in paragraph (b) and except that a
215.28 co-payment must not apply to tobacco and nicotine cessation services covered under section
215.29 256B.0625, subdivision 68. For purposes of this subdivision, a visit means an episode of
215.30 service which is required because of a recipient's symptoms, diagnosis, or established illness,
215.31 and which is delivered in an ambulatory setting by a physician or physician assistant,

216.1 chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or
216.2 optometrist;

216.3 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
216.4 co-payment shall be increased to \$20 upon federal approval;

216.5 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
216.6 prescription for a brand-name multisource drug listed in preferred status on the preferred
216.7 drug list, subject to a \$12 per month maximum for prescription drug co-payments. ~~No~~
216.8 Co-payments ~~shall~~ must not apply to antipsychotic drugs when used for the treatment of
216.9 mental illness. Co-payments must not apply to drugs when used for tobacco and nicotine
216.10 cessation;

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

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

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

216.22 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
216.23 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
216.24 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
216.25 of the family deductible ~~shall~~ must not be included in the capitation payment to managed
216.26 care plans and county-based purchasing plans. Managed care plans and county-based
216.27 purchasing plans ~~shall~~ must certify annually to the commissioner the dollar value of the
216.28 family deductible.

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

216.32 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process
216.33 under section 256B.0756 shall allow the pilot program in Hennepin County to waive

217.1 co-payments. The value of the co-payments ~~shall~~ must not be included in the capitation
217.2 payment amount to the integrated health care delivery networks under the pilot program.

217.3 Sec. 28. Minnesota Statutes 2020, section 256B.69, subdivision 4, is amended to read:

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

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

217.12 (1) persons eligible for medical assistance according to section 256B.055, subdivision
217.13 1;

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

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

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

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

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

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

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

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

218.1 (8) persons eligible for medical assistance according to section 256B.057, subdivision
218.2 10;

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

218.6 (10) persons who are absent from the state for more than 30 consecutive days but still
218.7 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
218.8 1, paragraph (b).

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

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

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

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

218.32 (f) An infant born to a woman who is eligible for and receiving medical assistance and
218.33 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to
218.34 the month of birth in the same managed care plan as the mother once the child is enrolled

219.1 in medical assistance unless the child is determined to be excluded from enrollment in a
219.2 prepaid plan under this section.

219.3 **EFFECTIVE DATE.** This section is effective January 1, 2023.

219.4 Sec. 29. Minnesota Statutes 2020, section 256B.69, subdivision 5c, is amended to read:

219.5 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
219.6 services shall transfer each year to the medical education and research fund established
219.7 under section 62J.692, an amount specified in this subdivision. The commissioner shall
219.8 calculate the following:

219.9 (1) an amount equal to the reduction in the prepaid medical assistance payments as
219.10 specified in this clause. After January 1, 2002, the county medical assistance capitation base
219.11 rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two
219.12 percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan
219.13 Minnesota counties. Nursing facility and elderly waiver payments and demonstration project
219.14 payments operating under subdivision 23 are excluded from this reduction. The amount
219.15 calculated under this clause shall not be adjusted for periods already paid due to subsequent
219.16 changes to the capitation payments;

219.17 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

219.18 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid
219.19 under this section; and

219.20 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under
219.21 this section.

219.22 (b) This subdivision shall be effective upon approval of a federal waiver which allows
219.23 federal financial participation in the medical education and research fund. The amount
219.24 specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred
219.25 for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph
219.26 (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the
219.27 amount specified under paragraph (a), clause (1).

219.28 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
219.29 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

219.30 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer
219.31 under paragraph (c), the commissioner shall transfer to the medical education research fund
219.32 ~~\$23,936,000 in fiscal years 2012 and 2013 and~~ \$49,552,000 in fiscal year 2014 and thereafter.

220.1 (e) If the federal waiver described in paragraph (b) is not renewed, the transfer described
 220.2 in paragraph (c) and corresponding payments under section 62J.692, subdivision 7, are
 220.3 terminated effective the first month in which the waiver is no longer in effect, and the state
 220.4 share of the amount described in paragraph (d) must be transferred to the medical education
 220.5 and research fund and distributed according to the provisions of section 62J.692, subdivision
 220.6 4a.

220.7 Sec. 30. Minnesota Statutes 2020, section 256B.69, subdivision 28, is amended to read:

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

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

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

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

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

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

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

221.10 (1) implementation efforts;

221.11 (2) consumer protections; and

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

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

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

221.24 **EFFECTIVE DATE.** This section is effective January 1, 2023.

221.25 Sec. 31. Minnesota Statutes 2020, section 256B.69, subdivision 36, is amended to read:

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

221.29 (b) The enrollee support system must:

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

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

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

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

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

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

222.15 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting
222.16 a managed care organization and providing necessary enrollment information. For purposes
222.17 of this subdivision, "enrollment broker" means an individual or entity that performs choice
222.18 counseling or enrollment activities in accordance with Code of Federal Regulations, part
222.19 42, section 438.810, or both.

222.20 **EFFECTIVE DATE.** This section is effective January 1, 2023.

222.21 Sec. 32. Minnesota Statutes 2020, section 256B.692, subdivision 1, is amended to read:

222.22 Subdivision 1. **In general.** County boards or groups of county boards may elect to
222.23 purchase or provide health care services on behalf of persons eligible for medical assistance
222.24 who would otherwise be required to or may elect to participate in the prepaid medical
222.25 assistance program according to section 256B.69, subject to the opt-out provision of section
222.26 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health
222.27 care under this section must provide all services included in prepaid managed care programs
222.28 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this
222.29 section is governed by section 256B.69, unless otherwise provided for under this section.

222.30 **EFFECTIVE DATE.** This section is effective January 1, 2023.

223.1 Sec. 33. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

223.2 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
223.3 to each potential enrollee the following information:

223.4 (1) basic features of receiving services through managed care;

223.5 (2) which individuals are excluded from managed care enrollment, subject to ~~mandatory~~
223.6 ~~managed care enrollment~~ the opt-out provision of section 256B.69, subdivision 4, paragraph
223.7 (a), or who may choose to enroll voluntarily;

223.8 (3) ~~for mandatory and voluntary enrollment~~, the length of the enrollment period and
223.9 information about an enrollee's right to disenroll in accordance with Code of Federal
223.10 Regulations, part 42, section 438.56;

223.11 (4) the service area covered by each managed care organization;

223.12 (5) covered services, including services provided by the managed care organization and
223.13 services provided by the commissioner;

223.14 (6) the provider directory and drug formulary for each managed care organization;

223.15 (7) cost-sharing requirements;

223.16 (8) requirements for adequate access to services, including provider network adequacy
223.17 standards;

223.18 (9) a managed care organization's responsibility for coordination of enrollee care; and

223.19 (10) quality and performance indicators, including enrollee satisfaction for each managed
223.20 care organization, if available.

223.21 Sec. 34. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

223.22 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
223.23 to each potential enrollee the following information:

223.24 (1) basic features of receiving services through managed care;

223.25 (2) which individuals are excluded from managed care enrollment, subject to mandatory
223.26 managed care enrollment, or who may choose to enroll voluntarily;

223.27 (3) for mandatory and voluntary enrollment, the length of the enrollment period and
223.28 information about an enrollee's right to disenroll in accordance with Code of Federal
223.29 Regulations, part 42, section 438.56;

223.30 (4) the service area covered by each managed care organization;

224.1 (5) covered services, including services provided by the managed care organization and
 224.2 services provided by the commissioner;

224.3 (6) the provider directory and drug formulary for each managed care organization;

224.4 ~~(7) cost-sharing requirements;~~

224.5 ~~(8)~~ (7) requirements for adequate access to services, including provider network adequacy
 224.6 standards;

224.7 ~~(9)~~ (8) a managed care organization's responsibility for coordination of enrollee care;
 224.8 and

224.9 ~~(10)~~ (9) quality and performance indicators, including enrollee satisfaction for each
 224.10 managed care organization, if available.

224.11 **EFFECTIVE DATE.** This section is effective January 1, 2023.

224.12 Sec. 35. Minnesota Statutes 2020, section 256B.6925, subdivision 2, is amended to read:

224.13 Subd. 2. **Information provided by managed care organization.** The commissioner
 224.14 shall ensure that managed care organizations provide to each enrollee the following
 224.15 information:

224.16 (1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's
 224.17 enrollment. The handbook must, at a minimum, include information on benefits provided,
 224.18 how and where to access benefits, ~~cost-sharing requirements~~, how transportation is provided,
 224.19 and other information as required by Code of Federal Regulations, part 42, section 438.10,
 224.20 paragraph (g);

224.21 (2) a provider directory for the following provider types: physicians, specialists, hospitals,
 224.22 pharmacies, behavioral health providers, and long-term supports and services providers, as
 224.23 appropriate. The directory must include the provider's name, group affiliation, street address,
 224.24 telephone number, website, specialty if applicable, whether the provider accepts new
 224.25 enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal
 224.26 Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office
 224.27 accommodates people with disabilities;

224.28 (3) a drug formulary that includes both generic and name brand medications that are
 224.29 covered and each medication tier, if applicable;

224.30 (4) written notice of termination of a contracted provider. Within 15 calendar days after
 224.31 receipt or issuance of the termination notice, the managed care organization must make a

225.1 good faith effort to provide notice to each enrollee who received primary care from, or was
 225.2 seen on a regular basis by, the terminated provider; and
 225.3 (5) upon enrollee request, the managed care organization's physician incentive plan.

225.4 **EFFECTIVE DATE.** This section is effective January 1, 2023.

225.5 Sec. 36. Minnesota Statutes 2020, section 256B.6928, subdivision 3, is amended to read:

225.6 Subd. 3. **Rate development standards.** (a) In developing capitation rates, the
 225.7 commissioner shall:

225.8 (1) identify and develop base utilization and price data, including validated encounter
 225.9 data and audited financial reports received from the managed care organizations that
 225.10 demonstrate experience for the populations served by the managed care organizations, for
 225.11 the three most recent and complete years before the rating period;

225.12 (2) develop and apply reasonable trend factors, including cost and utilization, to base
 225.13 data that are developed from actual experience of the medical assistance population or a
 225.14 similar population according to generally accepted actuarial practices and principles;

225.15 (3) develop the nonbenefit component of the rate to account for reasonable expenses
 225.16 related to the managed care organization's administration; taxes; licensing and regulatory
 225.17 fees; contribution to reserves; risk margin; cost of capital and other operational costs
 225.18 associated with the managed care organization's provision of covered services to enrollees;

225.19 ~~(4) consider the value of cost-sharing for rate development purposes, regardless of~~
 225.20 ~~whether the managed care organization imposes the cost-sharing on the enrollee or the~~
 225.21 ~~cost-sharing is collected by the provider;~~

225.22 ~~(5)~~ (4) make appropriate and reasonable adjustments to account for changes to the base
 225.23 data, programmatic changes, changes to nonbenefit components, and any other adjustment
 225.24 necessary to establish actuarially sound rates. Each adjustment must reasonably support the
 225.25 development of an accurate base data set for purposes of rate setting, reflect the health status
 225.26 of the enrolled population, and be developed in accordance with generally accepted actuarial
 225.27 principles and practices;

225.28 ~~(6)~~ (5) consider the managed care organization's past medical loss ratio in the development
 225.29 of the capitation rates and consider the projected medical loss ratio; and

225.30 ~~(7)~~ (6) select a prospective or retrospective risk adjustment methodology that must be
 225.31 developed in a budget-neutral manner consistent with generally accepted actuarial principles
 225.32 and practices.

226.1 (b) The base data must be derived from the medical assistance population or, if data on
226.2 the medical assistance population is not available, derived from a similar population and
226.3 adjusted to make the utilization and price data comparable to the medical assistance
226.4 population. Data must be in accordance with actuarial standards for data quality and an
226.5 explanation of why that specific data is used must be provided in the rate certification. If
226.6 the commissioner is unable to base the rates on data that are within the three most recent
226.7 and complete years before the rating period, the commissioner may request an approval
226.8 from the Centers for Medicare and Medicaid Services for an exception. The request must
226.9 describe why an exception is necessary and describe the actions that the commissioner
226.10 intends to take to comply with the request.

226.11 **EFFECTIVE DATE.** This section is effective January 1, 2023.

226.12 Sec. 37. Minnesota Statutes 2020, section 256B.76, subdivision 1, is amended to read:

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

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

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

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

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

226.31 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
226.32 and professional services shall be reduced by five percent, except that for the period July
226.33 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical

227.1 assistance and general assistance medical care programs, over the rates in effect on June
227.2 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
227.3 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
227.4 advanced practice nurses, or physician assistants in a family planning agency or in one of
227.5 the following primary care practices: general practice, general internal medicine, general
227.6 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
227.7 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
227.8 Indian health services. Effective October 1, 2009, payments made to managed care plans
227.9 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
227.10 reflect the payment reduction described in this paragraph.

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

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

227.24 (f) Effective for services rendered on or after September 1, 2014, payment rates for
227.25 physician and professional services, including physical therapy, occupational therapy, speech
227.26 pathology, and mental health services shall be increased by five percent from the rates in
227.27 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
227.28 include in the base rate for August 31, 2014, the rate increase provided under section
227.29 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
227.30 rural health centers, and Indian health services. Payments made to managed care plans and
227.31 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

227.32 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical
227.33 therapy, occupational therapy, and speech pathology and related services provided by a
227.34 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
227.35 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments

228.1 made to managed care plans and county-based purchasing plans shall not be adjusted to
228.2 reflect payments under this paragraph.

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

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

228.11 Sec. 38. Minnesota Statutes 2020, section 256L.03, subdivision 1a, is amended to read:

228.12 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible
228.13 for coverage of all services that are eligible for reimbursement under the medical assistance
228.14 program according to chapter 256B, except special education services and that abortion
228.15 services under MinnesotaCare shall be limited as provided under subdivision 1. ~~Children~~
228.16 ~~are exempt from the provisions of subdivision 5, regarding co-payments.~~ Children who are
228.17 lawfully residing in the United States but who are not "qualified noncitizens" under title IV
228.18 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public
228.19 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all
228.20 services provided under the medical assistance program according to chapter 256B.

228.21 **EFFECTIVE DATE.** This section is effective January 1, 2023.

228.22 Sec. 39. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

228.26 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
228.27 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
228.28 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
228.29 services exempt from cost-sharing under state law. The cost-sharing changes described in
228.30 this paragraph shall not be implemented prior to January 1, 2016, or after December 31,
228.31 2022.

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

229.4 (d) Paragraphs (a) to (c) apply only to services provided through December 31, 2022.
 229.5 Effective for services provided on or after January 1, 2023, the MinnesotaCare program
 229.6 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
 229.7 cost-sharing.

229.8 Sec. 40. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

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

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

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

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

229.22 Sec. 41. Minnesota Statutes 2020, section 256L.04, subdivision 1c, is amended to read:

229.23 Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet
 229.24 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with
 229.25 an income less than or equal to 200 percent of the federal poverty guidelines must not be
 229.26 considered a qualified individual under section 1312 of the Affordable Care Act, and is not
 229.27 eligible for enrollment in a qualified health plan offered through MNsure under chapter
 229.28 62V.

229.29 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 229.30 whichever is later, but only if the commissioner of human services certifies to the legislature
 229.31 that implementation of this section will not result in federal penalties to federal basic health
 229.32 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of

230.1 the federal poverty guidelines. The commissioner of human services shall notify the revisor
 230.2 of statutes when federal approval is obtained.

230.3 Sec. 42. Minnesota Statutes 2020, section 256L.04, subdivision 7a, is amended to read:

230.4 Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under
 230.5 this section may not enroll in the MinnesotaCare program, except as provided in subdivision
 230.6 15.

230.7 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 230.8 whichever is later, but only if the commissioner of human services certifies to the legislature
 230.9 that implementation of this section will not result in federal penalties to federal basic health
 230.10 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
 230.11 the federal poverty guidelines. The commissioner of human services shall notify the revisor
 230.12 of statutes when federal approval is obtained.

230.13 Sec. 43. Minnesota Statutes 2020, section 256L.04, subdivision 10, is amended to read:

230.14 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
 230.15 citizens or nationals of the United States and lawfully present noncitizens as defined in
 230.16 Code of Federal Regulations, title 8, section 103.12. Undocumented noncitizens, with the
 230.17 exception of children under age 19, are ineligible for MinnesotaCare. For purposes of this
 230.18 subdivision, an undocumented noncitizen is an individual who resides in the United States
 230.19 without the approval or acquiescence of the United States Citizenship and Immigration
 230.20 Services. Families with children who are citizens or nationals of the United States must
 230.21 cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
 230.22 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
 230.23 109-171.

230.24 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
 230.25 individuals who are lawfully present and ineligible for medical assistance by reason of
 230.26 immigration status and who have incomes equal to or less than 200 percent of federal poverty
 230.27 guidelines.

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

230.29 Sec. 44. Minnesota Statutes 2020, section 256L.04, is amended by adding a subdivision
 230.30 to read:

230.31 **Subd. 15. Persons eligible for public option.** (a) Families and individuals with income
 230.32 above the maximum income eligibility limit specified in subdivision 1 or 7, who meet all

231.1 other MinnesotaCare eligibility requirements, are eligible for MinnesotaCare. All other
 231.2 provisions of this chapter apply unless otherwise specified.

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

231.6 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 231.7 whichever is later, but only if the commissioner of human services certifies to the legislature
 231.8 that implementation of this section will not result in federal penalties to federal basic health
 231.9 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
 231.10 the federal poverty guidelines. The commissioner of human services shall notify the revisor
 231.11 of statutes when federal approval is obtained.

231.12 Sec. 45. Minnesota Statutes 2020, section 256L.07, subdivision 1, is amended to read:

231.13 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under
 231.14 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section
 231.15 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty
 231.16 guidelines; are no longer eligible for the program and ~~shall~~ must be disenrolled by the
 231.17 commissioner, unless the individuals continue MinnesotaCare enrollment through the public
 231.18 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,
 231.19 MinnesotaCare coverage terminates the last day of the calendar month in which the
 231.20 commissioner sends advance notice according to Code of Federal Regulations, title 42,
 231.21 section 431.211, that indicates the income of a family or individual exceeds program income
 231.22 limits.

231.23 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
 231.24 whichever is later, but only if the commissioner of human services certifies to the legislature
 231.25 that implementation of this section will not result in federal penalties to federal basic health
 231.26 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
 231.27 the federal poverty guidelines. The commissioner of human services shall notify the revisor
 231.28 of statutes when federal approval is obtained.

231.29 Sec. 46. Minnesota Statutes 2021 Supplement, section 256L.15, subdivision 2, is amended
 231.30 to read:

231.31 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner
 231.32 shall establish a sliding fee scale to determine the percentage of monthly individual or family
 231.33 income that households at different income levels must pay to obtain coverage through the

232.1 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly
 232.2 individual or family income.

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

232.5 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

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

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

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

232.11	Federal Poverty Guideline	Less than	Individual Premium
232.12	Greater than or Equal to		Amount
232.13	35%	55%	\$4
232.14	55%	80%	\$6
232.15	80%	90%	\$8
232.16	90%	100%	\$10
232.17	100%	110%	\$12
232.18	110%	120%	\$14
232.19	120%	130%	\$15
232.20	130%	140%	\$16
232.21	140%	150%	\$25
232.22	150%	160%	\$37
232.23	160%	170%	\$44
232.24	170%	180%	\$52
232.25	180%	190%	\$61
232.26	190%	200%	\$71
232.27	200%		\$80

232.28 ~~(e) (c) Beginning January 1, 2021~~ 2023, the commissioner shall continue to charge
 232.29 premiums in accordance with the simplified premium scale established to comply with the
 232.30 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,
 232.31 2022, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The
 232.32 commissioner shall adjust the premium scale established under paragraph (d) as needed to
 232.33 ensure that premiums do not exceed the amount that an individual would have been required
 232.34 to pay if the individual was enrolled in an applicable benchmark plan in accordance with
 232.35 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

233.1 (d) The commissioner shall establish a sliding premium scale for persons eligible through
 233.2 the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2025, persons
 233.3 eligible through the buy-in option shall pay premiums according to the premium scale
 233.4 established by the commissioner. Persons 20 years of age or younger are exempt from
 233.5 paying premiums.

233.6 **EFFECTIVE DATE.** This section is effective January 1, 2023, except that the sliding
 233.7 premium scale established under paragraph (d) is effective January 1, 2025, or upon federal
 233.8 approval, whichever is later, but only if the commissioner of human services certifies to the
 233.9 legislature that implementation of paragraph (d) will not result in federal penalties to federal
 233.10 basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200
 233.11 percent of the federal poverty guidelines. The commissioner of human services shall notify
 233.12 the revisor of statutes when federal approval is obtained.

233.13 Sec. 47. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by Laws
 233.14 2015, First Special Session chapter 6, section 1, is amended to read:

233.15 **Subd. 5. Grant Programs**

233.16 The amounts that may be spent from this
 233.17 appropriation for each purpose are as follows:

233.18 **(a) Support Services Grants**

233.19	Appropriations by Fund		
233.20	General	13,133,000	8,715,000
233.21	Federal TANF	96,311,000	96,311,000

233.22	(b) Basic Sliding Fee Child Care Assistance		
233.23	Grants	48,439,000	51,559,000

233.24 **Basic Sliding Fee Waiting List Allocation.**

233.25 Notwithstanding Minnesota Statutes, section
 233.26 119B.03, \$5,413,000 in fiscal year 2016 is to
 233.27 reduce the basic sliding fee program waiting
 233.28 list as follows:

233.29 (1) The calendar year 2016 allocation shall be
 233.30 increased to serve families on the waiting list.
 233.31 To receive funds appropriated for this purpose,
 233.32 a county must have:

234.1 (i) a waiting list in the most recent published
234.2 waiting list month;

234.3 (ii) an average of at least ten families on the
234.4 most recent six months of published waiting
234.5 list; and

234.6 (iii) total expenditures in calendar year 2014
234.7 that met or exceeded 80 percent of the county's
234.8 available final allocation.

234.9 (2) Funds shall be distributed proportionately
234.10 based on the average of the most recent six
234.11 months of published waiting lists to counties
234.12 that meet the criteria in clause (1).

234.13 (3) Allocations in calendar years 2017 and
234.14 beyond shall be calculated using the allocation
234.15 formula in Minnesota Statutes, section
234.16 119B.03.

234.17 (4) The guaranteed floor for calendar year
234.18 2017 shall be based on the revised calendar
234.19 year 2016 allocation.

234.20 **Base Level Adjustment.** The general fund
234.21 base is increased by \$810,000 in fiscal year
234.22 2018 and increased by \$821,000 in fiscal year
234.23 2019.

234.24 (c) **Child Care Development Grants** 1,737,000 1,737,000

234.25 (d) **Child Support Enforcement Grants** 50,000 50,000

234.26 (e) **Children's Services Grants**

234.27	Appropriations by Fund		
234.28	General	39,015,000	38,665,000
234.29	Federal TANF	140,000	140,000

234.30 **Safe Place for Newborns.** \$350,000 from the
234.31 general fund in fiscal year 2016 is to distribute
234.32 information on the Safe Place for Newborns

235.1 law in Minnesota to increase public awareness
235.2 of the law. This is a onetime appropriation.

235.3 **Child Protection.** \$23,350,000 in fiscal year
235.4 2016 and \$23,350,000 in fiscal year 2017 are
235.5 to address child protection staffing and
235.6 services under Minnesota Statutes, section
235.7 256M.41. \$1,650,000 in fiscal year 2016 and
235.8 \$1,650,000 in fiscal year 2017 are for child
235.9 protection grants to address child welfare
235.10 disparities under Minnesota Statutes, section
235.11 256E.28.

235.12 **Title IV-E Adoption Assistance.** Additional
235.13 federal reimbursement to the state as a result
235.14 of the Fostering Connections to Success and
235.15 Increasing Adoptions Act's expanded
235.16 eligibility for title IV-E adoption assistance is
235.17 appropriated to the commissioner for
235.18 postadoption services, including a
235.19 parent-to-parent support network.

235.20 **Adoption Assistance Incentive Grants.**
235.21 Federal funds available during fiscal years
235.22 2016 and 2017 for adoption incentive grants
235.23 are appropriated to the commissioner for
235.24 postadoption services, including a
235.25 parent-to-parent support network.

235.26 (f) Children and Community Service Grants	56,301,000	56,301,000
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235.27 (g) Children and Economic Support Grants	26,778,000	26,966,000
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235.28 **Mobile Food Shelf Grants.** (a) \$1,000,000
235.29 in fiscal year 2016 and \$1,000,000 in fiscal
235.30 year 2017 are for a grant to Hunger Solutions.
235.31 This is a onetime appropriation and is
235.32 available until June 30, 2017.

- 236.1 (b) Hunger Solutions shall award grants of up
236.2 to \$75,000 on a competitive basis. Grant
236.3 applications must include:
- 236.4 (1) the location of the project;
 - 236.5 (2) a description of the mobile program,
236.6 including size and scope;
 - 236.7 (3) evidence regarding the unserved or
236.8 underserved nature of the community in which
236.9 the project is to be located;
 - 236.10 (4) evidence of community support for the
236.11 project;
 - 236.12 (5) the total cost of the project;
 - 236.13 (6) the amount of the grant request and how
236.14 funds will be used;
 - 236.15 (7) sources of funding or in-kind contributions
236.16 for the project that will supplement any grant
236.17 award;
 - 236.18 (8) a commitment to mobile programs by the
236.19 applicant and an ongoing commitment to
236.20 maintain the mobile program; and
 - 236.21 (9) any additional information requested by
236.22 Hunger Solutions.
- 236.23 (c) Priority may be given to applicants who:
- 236.24 (1) serve underserved areas;
 - 236.25 (2) create a new or expand an existing mobile
236.26 program;
 - 236.27 (3) serve areas where a high amount of need
236.28 is identified;
 - 236.29 (4) provide evidence of strong support for the
236.30 project from citizens and other institutions in
236.31 the community;

237.1 (5) leverage funding for the project from other
237.2 private and public sources; and

237.3 (6) commit to maintaining the program on a
237.4 multilayer basis.

237.5 **Homeless Youth Act.** At least \$500,000 of
237.6 the appropriation for the Homeless Youth Act
237.7 must be awarded to providers in greater
237.8 Minnesota, with at least 25 percent of this
237.9 amount for new applicant providers. The
237.10 commissioner shall provide outreach and
237.11 technical assistance to greater Minnesota
237.12 providers and new providers to encourage
237.13 responding to the request for proposals.

237.14 **Stearns County Veterans Housing.** \$85,000
237.15 in fiscal year 2016 and \$85,000 in fiscal year
237.16 2017 are for a grant to Stearns County to
237.17 provide administrative funding in support of
237.18 a service provider serving veterans in Stearns
237.19 County. The administrative funding grant may
237.20 be used to support group residential housing
237.21 services, corrections-related services, veteran
237.22 services, and other social services related to
237.23 the service provider serving veterans in
237.24 Stearns County.

237.25 **Safe Harbor.** \$800,000 in fiscal year 2016
237.26 and \$800,000 in fiscal year 2017 are from the
237.27 general fund for emergency shelter and
237.28 transitional and long-term housing beds for
237.29 sexually exploited youth and youth at risk of
237.30 sexual exploitation. Of this appropriation,
237.31 \$150,000 in fiscal year 2016 and \$150,000 in
237.32 fiscal year 2017 are from the general fund for
237.33 statewide youth outreach workers connecting
237.34 sexually exploited youth and youth at risk of
237.35 sexual exploitation with shelter and services.

238.1 **Minnesota Food Assistance Program.**

238.2 Unexpended funds for the Minnesota food
238.3 assistance program for fiscal year 2016 do not
238.4 cancel but are available for this purpose in
238.5 fiscal year 2017.

238.6 **Base Level Adjustment.** The general fund
238.7 base is decreased by \$816,000 in fiscal year
238.8 2018 and is decreased by \$606,000 in fiscal
238.9 year 2019.

238.10 **(h) Health Care Grants**

238.11	Appropriations by Fund		
238.12	General	536,000	2,482,000
238.13	Health Care Access	3,341,000	3,465,000

238.14 **Grants for Periodic Data Matching for**
238.15 **Medical Assistance and MinnesotaCare.** Of
238.16 the general fund appropriation, \$26,000 in
238.17 fiscal year 2016 and \$1,276,000 in fiscal year
238.18 2017 are for grants to counties for costs related
238.19 to periodic data matching for medical
238.20 assistance and MinnesotaCare recipients under
238.21 Minnesota Statutes, section 256B.0561. The
238.22 commissioner must distribute these grants to
238.23 counties in proportion to each county's number
238.24 of cases in the prior year in the affected
238.25 programs.

238.26 **Base Level Adjustment.** The general fund
238.27 base is ~~increased by \$1,637,000 in fiscal year~~
238.28 ~~2018 and increased by \$1,229,000 in fiscal~~
238.29 ~~year 2019~~ maintained in fiscal years 2020 and
238.30 2021.

238.31 **(i) Other Long-Term Care Grants** 1,551,000 3,069,000

238.32 **Transition Populations.** \$1,551,000 in fiscal
238.33 year 2016 and \$1,725,000 in fiscal year 2017
238.34 are for home and community-based services

239.1 transition grants to assist in providing home
 239.2 and community-based services and treatment
 239.3 for transition populations under Minnesota
 239.4 Statutes, section 256.478.

239.5 **Base Level Adjustment.** The general fund
 239.6 base is increased by \$156,000 in fiscal year
 239.7 2018 and by \$581,000 in fiscal year 2019.

239.8 **(j) Aging and Adult Services Grants** 28,463,000 28,162,000

239.9 **Dementia Grants.** \$750,000 in fiscal year
 239.10 2016 and \$750,000 in fiscal year 2017 are for
 239.11 the Minnesota Board on Aging for regional
 239.12 and local dementia grants authorized in
 239.13 Minnesota Statutes, section 256.975,
 239.14 subdivision 11.

239.15 **(k) Deaf and Hard-of-Hearing Grants** 2,225,000 2,375,000

239.16 **Deaf, Deafblind, and Hard-of-Hearing**
 239.17 **Grants.** \$350,000 in fiscal year 2016 and
 239.18 \$500,000 in fiscal year 2017 are for deaf and
 239.19 hard-of-hearing grants. The funds must be
 239.20 used to increase the number of deafblind
 239.21 Minnesotans receiving services under
 239.22 Minnesota Statutes, section 256C.261, and to
 239.23 provide linguistically and culturally
 239.24 appropriate mental health services to children
 239.25 who are deaf, deafblind, and hard-of-hearing.
 239.26 This is a onetime appropriation.

239.27 **Base Level Adjustment.** The general fund
 239.28 base is decreased by \$500,000 in fiscal year
 239.29 2018 and by \$500,000 in fiscal year 2019.

239.30 **(l) Disabilities Grants** 20,820,000 20,858,000

239.31 **State Quality Council.** \$573,000 in fiscal
 239.32 year 2016 and \$600,000 in fiscal year 2017
 239.33 are for the State Quality Council to provide
 239.34 technical assistance and monitoring of

240.1 person-centered outcomes related to inclusive
 240.2 community living and employment. The
 240.3 funding must be used by the State Quality
 240.4 Council to assure a statewide plan for systems
 240.5 change in person-centered planning that will
 240.6 achieve desired outcomes including increased
 240.7 integrated employment and community living.

240.8 **(m) Adult Mental Health Grants**

240.9	Appropriations by Fund		
240.10	General	69,992,000	71,244,000
240.11	Health Care Access	1,575,000	2,473,000
240.12	Lottery Prize	1,733,000	1,733,000

240.13 **Funding Usage.** Up to 75 percent of a fiscal
 240.14 year's appropriation for adult mental health
 240.15 grants may be used to fund allocations in that
 240.16 portion of the fiscal year ending December
 240.17 31.

240.18 **Culturally Specific Mental Health Services.**
 240.19 \$100,000 in fiscal year 2016 is for grants to
 240.20 nonprofit organizations to provide resources
 240.21 and referrals for culturally specific mental
 240.22 health services to Southeast Asian veterans
 240.23 born before 1965 who do not qualify for
 240.24 services available to veterans formally
 240.25 discharged from the United States armed
 240.26 forces.

240.27 **Problem Gambling.** \$225,000 in fiscal year
 240.28 2016 and \$225,000 in fiscal year 2017 are
 240.29 from the lottery prize fund for a grant to the
 240.30 state affiliate recognized by the National
 240.31 Council on Problem Gambling. The affiliate
 240.32 must provide services to increase public
 240.33 awareness of problem gambling, education,
 240.34 and training for individuals and organizations
 240.35 providing effective treatment services to

241.1 problem gamblers and their families, and
 241.2 research related to problem gambling.

241.3 **Sustainability Grants.** \$2,125,000 in fiscal
 241.4 year 2016 and \$2,125,000 in fiscal year 2017
 241.5 are for sustainability grants under Minnesota
 241.6 Statutes, section 256B.0622, subdivision 11.

241.7 **Beltrami County Mental Health Services**
 241.8 **Grant.** \$1,000,000 in fiscal year 2016 and
 241.9 \$1,000,000 in fiscal year 2017 are from the
 241.10 general fund for a grant to Beltrami County
 241.11 to fund the planning and development of a
 241.12 comprehensive mental health services program
 241.13 under article 2, section 41, Comprehensive
 241.14 Mental Health Program in Beltrami County.
 241.15 This is a onetime appropriation.

241.16 **Base Level Adjustment.** The general fund
 241.17 base is increased by \$723,000 in fiscal year
 241.18 2018 and by \$723,000 in fiscal year 2019. The
 241.19 health care access fund base is decreased by
 241.20 \$1,723,000 in fiscal year 2018 and by
 241.21 \$1,723,000 in fiscal year 2019.

241.22 (n) Child Mental Health Grants	23,386,000	24,313,000
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241.23 **Services and Supports for First Episode**
 241.24 **Psychosis.** \$177,000 in fiscal year 2017 is for
 241.25 grants under Minnesota Statutes, section
 241.26 245.4889, to mental health providers to pilot
 241.27 evidence-based interventions for youth at risk
 241.28 of developing or experiencing a first episode
 241.29 of psychosis and for a public awareness
 241.30 campaign on the signs and symptoms of
 241.31 psychosis. The base for these grants is
 241.32 \$236,000 in fiscal year 2018 and \$301,000 in
 241.33 fiscal year 2019.

242.1 **Adverse Childhood Experiences.** The base
 242.2 for grants under Minnesota Statutes, section
 242.3 245.4889, to children's mental health and
 242.4 family services collaboratives for adverse
 242.5 childhood experiences (ACEs) training grants
 242.6 and for an interactive Web site connection to
 242.7 support ACEs in Minnesota is \$363,000 in
 242.8 fiscal year 2018 and \$363,000 in fiscal year
 242.9 2019.

242.10 **Funding Usage.** Up to 75 percent of a fiscal
 242.11 year's appropriation for child mental health
 242.12 grants may be used to fund allocations in that
 242.13 portion of the fiscal year ending December
 242.14 31.

242.15 **Base Level Adjustment.** The general fund
 242.16 base is increased by \$422,000 in fiscal year
 242.17 2018 and is increased by \$487,000 in fiscal
 242.18 year 2019.

242.19 (o) **Chemical Dependency Treatment Support**
 242.20 **Grants**

1,561,000

1,561,000

242.21 **Chemical Dependency Prevention.** \$150,000
 242.22 in fiscal year 2016 and \$150,000 in fiscal year
 242.23 2017 are for grants to nonprofit organizations
 242.24 to provide chemical dependency prevention
 242.25 programs in secondary schools. When making
 242.26 grants, the commissioner must consider the
 242.27 expertise, prior experience, and outcomes
 242.28 achieved by applicants that have provided
 242.29 prevention programming in secondary
 242.30 education environments. An applicant for the
 242.31 grant funds must provide verification to the
 242.32 commissioner that the applicant has available
 242.33 and will contribute sufficient funds to match
 242.34 the grant given by the commissioner. This is
 242.35 a onetime appropriation.

243.1 **Fetal Alcohol Syndrome Grants.** \$250,000
243.2 in fiscal year 2016 and \$250,000 in fiscal year
243.3 2017 are for grants to be administered by the
243.4 Minnesota Organization on Fetal Alcohol
243.5 Syndrome to provide comprehensive,
243.6 gender-specific services to pregnant and
243.7 parenting women suspected of or known to
243.8 use or abuse alcohol or other drugs. This
243.9 appropriation is for grants to no fewer than
243.10 three eligible recipients. Minnesota
243.11 Organization on Fetal Alcohol Syndrome must
243.12 report to the commissioner of human services
243.13 annually by January 15 on the grants funded
243.14 by this appropriation. The report must include
243.15 measurable outcomes for the previous year,
243.16 including the number of pregnant women
243.17 served and the number of toxic-free babies
243.18 born.

243.19 **Base Level Adjustment.** The general fund
243.20 base is decreased by \$150,000 in fiscal year
243.21 2018 and by \$150,000 in fiscal year 2019.

243.22 Sec. 48. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended
243.23 by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

243.24 Subdivision 1. **Waivers and modifications; federal funding extension.** When the
243.25 peacetime emergency declared by the governor in response to the COVID-19 outbreak
243.26 expires, is terminated, or is rescinded by the proper authority, the following waivers and
243.27 modifications to human services programs issued by the commissioner of human services
243.28 pursuant to Executive Orders 20-11 and 20-12 that are required to comply with federal law
243.29 may remain in effect for the time period set out in applicable federal law or for the time
243.30 period set out in any applicable federally approved waiver or state plan amendment,
243.31 whichever is later:

243.32 (1) CV15: allowing telephone or video visits for waiver programs;

243.33 (2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare
243.34 as needed to comply with federal guidance from the Centers for Medicare and Medicaid

244.1 Services, and until the enrollee's first renewal following the resumption of medical assistance
 244.2 and MinnesotaCare renewals after the end of the COVID-19 public health emergency
 244.3 declared by the United States Secretary of Health and Human Services;

244.4 (3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance
 244.5 Program;

244.6 (4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

244.7 (5) CV24: allowing telephone or video use for targeted case management visits;

244.8 (6) CV30: expanding telemedicine in health care, mental health, and substance use
 244.9 disorder settings;

244.10 (7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance
 244.11 Program;

244.12 (8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance
 244.13 Program;

244.14 (9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance
 244.15 Program;

244.16 (10) CV43: expanding remote home and community-based waiver services;

244.17 (11) CV44: allowing remote delivery of adult day services;

244.18 (12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance
 244.19 Program;

244.20 (13) CV60: modifying eligibility period for the federally funded Refugee Social Services
 244.21 Program; and

244.22 (14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and
 244.23 Minnesota Family Investment Program maximum food benefits.

244.24 Sec. 49. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to
 244.25 read:

244.26 **Sec. 36. RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

244.27 (a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06,
 244.28 subdivision 3, or any other provision to the contrary, the commissioner shall not collect any
 244.29 unpaid premium for a coverage month that occurred during until the enrollee's first renewal
 244.30 after the resumption of medical assistance renewals following the end of the COVID-19

245.1 public health emergency declared by the United States Secretary of Health and Human
245.2 Services.

245.3 (b) Notwithstanding any provision to the contrary, periodic data matching under
245.4 Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12
245.5 months following the ~~last day of~~ resumption of medical assistance and MinnesotaCare
245.6 renewals after the end of the COVID-19 public health emergency declared by the United
245.7 States Secretary of Health and Human Services.

245.8 (c) Notwithstanding any provision to the contrary, the requirement for the commissioner
245.9 of human services to issue an annual report on periodic data matching under Minnesota
245.10 Statutes, section 256B.0561, is suspended for one year following the last day of the
245.11 COVID-19 public health emergency declared by the United States Secretary of Health and
245.12 Human Services.

245.13 (d) The commissioner of human services shall take necessary actions to comply with
245.14 federal guidance pertaining to the appropriate redetermination of medical assistance enrollee
245.15 eligibility following the end of the COVID-19 public health emergency declared by the
245.16 United States Secretary of Health and Human Services and may waive currently existing
245.17 Minnesota statutes to the minimum level necessary to achieve federal compliance. All
245.18 changes implemented must be reported to the chairs and ranking minority members of the
245.19 legislative committees with jurisdiction over human services within 90 days.

245.20 Sec. 50. **DENTAL HOME PILOT PROJECT.**

245.21 Subdivision 1. Establishment; requirements. (a) The commissioner of human services
245.22 shall establish a dental home pilot project to increase access of medical assistance and
245.23 MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health
245.24 clinical outcomes, in a manner that sustains the financial viability of the dental workforce
245.25 and broader dental care delivery and financing system. Dental homes must provide
245.26 high-quality, patient-centered, comprehensive, and coordinated oral health services across
245.27 clinical and community-based settings, including virtual oral health care.

245.28 (b) The design and operation of the dental home pilot project must be consistent with
245.29 the recommendations made by the Dental Services Advisory Committee to the legislature
245.30 under Laws 2021, First Special Session chapter 7, article 1, section 33.

245.31 (c) The commissioner shall establish baseline requirements and performance measures
245.32 for dental homes participating in the pilot project. These baseline requirements and

246.1 performance measures must address access and patient experience and oral health clinical
246.2 outcomes.

246.3 Subd. 2. Project design and timeline. (a) The commissioner shall issue a preliminary
246.4 project description and a request for information to obtain stakeholder feedback and input
246.5 on project design issues, including but not limited to:

246.6 (1) the timeline for project implementation;

246.7 (2) the length of each project phase and the date for full project implementation;

246.8 (3) the number of providers to be selected for participation;

246.9 (4) grant amounts;

246.10 (5) criteria and procedures for any value-based payments;

246.11 (6) the extent to which pilot project requirements may vary with provider characteristics;

246.12 (7) procedures for data collection;

246.13 (8) the role of dental partners, such as dental professional organizations and educational
246.14 institutions;

246.15 (9) provider support and education; and

246.16 (10) other topics identified by the commissioner.

246.17 (b) The commissioner shall consider the feedback and input obtained in paragraph (a)
246.18 and shall develop and issue a request for proposals for participation in the pilot project.

246.19 (c) The pilot project must be implemented by July 1, 2023, and must include initial pilot
246.20 testing and the collection and analysis of data on baseline requirements and performance
246.21 measures to evaluate whether these requirements and measures are appropriate. Under this
246.22 phase, the commissioner shall provide grants to individual providers and provider networks
246.23 in addition to medical assistance and MinnesotaCare payments received for services provided.

246.24 (d) The pilot project may test and analyze value-based payments to providers to determine
246.25 whether varying payments based on dental home performance measures is appropriate and
246.26 effective.

246.27 (e) The commissioner shall ensure provider diversity in selecting project participants.
246.28 In selecting providers, the commissioner shall consider: geographic distribution; provider
246.29 size, type, and location; providers serving different priority populations; health equity issues;
246.30 and provider accessibility for patients with varying levels and types of disability.

247.1 (f) In designing and implementing the pilot project, the commissioner shall regularly
247.2 consult with project participants and other stakeholders, and as relevant shall continue to
247.3 seek the input of participants and other stakeholders on the topics listed in paragraph (a).

247.4 Subd. 3. **Reporting.** (a) The commissioner, beginning February 15, 2023, and each
247.5 February 15 thereafter for the duration of the demonstration project, shall report on the
247.6 design, implementation, operation, and results of the demonstration project to the chairs
247.7 and ranking minority members of the legislative committees with jurisdiction over health
247.8 care finance and policy.

247.9 (b) The commissioner, within six months from the date the pilot project ceases operation,
247.10 shall report to the chairs and ranking minority members of the legislative committees with
247.11 jurisdiction over health care finance and policy on the results of the demonstration project,
247.12 and shall include in the report recommendations on whether the demonstration project, or
247.13 specific features of the demonstration project, should be extended to all dental providers
247.14 serving medical assistance and MinnesotaCare enrollees.

247.15 **Sec. 51. SMALL EMPLOYER PUBLIC OPTION.**

247.16 The commissioner of human services, in consultation with representatives of small
247.17 employers, shall develop a small employer public option that allows employees of businesses
247.18 with fewer than 50 employees to receive employer contributions toward MinnesotaCare.
247.19 The commissioner shall determine whether the employer makes contributions to the
247.20 commissioner directly or the employee makes contributions through a qualified small
247.21 employer health reimbursement arrangement account or other arrangement. In determining
247.22 the structure of the small employer public option, the commissioner shall consult with
247.23 federal officials to determine which arrangement will result in the employer contributions
247.24 being tax deductible to the employer and not being considered taxable income to the
247.25 employee. The commissioner shall present recommendations for a small employer public
247.26 option to the chairs and ranking minority members of the legislative committees with
247.27 jurisdiction over health and human services policy and finance by December 15, 2023.

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

247.29 **Sec. 52. TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

247.30 (a) The commissioner of human services shall continue to administer MinnesotaCare
247.31 as a basic health program in accordance with Minnesota Statutes, section 256L.02,
247.32 subdivision 5, and shall seek federal waivers, approvals, and law changes necessary to
247.33 implement this act.

248.1 (b) The commissioner shall present an implementation plan for the MinnesotaCare public
248.2 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking
248.3 minority members of the legislative committees with jurisdiction over health care policy
248.4 and finance by December 15, 2023. The plan must include:

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

248.7 (2) recommendations for implementing any small employer option in a manner that
248.8 would allow any employee payments toward premiums to be pretax;

248.9 (3) recommendations for ensuring sufficient provider participation in MinnesotaCare;

248.10 (4) estimates of state costs related to the MinnesotaCare public option;

248.11 (5) a description of the proposed premium scale for persons eligible through the public
248.12 option, including an analysis of the extent to which the proposed premium scale:

248.13 (i) ensures affordable premiums for persons across the income spectrum enrolled under
248.14 the public option; and

248.15 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public
248.16 option; and

248.17 (6) draft legislation that includes any additional policy and conforming changes necessary
248.18 to implement the MinnesotaCare public option and the implementation plan
248.19 recommendations.

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

248.21 **Sec. 53. REQUEST FOR FEDERAL APPROVAL.**

248.22 (a) The commissioner of human services shall seek any federal waivers, approvals, and
248.23 law changes necessary to implement this act, including but not limited to those waivers,
248.24 approvals, and law changes necessary to allow the state to:

248.25 (1) continue receiving federal basic health program payments for basic health
248.26 program-eligible MinnesotaCare enrollees and to receive other federal funding for the
248.27 MinnesotaCare public option;

248.28 (2) receive federal payments equal to the value of premium tax credits and cost-sharing
248.29 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent
248.30 of the federal poverty guidelines would otherwise have received; and

249.1 (3) receive federal payments equal to the value of emergency medical assistance that
249.2 would otherwise have been paid to the state for covered services provided to eligible
249.3 enrollees.

249.4 (b) In implementing this section, the commissioner of human services shall consult with
249.5 the commissioner of commerce and the Board of Directors of MNsure and may contract
249.6 for technical and actuarial assistance.

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

249.8 Sec. 54. **DELIVERY REFORM ANALYSIS REPORT.**

249.9 (a) The commissioner of human services shall present to the chairs and ranking minority
249.10 members of the legislative committees with jurisdiction over health care policy and finance,
249.11 by January 15, 2024, a report comparing service delivery and payment system models for
249.12 delivering services to medical assistance enrollees for whom income eligibility is determined
249.13 using the modified adjusted gross income methodology under Minnesota Statutes, section
249.14 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
249.15 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
249.16 model with at least two alternative models. The alternative models must include a state-based
249.17 model in which the state holds the plan risk as the insurer and may contract with a third-party
249.18 administrator for claims processing and plan administration. The alternative models may
249.19 include but are not limited to:

249.20 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
249.21 256B.0755;

249.22 (2) delivering care under fee-for-service through a primary care case management system;
249.23 and

249.24 (3) continuing to contract with managed care and county-based purchasing plans for
249.25 some or all enrollees under modified contracts.

249.26 (b) The report must include:

249.27 (1) a description of how each model would address:

249.28 (i) racial and other inequities in the delivery of health care and health care outcomes;

249.29 (ii) geographic inequities in the delivery of health care;

249.30 (iii) the provision of incentives for preventive care and other best practices;

250.1 (iv) reimbursement of providers for high-quality, value-based care at levels sufficient
 250.2 to sustain or increase enrollee access to care; and

250.3 (v) transparency and simplicity for enrollees, health care providers, and policymakers;

250.4 (2) a comparison of the projected cost of each model; and

250.5 (3) an implementation timeline for each model that includes the earliest date by which
 250.6 each model could be implemented if authorized during the 2024 legislative session and a
 250.7 discussion of barriers to implementation.

250.8 **Sec. 55. RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

250.9 (a) The commissioners of human services, health, and commerce and the MNsure board
 250.10 shall submit to the health care affordability board and the chairs and ranking minority
 250.11 members of the legislative committees with primary jurisdiction over health and human
 250.12 services finance and policy and commerce by January 15, 2023, a report on the organization
 250.13 and duties of the Office of Patient Protection, to be established under Minnesota Statutes,
 250.14 section 62J.89, subdivision 4. The report must include recommendations on how the office
 250.15 shall:

250.16 (1) coordinate or consolidate within the office existing state agency patient protection
 250.17 activities, including but not limited to the activities of ombudsman offices and the MNsure
 250.18 board;

250.19 (2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for
 250.20 utilization review organizations;

250.21 (3) work with private sector and state agency consumer assistance programs to assist
 250.22 consumers with questions or concerns relating to public programs and private insurance
 250.23 coverage;

250.24 (4) establish and implement procedures to assist consumers aggrieved by restrictions on
 250.25 patient choice, denials of services, and reductions in quality of care resulting from any final
 250.26 action by a payer or provider; and

250.27 (5) make health plan company quality of care and patient satisfaction information and
 250.28 other information collected by the office readily accessible to consumers on the board's
 250.29 website.

250.30 (b) The commissioners and the MNsure board shall consult with stakeholders as they
 250.31 develop the recommendations. The stakeholders consulted must include but are not limited
 250.32 to organizations and individuals representing: underserved communities; persons with

251.1 disabilities; low-income Minnesotans; senior citizens; and public and private sector health
 251.2 plan enrollees, including persons who purchase coverage through MNsure, health plan
 251.3 companies, and public and private sector purchasers of health coverage.

251.4 (c) The commissioners and the MNsure board may contract with a third party to develop
 251.5 the report and recommendations.

251.6 Sec. 56. **REPEALER.**

251.7 Minnesota Statutes 2020, section 256B.063, is repealed.

251.8 **EFFECTIVE DATE.** This section is effective January 1, 2023.

251.9 **ARTICLE 4**

251.10 **HEALTH CARE POLICY**

251.11 Section 1. Minnesota Statutes 2020, section 62J.2930, subdivision 3, is amended to read:

251.12 Subd. 3. **Consumer information.** (a) The information clearinghouse or another entity
 251.13 designated by the commissioner shall provide consumer information to health plan company
 251.14 enrollees to:

251.15 (1) assist enrollees in understanding their rights;

251.16 (2) explain and assist in the use of all available complaint systems, including internal
 251.17 complaint systems within health carriers, community integrated service networks, and the
 251.18 Departments of Health and Commerce;

251.19 (3) provide information on coverage options in each region of the state;

251.20 (4) provide information on the availability of purchasing pools and enrollee subsidies;
 251.21 and

251.22 (5) help consumers use the health care system to obtain coverage.

251.23 (b) The information clearinghouse or other entity designated by the commissioner for
 251.24 the purposes of this subdivision shall not:

251.25 (1) provide legal services to consumers;

251.26 (2) represent a consumer or enrollee; or

251.27 (3) serve as an advocate for consumers in disputes with health plan companies.

251.28 (c) Nothing in this subdivision shall interfere with the ombudsman program established
 251.29 under section ~~256B.69, subdivision 20~~ 256B.6903, or other existing ombudsman programs.

252.1 Sec. 2. Minnesota Statutes 2020, section 256B.055, subdivision 2, is amended to read:

252.2 Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible
 252.3 for or receiving foster care maintenance payments under Title IV-E of the Social Security
 252.4 Act, United States Code, title 42, sections 670 to 676, and for a child who is not eligible for
 252.5 Title IV-E of the Social Security Act but who is ~~determined eligible for~~ placed in foster
 252.6 care as determined by Minnesota Statutes or kinship assistance under chapter 256N.

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

252.8 Sec. 3. Minnesota Statutes 2020, section 256B.056, subdivision 3b, is amended to read:

252.9 Subd. 3b. **Treatment of trusts.** (a) It is the public policy of this state that individuals
 252.10 use all available resources to pay for the cost of long-term care services, as defined in section
 252.11 256B.0595, before turning to Minnesota health care program funds, and that trust instruments
 252.12 should not be permitted to shield available resources of an individual or an individual's
 252.13 spouse from such use.

252.14 ~~(a)~~ (b) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or
 252.15 similar legal device, established on or before August 10, 1993, by a person or the person's
 252.16 spouse under the terms of which the person receives or could receive payments from the
 252.17 trust principal or income and the trustee has discretion in making payments to the person
 252.18 from the trust principal or income. Notwithstanding that definition, a medical assistance
 252.19 qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7,
 252.20 1986, solely to benefit a person with a developmental disability living in an intermediate
 252.21 care facility for persons with developmental disabilities; or (3) a trust set up by a person
 252.22 with payments made by the Social Security Administration pursuant to the United States
 252.23 Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount
 252.24 of payments that a trustee of a medical assistance qualifying trust may make to a person
 252.25 under the terms of the trust is considered to be available assets to the person, without regard
 252.26 to whether the trustee actually makes the maximum payments to the person and without
 252.27 regard to the purpose for which the medical assistance qualifying trust was established.

252.28 ~~(b)~~ (c) Trusts established after August 10, 1993, are treated according to United States
 252.29 Code, title 42, section 1396p(d).

252.30 ~~(e)~~ (d) For purposes of paragraph ~~(d)~~ (e), a pooled trust means a trust established under
 252.31 United States Code, title 42, section 1396p(d)(4)(C).

252.32 ~~(d)~~ (e) A beneficiary's interest in a pooled trust is considered an available asset unless
 252.33 the trust provides that upon the death of the beneficiary or termination of the trust during

253.1 the beneficiary's lifetime, whichever is sooner, the department receives any amount, up to
 253.2 the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in
 253.3 the beneficiary's trust account after a deduction for reasonable administrative fees and
 253.4 expenses, and an additional remainder amount. The retained remainder amount of the
 253.5 subaccount must not exceed ten percent of the account value at the time of the beneficiary's
 253.6 death or termination of the trust, and must only be used for the benefit of disabled individuals
 253.7 who have a beneficiary interest in the pooled trust.

253.8 ~~(e)~~ (f) Trusts may be established on or after December 12, 2016, by a person who has
 253.9 been determined to be disabled, according to United States Code, title 42, section
 253.10 1396p(d)(4)(A), as amended by section 5007 of the 21st Century Cures Act, Public Law
 253.11 114-255.

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

253.13 Sec. 4. Minnesota Statutes 2020, section 256B.056, subdivision 3c, is amended to read:

253.14 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more
 253.15 persons must not own more than \$20,000 in total net assets, and a household of one person
 253.16 must not own more than \$10,000 in total net assets. In addition to these maximum amounts,
 253.17 an eligible individual or family may accrue interest on these amounts, but they must be
 253.18 reduced to the maximum at the time of an eligibility redetermination. The value of assets
 253.19 that are not considered in determining eligibility for medical assistance for families and
 253.20 children is the value of those assets excluded under the AFDC state plan as of July 16, 1996,
 253.21 as required by the Personal Responsibility and Work Opportunity Reconciliation Act of
 253.22 1996 (PRWORA), Public Law 104-193, with the following exceptions:

253.23 (1) household goods and personal effects are not considered;

253.24 (2) capital and operating assets of a trade or business up to \$200,000 are not considered;

253.25 (3) one motor vehicle is excluded for each person of legal driving age who is employed
 253.26 or seeking employment;

253.27 (4) assets designated as burial expenses are excluded to the same extent they are excluded
 253.28 by the Supplemental Security Income program;

253.29 (5) court-ordered settlements up to \$10,000 are not considered;

253.30 (6) individual retirement accounts and funds are not considered;

253.31 (7) assets owned by children are not considered; and

254.1 (8) ~~effective July 1, 2009~~, certain assets owned by American Indians are excluded as
254.2 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
254.3 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
254.4 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

254.5 (b) ~~Beginning January 1, 2014, this subdivision~~ Paragraph (a) applies only to parents
254.6 and caretaker relatives who qualify for medical assistance under subdivision 5.

254.7 (c) Eligibility for children under age 21 must be determined without regard to the asset
254.8 limitations described in paragraphs (a) and (b) and subdivision 3.

254.9 Sec. 5. Minnesota Statutes 2020, section 256B.056, subdivision 11, is amended to read:

254.10 Subd. 11. **Treatment of annuities.** (a) Any person requesting medical assistance payment
254.11 of long-term care services shall provide a complete description of any interest either the
254.12 person or the person's spouse has in annuities on a form designated by the department. The
254.13 form shall include a statement that the state becomes a preferred remainder beneficiary of
254.14 annuities or similar financial instruments by virtue of the receipt of medical assistance
254.15 payment of long-term care services. The person and the person's spouse shall furnish the
254.16 agency responsible for determining eligibility with complete current copies of their annuities
254.17 and related documents and complete the form designating the state as the preferred remainder
254.18 beneficiary for each annuity in which the person or the person's spouse has an interest.

254.19 (b) The department shall provide notice to the issuer of the department's right under this
254.20 section as a preferred remainder beneficiary under the annuity or similar financial instrument
254.21 for medical assistance furnished to the person or the person's spouse, and provide notice of
254.22 the issuer's responsibilities as provided in paragraph (c).

254.23 (c) An issuer of an annuity or similar financial instrument who receives notice of the
254.24 state's right to be named a preferred remainder beneficiary as described in paragraph (b)
254.25 shall provide confirmation to the requesting agency that the state has been made a preferred
254.26 remainder beneficiary. The issuer shall also notify the county agency when a change in the
254.27 amount of income or principal being withdrawn from the annuity or other similar financial
254.28 instrument or a change in the state's preferred remainder beneficiary designation under the
254.29 annuity or other similar financial instrument occurs. The county agency shall provide the
254.30 issuer with the name, address, and telephone number of a unit within the department that
254.31 the issuer can contact to comply with this paragraph.

254.32 (d) "Preferred remainder beneficiary" for purposes of this subdivision and sections
254.33 256B.0594 and 256B.0595 means the state is a remainder beneficiary in the first position

255.1 in an amount equal to the amount of medical assistance paid on behalf of the institutionalized
255.2 person, or is a remainder beneficiary in the second position if the institutionalized person
255.3 designates and is survived by a remainder beneficiary who is (1) a spouse who does not
255.4 reside in a medical institution, (2) a minor child, or (3) a child of any age who is blind or
255.5 permanently and totally disabled as defined in the Supplemental Security Income program.
255.6 Notwithstanding this paragraph, the state is the remainder beneficiary in the first position
255.7 if the spouse or child disposes of the remainder for less than fair market value.

255.8 (e) For purposes of this subdivision, "institutionalized person" and "long-term care
255.9 services" have the meanings given in section 256B.0595, subdivision 1, paragraph ~~(g)~~ (f).

255.10 (f) For purposes of this subdivision, "medical institution" means a skilled nursing facility,
255.11 intermediate care facility, intermediate care facility for persons with developmental
255.12 disabilities, nursing facility, or inpatient hospital.

255.13 Sec. 6. Minnesota Statutes 2020, section 256B.0595, subdivision 1, is amended to read:

255.14 Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10,
255.15 1993, an institutionalized person, an institutionalized person's spouse, or any person, court,
255.16 or administrative body with legal authority to act in place of, on behalf of, at the direction
255.17 of, or upon the request of the institutionalized person or institutionalized person's spouse,
255.18 may not give away, sell, or dispose of, for less than fair market value, any asset or interest
255.19 therein, except assets other than the homestead that are excluded under the Supplemental
255.20 Security Income program, for the purpose of establishing or maintaining medical assistance
255.21 eligibility. This applies to all transfers, including those made by a community spouse after
255.22 the month in which the institutionalized spouse is determined eligible for medical assistance.
255.23 For purposes of determining eligibility for long-term care services, any transfer of such
255.24 assets within 36 months before or any time after an institutionalized person requests medical
255.25 assistance payment of long-term care services, or 36 months before or any time after a
255.26 medical assistance recipient becomes an institutionalized person, for less than fair market
255.27 value may be considered. Any such transfer is presumed to have been made for the purpose
255.28 of establishing or maintaining medical assistance eligibility and the institutionalized person
255.29 is ineligible for long-term care services for the period of time determined under subdivision
255.30 2, unless the institutionalized person furnishes convincing evidence to establish that the
255.31 transaction was exclusively for another purpose, or unless the transfer is permitted under
255.32 subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are
255.33 considered transfers of assets under federal law, or in the case of any other disposal of assets
255.34 made on or after February 8, 2006, any transfers made within 60 months before or any time

256.1 after an institutionalized person requests medical assistance payment of long-term care
 256.2 services and within 60 months before or any time after a medical assistance recipient becomes
 256.3 an institutionalized person, may be considered.

256.4 (b) This section applies to transfers, for less than fair market value, of income or assets,
 256.5 including assets that are considered income in the month received, such as inheritances,
 256.6 court settlements, and retroactive benefit payments or income to which the institutionalized
 256.7 person or the institutionalized person's spouse is entitled but does not receive due to action
 256.8 by the institutionalized person, the institutionalized person's spouse, or any person, court,
 256.9 or administrative body with legal authority to act in place of, on behalf of, at the direction
 256.10 of, or upon the request of the institutionalized person or the institutionalized person's spouse.

256.11 (c) This section applies to payments for care or personal services provided by a relative,
 256.12 unless the compensation was stipulated in a notarized, written agreement ~~which~~ that was
 256.13 in existence when the service was performed, the care or services directly benefited the
 256.14 person, and the payments made represented reasonable compensation for the care or services
 256.15 provided. A notarized written agreement is not required if payment for the services was
 256.16 made within 60 days after the service was provided.

256.17 ~~(d) This section applies to the portion of any asset or interest that an institutionalized~~
 256.18 ~~person, an institutionalized person's spouse, or any person, court, or administrative body~~
 256.19 ~~with legal authority to act in place of, on behalf of, at the direction of, or upon the request~~
 256.20 ~~of the institutionalized person or the institutionalized person's spouse, transfers to any~~
 256.21 ~~annuity that exceeds the value of the benefit likely to be returned to the institutionalized~~
 256.22 ~~person or institutionalized person's spouse while alive, based on estimated life expectancy~~
 256.23 ~~as determined according to the current actuarial tables published by the Office of the Chief~~
 256.24 ~~Actuary of the Social Security Administration. The commissioner may adopt rules reducing~~
 256.25 ~~life expectancies based on the need for long-term care. This section applies to an annuity~~
 256.26 ~~purchased on or after March 1, 2002, that:~~

256.27 ~~(1) is not purchased from an insurance company or financial institution that is subject~~
 256.28 ~~to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory~~
 256.29 ~~agency of another state;~~

256.30 ~~(2) does not pay out principal and interest in equal monthly installments; or~~

256.31 ~~(3) does not begin payment at the earliest possible date after annuitization.~~

256.32 ~~(e)~~ (d) Effective for transactions, including the purchase of an annuity, occurring on or
 256.33 after February 8, 2006, by or on behalf of an institutionalized person who has applied for
 256.34 or is receiving long-term care services or the institutionalized person's spouse shall be treated

257.1 as the disposal of an asset for less than fair market value unless the department is named a
257.2 preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any
257.3 subsequent change to the designation of the department as a preferred remainder beneficiary
257.4 shall result in the annuity being treated as a disposal of assets for less than fair market value.
257.5 The amount of such transfer shall be the maximum amount the institutionalized person or
257.6 the institutionalized person's spouse could receive from the annuity or similar financial
257.7 instrument. Any change in the amount of the income or principal being withdrawn from the
257.8 annuity or other similar financial instrument at the time of the most recent disclosure shall
257.9 be deemed to be a transfer of assets for less than fair market value unless the institutionalized
257.10 person or the institutionalized person's spouse demonstrates that the transaction was for fair
257.11 market value. In the event a distribution of income or principal has been improperly
257.12 distributed or disbursed from an annuity or other retirement planning instrument of an
257.13 institutionalized person or the institutionalized person's spouse, a cause of action exists
257.14 against the individual receiving the improper distribution for the cost of medical assistance
257.15 services provided or the amount of the improper distribution, whichever is less.

257.16 ~~(f)~~ (e) Effective for transactions, including the purchase of an annuity, occurring on or
257.17 after February 8, 2006, by or on behalf of an institutionalized person applying for or receiving
257.18 long-term care services shall be treated as a disposal of assets for less than fair market value
257.19 unless it is:

257.20 (1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue
257.21 Code of 1986; or

257.22 (2) purchased with proceeds from:

257.23 (i) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal
257.24 Revenue Code;

257.25 (ii) a simplified employee pension within the meaning of section 408(k) of the Internal
257.26 Revenue Code; or

257.27 (iii) a Roth IRA described in section 408A of the Internal Revenue Code; or

257.28 (3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined
257.29 in accordance with actuarial publications of the Office of the Chief Actuary of the Social
257.30 Security Administration; and provides for payments in equal amounts during the term of
257.31 the annuity, with no deferral and no balloon payments made.

257.32 ~~(g)~~ (f) For purposes of this section, long-term care services include services in a nursing
257.33 facility, services that are eligible for payment according to section 256B.0625, subdivision

258.1 2, because they are provided in a swing bed, intermediate care facility for persons with
 258.2 developmental disabilities, and home and community-based services provided pursuant to
 258.3 chapter 256S and sections 256B.092 and 256B.49. For purposes of this subdivision and
 258.4 subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in
 258.5 a nursing facility or in a swing bed, or intermediate care facility for persons with
 258.6 developmental disabilities or who is receiving home and community-based services under
 258.7 chapter 256S and sections 256B.092 and 256B.49.

258.8 ~~(h)~~ (g) This section applies to funds used to purchase a promissory note, loan, or mortgage
 258.9 unless the note, loan, or mortgage:

258.10 (1) has a repayment term that is actuarially sound;

258.11 (2) provides for payments to be made in equal amounts during the term of the loan, with
 258.12 no deferral and no balloon payments made; and

258.13 (3) prohibits the cancellation of the balance upon the death of the lender.

258.14 (h) In the case of a promissory note, loan, or mortgage that does not meet an exception
 258.15 in paragraph (g), clauses (1) to (3), the value of such note, loan, or mortgage shall be the
 258.16 outstanding balance due as of the date of the institutionalized person's request for medical
 258.17 assistance payment of long-term care services.

258.18 (i) This section applies to the purchase of a life estate interest in another person's home
 258.19 unless the purchaser resides in the home for a period of at least one year after the date of
 258.20 purchase.

258.21 (j) This section applies to transfers into a pooled trust that qualifies under United States
 258.22 Code, title 42, section 1396p(d)(4)(C), by:

258.23 (1) a person age 65 or older or the person's spouse; or

258.24 (2) any person, court, or administrative body with legal authority to act in place of, on
 258.25 behalf of, at the direction of, or upon the request of a person age 65 or older or the person's
 258.26 spouse.

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

258.28 Sec. 7. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 3b, is
 258.29 amended to read:

258.30 Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services
 258.31 and consultations delivered by a health care provider through telehealth in the same manner

259.1 as if the service or consultation was delivered through in-person contact. Services or
259.2 consultations delivered through telehealth shall be paid at the full allowable rate.

259.3 (b) The commissioner may establish criteria that a health care provider must attest to in
259.4 order to demonstrate the safety or efficacy of delivering a particular service through
259.5 telehealth. The attestation may include that the health care provider:

259.6 (1) has identified the categories or types of services the health care provider will provide
259.7 through telehealth;

259.8 (2) has written policies and procedures specific to services delivered through telehealth
259.9 that are regularly reviewed and updated;

259.10 (3) has policies and procedures that adequately address patient safety before, during,
259.11 and after the service is delivered through telehealth;

259.12 (4) has established protocols addressing how and when to discontinue telehealth services;
259.13 and

259.14 (5) has an established quality assurance process related to delivering services through
259.15 telehealth.

259.16 (c) As a condition of payment, a licensed health care provider must document each
259.17 occurrence of a health service delivered through telehealth to a medical assistance enrollee.
259.18 Health care service records for services delivered through telehealth must meet the
259.19 requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must
259.20 document:

259.21 (1) the type of service delivered through telehealth;

259.22 (2) the time the service began and the time the service ended, including an a.m. and p.m.
259.23 designation;

259.24 (3) the health care provider's basis for determining that telehealth is an appropriate and
259.25 effective means for delivering the service to the enrollee;

259.26 (4) the mode of transmission used to deliver the service through telehealth and records
259.27 evidencing that a particular mode of transmission was utilized;

259.28 (5) the location of the originating site and the distant site;

259.29 (6) if the claim for payment is based on a physician's consultation with another physician
259.30 through telehealth, the written opinion from the consulting physician providing the telehealth
259.31 consultation; and

260.1 (7) compliance with the criteria attested to by the health care provider in accordance
260.2 with paragraph (b).

260.3 (d) Telehealth visits, ~~as described in this subdivision provided through audio and visual~~
260.4 ~~communication~~, may be used to satisfy the face-to-face requirement for reimbursement
260.5 under the payment methods that apply to a federally qualified health center, rural health
260.6 clinic, Indian health service, 638 Tribal clinic, and certified community behavioral health
260.7 clinic, if the service would have otherwise qualified for payment if performed in person.

260.8 (e) For mental health services or assessments delivered through telehealth that are based
260.9 on an individual treatment plan, the provider may document the client's verbal approval or
260.10 electronic written approval of the treatment plan or change in the treatment plan in lieu of
260.11 the client's signature in accordance with Minnesota Rules, part 9505.0371.

260.12 (f) For purposes of this subdivision, unless otherwise covered under this chapter:

260.13 (1) "telehealth" means the delivery of health care services or consultations ~~through the~~
260.14 ~~use of~~ using real-time two-way interactive audio and visual communication or accessible
260.15 telemedicine video-based platforms to provide or support health care delivery and facilitate
260.16 the assessment, diagnosis, consultation, treatment, education, and care management of a
260.17 patient's health care. Telehealth includes the application of secure video conferencing,
260.18 consisting of a real-time, full-motion synchronized video; store-and-forward technology;
260.19 and synchronous interactions between a patient located at an originating site and a health
260.20 care provider located at a distant site. Telehealth does not include communication between
260.21 health care providers, or between a health care provider and a patient that consists solely
260.22 of an audio-only communication, e-mail, or facsimile transmission or as specified by law;

260.23 (2) "health care provider" means:

260.24 (i) a health care provider as defined under section 62A.673;

260.25 (ii) a community paramedic as defined under section 144E.001, subdivision 5f;

260.26 (iii) a community health worker who meets the criteria under subdivision 49, paragraph
260.27 (a);

260.28 (iv) a mental health certified peer specialist under section 256B.0615, subdivision 5;

260.29 (v) a mental health certified family peer specialist under section 256B.0616, subdivision
260.30 5;

260.31 (vi) a mental health rehabilitation worker under section 256B.0623, subdivision 5,
260.32 paragraph (a), clause (4), and paragraph (b);

- 261.1 (vii) a mental health behavioral aide under section 256B.0943, subdivision 7, paragraph
 261.2 (b), clause (3);
 261.3 (viii) a treatment coordinator under section 245G.11, subdivision 7;
 261.4 (ix) an alcohol and drug counselor under section 245G.11, subdivision 5; or
 261.5 (x) a recovery peer under section 245G.11, subdivision 8; and
 261.6 (3) "originating site," "distant site," and "store-and-forward technology" have the
 261.7 meanings given in section 62A.673, subdivision 2.

261.8 Sec. 8. Minnesota Statutes 2020, section 256B.0625, subdivision 64, is amended to read:

261.9 Subd. 64. **Investigational drugs, biological products, devices, and clinical**
 261.10 **trials.** Medical assistance and the early periodic screening, diagnosis, and treatment (EPSDT)
 261.11 program do not cover the costs of any services that are incidental to, associated with, or
 261.12 resulting from the use of investigational drugs, biological products, or devices as defined
 261.13 in section 151.375 or any other treatment that is part of an approved clinical trial as defined
 261.14 in section 62Q.526. Participation of an enrollee in an approved clinical trial does not preclude
 261.15 coverage of medically necessary services covered under this chapter that are not related to
 261.16 the approved clinical trial. Any items or services that are provided solely to satisfy data
 261.17 collection and analysis for a clinical trial, and not for direct clinical management of the
 261.18 enrollee, are not covered.

261.19 Sec. 9. **[256B.6903] OMBUDSPERSON FOR MANAGED CARE.**

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

261.22 (b) "Adverse benefit determination" has the meaning provided in Code of Federal
 261.23 Regulations, title 42, section 438.400, subpart (b).

261.24 (c) "Appeal" means an oral or written request from an enrollee to the managed care
 261.25 organization for review of an adverse benefit determination.

261.26 (d) "Commissioner" means the commissioner of human services.

261.27 (e) "Complaint" means an enrollee's informal expression of dissatisfaction about any
 261.28 matter relating to the enrollee's prepaid health plan other than an adverse benefit
 261.29 determination.

261.30 (f) "Data analyst" means the person employed by the ombudsperson that uses research
 261.31 methodologies to conduct research on data collected from prepaid health plans, including

262.1 but not limited to scientific theory; hypothesis testing; survey research techniques; data
 262.2 collection; data manipulation; and statistical analysis interpretation, including multiple
 262.3 regression techniques.

262.4 (g) "Enrollee" means a person enrolled in a prepaid health plan under section 256B.69.
 262.5 When applicable, an enrollee includes an enrollee's authorized representative.

262.6 (h) "External review" means the process described under Code of Federal Regulations,
 262.7 title 42, section 438.408, subpart (f); and section 62Q.73, subdivision 2.

262.8 (i) "Grievance" means an enrollee's expression of dissatisfaction about any matter relating
 262.9 to the enrollee's prepaid health plan other than an adverse benefit determination that follows
 262.10 the procedures outlined in Code of Federal Regulations, title 42, part 438, subpart (f). A
 262.11 grievance may include but is not limited to concerns relating to quality of care, services
 262.12 provided, or failure to respect an enrollee's rights under a prepaid health plan.

262.13 (j) "Managed care advocate" means a county or Tribal employee who works with
 262.14 managed care enrollees when the enrollee has service, billing, or access problems with the
 262.15 enrollee's prepaid health plan.

262.16 (k) "Prepaid health plan" means a plan under contract with the commissioner according
 262.17 to section 256B.69.

262.18 (l) "State fair hearing" means the appeals process mandated under section 256.045,
 262.19 subdivision 3a.

262.20 Subd. 2. **Ombudsperson.** The commissioner must designate an ombudsperson to advocate
 262.21 for enrollees. At the time of enrollment in a prepaid health plan, the local agency must
 262.22 inform enrollees about the ombudsperson.

262.23 Subd. 3. **Duties and cost.** (a) The ombudsperson must work to ensure enrollees receive
 262.24 covered services as described in the enrollee's prepaid health plan by:

262.25 (1) providing assistance and education to enrollees, when requested, regarding covered
 262.26 health care benefits or services; billing and access; or the grievance, appeal, or state fair
 262.27 hearing processes;

262.28 (2) with the enrollee's permission and within the ombudsperson's discretion, using an
 262.29 informal review process to assist an enrollee with a resolution involving the enrollee's
 262.30 prepaid health plan's benefits;

262.31 (3) assisting enrollees, when requested, with prepaid health plan grievances, appeals, or
 262.32 the state fair hearing process;

263.1 (4) overseeing, reviewing, and approving documents used by enrollees relating to prepaid
263.2 health plans' grievances, appeals, and state fair hearings;

263.3 (5) reviewing all state fair hearings and requests by enrollees for external review;
263.4 overseeing entities under contract to provide external reviews, processes, and payments for
263.5 services; and utilizing aggregated results of external reviews to recommend health care
263.6 benefits policy changes; and

263.7 (6) providing trainings to managed care advocates.

263.8 (b) The ombudsperson must not charge an enrollee for the ombudsperson's services.

263.9 Subd. 4. Powers. In exercising the ombudsperson's authority under this section, the
263.10 ombudsperson may:

263.11 (1) gather information and evaluate any practice, policy, procedure, or action by a prepaid
263.12 health plan, state human services agency, county, or Tribe; and

263.13 (2) prescribe the methods by which complaints are to be made, received, and acted upon.
263.14 The ombudsperson's authority under this clause includes but is not limited to:

263.15 (i) determining the scope and manner of a complaint;

263.16 (ii) holding a prepaid health plan accountable to address a complaint in a timely manner
263.17 as outlined in state and federal laws;

263.18 (iii) requiring a prepaid health plan to respond in a timely manner to a request for data,
263.19 case details, and other information as needed to help resolve a complaint or to improve a
263.20 prepaid health plan's policy; and

263.21 (iv) making recommendations for policy, administrative, or legislative changes regarding
263.22 prepaid health plans to the proper partners.

263.23 Subd. 5. Data. (a) The data analyst must review and analyze prepaid health plan data
263.24 on denial, termination, and reduction notices (DTRs), grievances, appeals, and state fair
263.25 hearings by:

263.26 (1) analyzing, reviewing, and reporting on DTRs, grievances, appeals, and state fair
263.27 hearings data collected from each prepaid health plan;

263.28 (2) collaborating with the commissioner's partners and the Department of Health for the
263.29 Triennial Compliance Assessment under Code of Federal Regulations, title 42, section
263.30 438.358, subpart (b);

264.1 (3) reviewing state fair hearing decisions for policy or coverage issues that may affect
 264.2 enrollees; and

264.3 (4) providing data required under Code of Federal Regulations, title 42, section 438.66
 264.4 (2016), to the Centers for Medicare and Medicaid Services.

264.5 (b) The data analyst must share the data analyst's data observations and trends under
 264.6 this subdivision with the ombudsperson, prepaid health plans, and commissioner's partners.

264.7 Subd. 6. **Collaboration and independence.** (a) The ombudsperson must work in
 264.8 collaboration with the commissioner and the commissioner's partners when the
 264.9 ombudsperson's collaboration does not otherwise interfere with the ombudsperson's duties
 264.10 under this section.

264.11 (b) The ombudsperson may act independently of the commissioner when:

264.12 (1) providing information or testimony to the legislature; and

264.13 (2) contacting and making reports to federal and state officials.

264.14 Subd. 7. **Civil actions.** The ombudsperson is not civilly liable for actions taken under
 264.15 this section if the action was taken in good faith, was within the scope of the ombudsperson's
 264.16 authority, and did not constitute willful or reckless misconduct.

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

264.18 Sec. 10. Minnesota Statutes 2020, section 256B.77, subdivision 13, is amended to read:

264.19 Subd. 13. **Ombudsman.** Enrollees shall have access to ombudsman services established
 264.20 in section ~~256B.69~~, ~~subdivision 20~~ 256B.6903, and advocacy services provided by the
 264.21 ombudsman for mental health and developmental disabilities established in sections 245.91
 264.22 to 245.97. The managed care ombudsman and the ombudsman for mental health and
 264.23 developmental disabilities shall coordinate services provided to avoid duplication of services.
 264.24 For purposes of the demonstration project, the powers and responsibilities of the Office of
 264.25 Ombudsman for Mental Health and Developmental Disabilities, as provided in sections
 264.26 245.91 to 245.97 are expanded to include all eligible individuals, health plan companies,
 264.27 agencies, and providers participating in the demonstration project.

264.28 Sec. 11. **REPEALER.**

264.29 (a) Minnesota Statutes 2020, section 256B.057, subdivision 7, is repealed on July 1,
 264.30 2022.

265.1 (b) Minnesota Statutes 2020, sections 256B.69, subdivision 20; 501C.0408, subdivision
265.2 4; and 501C.1206, are repealed the day following final enactment.

265.3 ARTICLE 5

265.4 HEALTH-RELATED LICENSING BOARDS

265.5 Section 1. Minnesota Statutes 2020, section 148B.33, is amended by adding a subdivision
265.6 to read:

265.7 Subd. 1a. **Supervision requirement; postgraduate experience.** The board must allow
265.8 an applicant to satisfy the requirement for supervised postgraduate experience in marriage
265.9 and family therapy with all required hours of supervision provided through real-time,
265.10 two-way interactive audio and visual communication.

265.11 **EFFECTIVE DATE.** This section is effective the day following final enactment and
265.12 applies to supervision requirements in effect on or after that date.

265.13 Sec. 2. Minnesota Statutes 2021 Supplement, section 148B.5301, subdivision 2, is amended
265.14 to read:

265.15 Subd. 2. **Supervision.** (a) To qualify as a LPCC, an applicant must have completed
265.16 4,000 hours of post-master's degree supervised professional practice in the delivery of
265.17 clinical services in the diagnosis and treatment of mental illnesses and disorders in both
265.18 children and adults. The supervised practice shall be conducted according to the requirements
265.19 in paragraphs (b) to (e).

265.20 (b) The supervision must have been received under a contract that defines clinical practice
265.21 and supervision from a mental health professional who is qualified according to section
265.22 245I.04, subdivision 2, or by a board-approved supervisor, who has at least two years of
265.23 postlicensure experience in the delivery of clinical services in the diagnosis and treatment
265.24 of mental illnesses and disorders. All supervisors must meet the supervisor requirements in
265.25 Minnesota Rules, part 2150.5010.

265.26 (c) The supervision must be obtained at the rate of two hours of supervision per 40 hours
265.27 of professional practice. The supervision must be evenly distributed over the course of the
265.28 supervised professional practice. At least 75 percent of the required supervision hours must
265.29 be received in person or through real-time, two-way interactive audio and visual
265.30 communication, and the board must allow an applicant to satisfy this supervision requirement
265.31 with all required hours of supervision received through real-time, two-way interactive audio
265.32 and visual communication. The remaining 25 percent of the required hours may be received

266.1 by telephone or by audio or audiovisual electronic device. At least 50 percent of the required
 266.2 hours of supervision must be received on an individual basis. The remaining 50 percent
 266.3 may be received in a group setting.

266.4 (d) The supervised practice must include at least 1,800 hours of clinical client contact.

266.5 (e) The supervised practice must be clinical practice. Supervision includes the observation
 266.6 by the supervisor of the successful application of professional counseling knowledge, skills,
 266.7 and values in the differential diagnosis and treatment of psychosocial function, disability,
 266.8 or impairment, including addictions and emotional, mental, and behavioral disorders.

266.9 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 266.10 applies to supervision requirements in effect on or after that date.

266.11 Sec. 3. Minnesota Statutes 2020, section 148E.100, subdivision 3, is amended to read:

266.12 Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under
 266.13 subdivision 1:

266.14 (1) 50 hours must be provided through one-on-one supervision, ~~including: (i) a minimum~~
 266.15 ~~of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision.~~ The
 266.16 supervision must be provided either in person or via eye-to-eye electronic media, while
 266.17 maintaining visual contact. The board must allow a licensed social worker to satisfy the
 266.18 supervision requirement of this clause with all required hours of supervision provided via
 266.19 eye-to-eye electronic media, while maintaining visual contact; and

266.20 (2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group
 266.21 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
 266.22 media, while maintaining visual contact. The supervision must not be provided by e-mail.
 266.23 Group supervision is limited to six supervisees.

266.24 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 266.25 applies to supervision requirements in effect on or after that date.

266.26 Sec. 4. Minnesota Statutes 2020, section 148E.105, subdivision 3, is amended to read:

266.27 Subd. 3. **Types of supervision.** Of the 100 hours of supervision required under
 266.28 subdivision 1:

266.29 (1) 50 hours must be provided ~~though~~ through one-on-one supervision, ~~including: (i) a~~
 266.30 ~~minimum of 25 hours of in-person supervision, and (ii) no more than 25 hours of supervision.~~
 266.31 The supervision must be provided either in person or via eye-to-eye electronic media, while

267.1 maintaining visual contact. The board must allow a licensed graduate social worker to satisfy
 267.2 the supervision requirement of this clause with all required hours of supervision provided
 267.3 via eye-to-eye electronic media, while maintaining visual contact; and

267.4 (2) 50 hours must be provided through: (i) one-on-one supervision, or (ii) group
 267.5 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
 267.6 media, while maintaining visual contact. The supervision must not be provided by e-mail.
 267.7 Group supervision is limited to six supervisees.

267.8 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 267.9 applies to supervision requirements in effect on or after that date.

267.10 Sec. 5. Minnesota Statutes 2020, section 148E.106, subdivision 3, is amended to read:

267.11 Subd. 3. **Types of supervision.** Of the 200 hours of supervision required under
 267.12 subdivision 1:

267.13 (1) 100 hours must be provided through one-on-one supervision, ~~including: (i) a minimum~~
 267.14 ~~of 50 hours of in-person supervision, and (ii) no more than 50 hours of supervision.~~ The
 267.15 supervision must be provided either in person or via eye-to-eye electronic media, while
 267.16 maintaining visual contact. The board must allow a licensed graduate social worker to satisfy
 267.17 the supervision requirement of this clause with all required hours of supervision provided
 267.18 via eye-to-eye electronic media, while maintaining visual contact; and

267.19 (2) 100 hours must be provided through: (i) one-on-one supervision, or (ii) group
 267.20 supervision. The supervision may be in person, by telephone, or via eye-to-eye electronic
 267.21 media, while maintaining visual contact. The supervision must not be provided by e-mail.
 267.22 Group supervision is limited to six supervisees.

267.23 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 267.24 applies to supervision requirements in effect on or after that date.

267.25 Sec. 6. Minnesota Statutes 2020, section 148E.110, subdivision 7, is amended to read:

267.26 Subd. 7. **Supervision; clinical social work practice after licensure as licensed**
 267.27 **independent social worker.** Of the 200 hours of supervision required under subdivision
 267.28 5:

267.29 (1) 100 hours must be provided through one-on-one supervision, ~~including:~~ The
 267.30 supervision must be provided either in person or via eye-to-eye electronic media, while
 267.31 maintaining visual contact. The board must allow a licensed independent social worker to

268.1 satisfy the supervision requirement of this clause with all required hours of supervision
 268.2 provided via eye-to-eye electronic media, while maintaining visual contact; and

268.3 ~~(i) a minimum of 50 hours of in-person supervision; and~~

268.4 ~~(ii) no more than 50 hours of supervision via eye-to-eye electronic media, while~~
 268.5 ~~maintaining visual contact; and~~

268.6 (2) 100 hours must be provided through:

268.7 (i) one-on-one supervision; or

268.8 (ii) group supervision.

268.9 The supervision may be in person, by telephone, or via eye-to-eye electronic media, while
 268.10 maintaining visual contact. The supervision must not be provided by e-mail. Group
 268.11 supervision is limited to six supervisees.

268.12 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 268.13 applies to supervision requirements in effect on or after that date.

268.14 Sec. 7. Minnesota Statutes 2020, section 150A.06, subdivision 1c, is amended to read:

268.15 Subd. 1c. **Specialty dentists.** (a) The board may grant one or more specialty licenses in
 268.16 the specialty areas of dentistry that are recognized by the Commission on Dental
 268.17 Accreditation.

268.18 (b) An applicant for a specialty license shall:

268.19 (1) have successfully completed a postdoctoral specialty program accredited by the
 268.20 Commission on Dental Accreditation, or have announced a limitation of practice before
 268.21 1967;

268.22 (2) have been certified by a specialty board approved by the Minnesota Board of
 268.23 Dentistry, or provide evidence of having passed a clinical examination for licensure required
 268.24 for practice in any state or Canadian province, or in the case of oral and maxillofacial
 268.25 surgeons only, have a Minnesota medical license in good standing;

268.26 (3) have been in active practice or a postdoctoral specialty education program or United
 268.27 States government service at least 2,000 hours in the 36 months prior to applying for a
 268.28 specialty license;

268.29 (4) if requested by the board, be interviewed by a committee of the board, which may
 268.30 include the assistance of specialists in the evaluation process, and satisfactorily respond to

269.1 questions designed to determine the applicant's knowledge of dental subjects and ability to
269.2 practice;

269.3 (5) if requested by the board, present complete records on a sample of patients treated
269.4 by the applicant. The sample must be drawn from patients treated by the applicant during
269.5 the 36 months preceding the date of application. The number of records shall be established
269.6 by the board. The records shall be reasonably representative of the treatment typically
269.7 provided by the applicant for each specialty area;

269.8 (6) at board discretion, pass a board-approved English proficiency test if English is not
269.9 the applicant's primary language;

269.10 (7) pass all components of the National Board Dental Examinations;

269.11 (8) pass the Minnesota Board of Dentistry jurisprudence examination;

269.12 (9) abide by professional ethical conduct requirements; and

269.13 (10) meet all other requirements prescribed by the Board of Dentistry.

269.14 (c) The application must include:

269.15 (1) a completed application furnished by the board;

269.16 ~~(2) at least two character references from two different dentists for each specialty area,~~
269.17 ~~one of whom must be a dentist practicing in the same specialty area, and the other from the~~
269.18 ~~director of each specialty program attended;~~

269.19 ~~(3) a licensed physician's statement attesting to the applicant's physical and mental~~
269.20 ~~condition;~~

269.21 ~~(4) a statement from a licensed ophthalmologist or optometrist attesting to the applicant's~~
269.22 ~~visual acuity;~~

269.23 ~~(5)~~ (2) a nonrefundable fee; and

269.24 ~~(6)~~ (3) a notarized, unmounted passport-type photograph, three inches by three inches,
269.25 ~~taken not more than six months before the date of application~~ copy of the applicant's
269.26 government issued photo identification card.

269.27 (d) A specialty dentist holding one or more specialty licenses is limited to practicing in
269.28 the dentist's designated specialty area or areas. The scope of practice must be defined by
269.29 each national specialty board recognized by the Commission on Dental Accreditation.

269.30 (e) A specialty dentist holding a general dental license is limited to practicing in the
269.31 dentist's designated specialty area or areas if the dentist has announced a limitation of

270.1 practice. The scope of practice must be defined by each national specialty board recognized
270.2 by the Commission on Dental Accreditation.

270.3 (f) All specialty dentists who have fulfilled the specialty dentist requirements and who
270.4 intend to limit their practice to a particular specialty area or areas may apply for one or more
270.5 specialty licenses.

270.6 Sec. 8. Minnesota Statutes 2020, section 150A.06, subdivision 2c, is amended to read:

270.7 Subd. 2c. **Guest license.** (a) The board shall grant a guest license to practice as a dentist,
270.8 dental hygienist, or licensed dental assistant if the following conditions are met:

270.9 (1) the dentist, dental hygienist, or dental assistant is currently licensed in good standing
270.10 in another United States jurisdiction;

270.11 (2) the dentist, dental hygienist, or dental assistant is currently engaged in the practice
270.12 of that person's respective profession in another United States jurisdiction;

270.13 (3) the dentist, dental hygienist, or dental assistant will limit that person's practice to a
270.14 public health setting in Minnesota that (i) is approved by the board; (ii) was established by
270.15 a nonprofit organization that is tax exempt under chapter 501(c)(3) of the Internal Revenue
270.16 Code of 1986; and (iii) provides dental care to patients who have difficulty accessing dental
270.17 care;

270.18 (4) the dentist, dental hygienist, or dental assistant agrees to treat indigent patients who
270.19 meet the eligibility criteria established by the clinic; and

270.20 (5) the dentist, dental hygienist, or dental assistant has applied to the board for a guest
270.21 license and has paid a nonrefundable license fee to the board ~~not to exceed \$75~~.

270.22 (b) A guest license must be renewed annually with the board and an annual renewal fee
270.23 ~~not to exceed \$75~~ must be paid to the board. Guest licenses expire on December 31 of each
270.24 year.

270.25 (c) A dentist, dental hygienist, or dental assistant practicing under a guest license under
270.26 this subdivision shall have the same obligations as a dentist, dental hygienist, or dental
270.27 assistant who is licensed in Minnesota and shall be subject to the laws and rules of Minnesota
270.28 and the regulatory authority of the board. If the board suspends or revokes the guest license
270.29 of, or otherwise disciplines, a dentist, dental hygienist, or dental assistant practicing under
270.30 this subdivision, the board shall promptly report such disciplinary action to the dentist's,
270.31 dental hygienist's, or dental assistant's regulatory board in the jurisdictions in which they
270.32 are licensed.

271.1 (d) The board may grant a guest license to a dentist, dental hygienist, or dental assistant
271.2 licensed in another United States jurisdiction to provide dental care to patients on a voluntary
271.3 basis without compensation for a limited period of time. The board shall not assess a fee
271.4 for the guest license for volunteer services issued under this paragraph.

271.5 (e) The board shall issue a guest license for volunteer services if:

271.6 (1) the board determines that the applicant's services will provide dental care to patients
271.7 who have difficulty accessing dental care;

271.8 (2) the care will be provided without compensation; and

271.9 (3) the applicant provides adequate proof of the status of all licenses to practice in other
271.10 jurisdictions. The board may require such proof on an application form developed by the
271.11 board.

271.12 (f) The guest license for volunteer services shall limit the licensee to providing dental
271.13 care services for a period of time not to exceed ten days in a calendar year. Guest licenses
271.14 expire on December 31 of each year.

271.15 (g) The holder of a guest license for volunteer services shall be subject to state laws and
271.16 rules regarding dentistry and the regulatory authority of the board. The board may revoke
271.17 the license of a dentist, dental hygienist, or dental assistant practicing under this subdivision
271.18 or take other regulatory action against the dentist, dental hygienist, or dental assistant. If an
271.19 action is taken, the board shall report the action to the regulatory board of those jurisdictions
271.20 where an active license is held by the dentist, dental hygienist, or dental assistant.

271.21 Sec. 9. Minnesota Statutes 2020, section 150A.06, subdivision 6, is amended to read:

271.22 Subd. 6. **Display of name and certificates.** (a) The renewal certificate of ~~every dentist,~~
271.23 ~~dental therapist, dental hygienist, or dental assistant~~ every licensee or registrant must be
271.24 conspicuously displayed in plain sight of patients in every office in which that person
271.25 practices. Duplicate renewal certificates may be obtained from the board.

271.26 (b) Near or on the entrance door to every office where dentistry is practiced, the name
271.27 of each dentist practicing there, as inscribed on the current license certificate, must be
271.28 displayed in plain sight.

271.29 (c) The board must allow the display of a mini-license for guest license holders
271.30 performing volunteer dental services. There is no fee for the mini-license for guest volunteers.

272.1 Sec. 10. Minnesota Statutes 2020, section 150A.06, is amended by adding a subdivision
272.2 to read:

272.3 Subd. 12. Licensure by credentials for dental therapy. (a) Any dental therapist may,
272.4 upon application and payment of a fee established by the board, apply for licensure based
272.5 on an evaluation of the applicant's education, experience, and performance record. The
272.6 applicant may be interviewed by the board to determine if the applicant:

272.7 (1) graduated with a baccalaureate or master's degree from a dental therapy program
272.8 accredited by the Commission on Dental Accreditation;

272.9 (2) provided evidence of successfully completing the board's jurisprudence examination;

272.10 (3) actively practiced at least 2,000 hours within 36 months of the application date or
272.11 passed a board-approved reentry program within 36 months of the application date;

272.12 (4) either:

272.13 (i) is currently licensed in another state or Canadian province and not subject to any
272.14 pending or final disciplinary action; or

272.15 (ii) was previously licensed in another state or Canadian province in good standing and
272.16 not subject to any final or pending disciplinary action at the time of surrender;

272.17 (5) passed a board-approved English proficiency test if English is not the applicant's
272.18 primary language required at the board's discretion; and

272.19 (6) met all curriculum equivalency requirements regarding dental therapy scope of
272.20 practice in Minnesota.

272.21 (b) The 2,000 practice hours required by clause (3) may count toward the 2,000 practice
272.22 hours required for consideration for advanced dental therapy certification, provided that all
272.23 other requirements of section 150A.106, subdivision 1, are met.

272.24 (c) The board, at its discretion, may waive specific licensure requirements in paragraph
272.25 (a).

272.26 (d) The board must license an applicant who fulfills the conditions of this subdivision
272.27 and demonstrates the minimum knowledge in dental subjects required for licensure under
272.28 subdivision 1d to practice the applicant's profession.

272.29 (e) The board must deny the application if the applicant does not demonstrate the
272.30 minimum knowledge in dental subjects required for licensure under subdivision 1d. If
272.31 licensure is denied, the board may notify the applicant of any specific remedy the applicant

273.1 could take to qualify for licensure. A denial does not prohibit the applicant from applying
 273.2 for licensure under subdivision 1d.

273.3 (e) A candidate may appeal a denied application to the board according to subdivision
 273.4 4a.

273.5 Sec. 11. Minnesota Statutes 2020, section 150A.09, is amended to read:

273.6 **150A.09 REGISTRATION OF LICENSES AND OR REGISTRATION**
 273.7 **CERTIFICATES.**

273.8 Subdivision 1. **Registration information and procedure.** On or before the license
 273.9 certificate expiration date every ~~licensed dentist, dental therapist, dental hygienist, and~~
 273.10 ~~dental assistant~~ licensee or registrant shall ~~transmit to the executive secretary of the board,~~
 273.11 ~~pertinent information~~ submit the renewal required by the board, together with the applicable
 273.12 fee established by the board under section 150A.091. At least 30 days before a license
 273.13 certificate expiration date, the board shall send a written notice stating the amount and due
 273.14 date of the fee ~~and the information to be provided to every licensed dentist, dental therapist,~~
 273.15 ~~dental hygienist, and dental assistant.~~

273.16 Subd. 3. **Current address, change of address.** Every ~~dentist, dental therapist, dental~~
 273.17 ~~hygienist, and dental assistant~~ licensee or registrant shall maintain with the board a correct
 273.18 and current mailing address and electronic mail address. For dentists engaged in the practice
 273.19 of dentistry, the postal address shall be that of the location of the primary dental practice.
 273.20 Within 30 days after changing postal or electronic mail addresses, every ~~dentist, dental~~
 273.21 ~~therapist, dental hygienist, and dental assistant~~ licensee or registrant shall provide the board
 273.22 ~~written notice of the new address either personally or by first class mail.~~

273.23 Subd. 4. **Duplicate certificates.** Duplicate licenses or duplicate certificates of ~~license~~
 273.24 renewal may be issued by the board upon satisfactory proof of the need for the duplicates
 273.25 and upon payment of the fee established by the board.

273.26 Subd. 5. **Late fee.** A late fee established by the board shall be paid if the ~~information~~
 273.27 ~~and fee~~ required by subdivision 1 is not received by ~~the executive secretary of the board on~~
 273.28 or before the registration or ~~license~~ renewal date.

273.29 Sec. 12. Minnesota Statutes 2020, section 150A.091, subdivision 2, is amended to read:

273.30 Subd. 2. **Application and initial license or registration fees.** Each applicant shall
 273.31 submit with a license, advanced dental therapist certificate, or permit application a

274.1 nonrefundable fee in the following amounts in order to administratively process an
274.2 application:

274.3 (1) dentist, ~~\$140~~ \$308;

274.4 (2) full faculty dentist, ~~\$140~~ \$308;

274.5 (3) limited faculty dentist, \$140;

274.6 (4) resident dentist or dental provider, \$55;

274.7 (5) advanced dental therapist, \$100;

274.8 (6) dental therapist, ~~\$100~~ \$220;

274.9 (7) dental hygienist, ~~\$55~~ \$115;

274.10 (8) licensed dental assistant, ~~\$55~~; ~~and~~ \$115;

274.11 (9) dental assistant with a ~~permit~~ registration as described in Minnesota Rules, part
274.12 3100.8500, subpart 3, ~~\$15~~; \$27; and

274.13 (10) guest license, \$50.

274.14 Sec. 13. Minnesota Statutes 2020, section 150A.091, subdivision 5, is amended to read:

274.15 Subd. 5. **Biennial license or ~~permit~~ registration renewal fees.** Each of the following
274.16 applicants shall submit with a biennial license or permit renewal application a fee as
274.17 established by the board, not to exceed the following amounts:

274.18 (1) dentist or full faculty dentist, \$475;

274.19 (2) dental therapist, \$300;

274.20 (3) dental hygienist, \$200;

274.21 (4) licensed dental assistant, \$150; and

274.22 (5) dental assistant with a ~~permit~~ registration as described in Minnesota Rules, part
274.23 3100.8500, subpart 3, \$24.

274.24 Sec. 14. Minnesota Statutes 2020, section 150A.091, subdivision 8, is amended to read:

274.25 Subd. 8. **Duplicate license or certificate fee.** Each applicant shall submit, with a request
274.26 for issuance of a duplicate of the original license, or of an annual or biennial renewal
274.27 certificate for a license or permit, a fee in the following amounts:

275.1 (1) original dentist, full faculty dentist, dental therapist, dental hygiene, or dental assistant
 275.2 license, \$35; and

275.3 (2) annual or biennial renewal certificates, \$10; and

275.4 ~~(3) wallet-sized license and renewal certificate, \$15.~~

275.5 Sec. 15. Minnesota Statutes 2020, section 150A.091, subdivision 9, is amended to read:

275.6 Subd. 9. **Licensure by credentials.** Each applicant for licensure as a dentist, dental
 275.7 hygienist, or dental assistant by credentials pursuant to section 150A.06, subdivisions 4 and
 275.8 8, and Minnesota Rules, part 3100.1400, shall submit with the license application a fee in
 275.9 the following amounts:

275.10 (1) dentist, ~~\$725~~ \$893;

275.11 (2) dental hygienist, ~~\$175; and~~ \$235;

275.12 (3) dental assistant, ~~\$35;~~ \$71; and

275.13 (4) dental therapist, \$340.

275.14 Sec. 16. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision
 275.15 to read:

275.16 Subd. 21. **Failure to practice with a current license.** (a) If a licensee practices without
 275.17 a current license and pursues reinstatement, the board may take the following administrative
 275.18 actions based on the length of time practicing without a current license:

275.19 (1) for under one month, the board may not assess a penalty fee;

275.20 (2) for one month to six months, the board may assess a penalty of \$250;

275.21 (3) for over six months, the board may assess a penalty of \$500; and

275.22 (4) for over 12 months, the board may assess a penalty of \$1,000.

275.23 (b) In addition to the penalty fee, the board shall initiate the complaint process against
 275.24 the licensee for failure to practice with a current license for over 12 months.

275.25 Sec. 17. Minnesota Statutes 2020, section 150A.091, is amended by adding a subdivision
 275.26 to read:

275.27 Subd. 22. **Delegating regulated procedures to an individual with a terminated**
 275.28 license. (a) If a dentist or dental therapist delegates regulated procedures to another dental
 275.29 professional who had their license terminated, the board may take the following

276.1 administrative actions against the delegating dentist or dental therapist based on the length
 276.2 of time they delegated regulated procedures:

276.3 (1) for under one month, the board may not assess a penalty fee;

276.4 (2) for one month to six months, the board may assess a penalty of \$100;

276.5 (3) for over six months, the board may assess a penalty of \$250; and

276.6 (4) for over 12 months, the board may assess a penalty of \$500.

276.7 (b) In addition to the penalty fee, the board shall initiate the complaint process against
 276.8 a dentist or dental therapist who delegated regulated procedures to a dental professional
 276.9 with a terminated license for over 12 months.

276.10 Sec. 18. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

276.11 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

276.12 (1) interpretation and evaluation of prescription drug orders;

276.13 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
 276.14 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
 276.15 and devices);

276.16 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
 276.17 of safe and effective use of drugs, including the performance of laboratory tests that are
 276.18 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
 276.19 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory
 276.20 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
 276.21 agreement;

276.22 (4) participation in drug and therapeutic device selection; drug administration for first
 276.23 dosage and medical emergencies; intramuscular and subcutaneous drug administration used
 276.24 for the treatment of alcohol or opioid dependence under a prescription drug order; drug
 276.25 regimen reviews; and drug or drug-related research;

276.26 (5) drug administration, through intramuscular and subcutaneous administration used
 276.27 to treat mental illnesses as permitted under the following conditions:

276.28 (i) upon the order of a prescriber and the prescriber is notified after administration is
 276.29 complete; or

276.30 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
 276.31 151.01, subdivisions 27b and 27c, and participation in the initiation, management,

277.1 modification, administration, and discontinuation of drug therapy is according to the protocol
277.2 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
277.3 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
277.4 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
277.5 or medication administration made pursuant to a protocol or collaborative practice agreement
277.6 must be documented by the pharmacist in the patient's medical record or reported by the
277.7 pharmacist to a practitioner responsible for the patient's care;

277.8 (6) participation in administration of influenza vaccines and vaccines approved by the
277.9 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all
277.10 eligible individuals six years of age and older and all other vaccines to patients 13 years of
277.11 age and older by written protocol with a physician licensed under chapter 147, a physician
277.12 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered
277.13 nurse authorized to prescribe drugs under section 148.235, provided that:

277.14 (i) the protocol includes, at a minimum:

277.15 (A) the name, dose, and route of each vaccine that may be given;

277.16 (B) the patient population for whom the vaccine may be given;

277.17 (C) contraindications and precautions to the vaccine;

277.18 (D) the procedure for handling an adverse reaction;

277.19 (E) the name, signature, and address of the physician, physician assistant, or advanced
277.20 practice registered nurse;

277.21 (F) a telephone number at which the physician, physician assistant, or advanced practice
277.22 registered nurse can be contacted; and

277.23 (G) the date and time period for which the protocol is valid;

277.24 (ii) the pharmacist has successfully completed a program approved by the Accreditation
277.25 Council for Pharmacy Education specifically for the administration of immunizations or a
277.26 program approved by the board;

277.27 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
277.28 assess the immunization status of individuals prior to the administration of vaccines, except
277.29 when administering influenza vaccines to individuals age nine and older;

277.30 (iv) the pharmacist reports the administration of the immunization to the Minnesota
277.31 Immunization Information Connection; and

278.1 (v) the pharmacist complies with guidelines for vaccines and immunizations established
278.2 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
278.3 does not need to comply with those portions of the guidelines that establish immunization
278.4 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
278.5 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
278.6 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
278.7 drugs under section 148.235, provided that the order is consistent with the United States
278.8 Food and Drug Administration approved labeling of the vaccine;

278.9 (7) participation in the initiation, management, modification, and discontinuation of
278.10 drug therapy according to a written protocol or collaborative practice agreement between:
278.11 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
278.12 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
278.13 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
278.14 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
278.15 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement
278.16 must be documented by the pharmacist in the patient's medical record or reported by the
278.17 pharmacist to a practitioner responsible for the patient's care;

278.18 (8) participation in the storage of drugs and the maintenance of records;

278.19 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
278.20 devices;

278.21 (10) offering or performing those acts, services, operations, or transactions necessary
278.22 in the conduct, operation, management, and control of a pharmacy;

278.23 (11) participation in the initiation, management, modification, and discontinuation of
278.24 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

278.25 (i) a written protocol as allowed under clause (7); or

278.26 (ii) a written protocol with a community health board medical consultant or a practitioner
278.27 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
278.28 ~~and~~

278.29 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
278.30 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
278.31 to section 151.37, subdivision 14, 15, or 16; and

278.32 (13) participation in the placement of drug monitoring devices according to a prescription,
278.33 protocol, or collaborative practice agreement.

279.1 Sec. 19. Minnesota Statutes 2020, section 153.16, subdivision 1, is amended to read:

279.2 Subdivision 1. **License requirements.** The board shall issue a license to practice podiatric
279.3 medicine to a person who meets the following requirements:

279.4 (a) The applicant for a license shall file a written notarized application on forms provided
279.5 by the board, showing to the board's satisfaction that the applicant is of good moral character
279.6 and satisfies the requirements of this section.

279.7 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
279.8 a podiatric medical school approved by the board based upon its faculty, curriculum, facilities,
279.9 accreditation by a recognized national accrediting organization approved by the board, and
279.10 other relevant factors.

279.11 (c) The applicant must have received a passing score on each part of the national board
279.12 examinations, parts one and two, prepared and graded by the National Board of Podiatric
279.13 Medical Examiners. The passing score for each part of the national board examinations,
279.14 parts one and two, is as defined by the National Board of Podiatric Medical Examiners.

279.15 (d) Applicants graduating after ~~1986~~ 1990 from a podiatric medical school shall present
279.16 evidence of successful completion of a residency program approved by a national accrediting
279.17 podiatric medicine organization.

279.18 (e) The applicant shall appear in person before the board or its designated representative
279.19 to show that the applicant satisfies the requirements of this section, including knowledge
279.20 of laws, rules, and ethics pertaining to the practice of podiatric medicine. The board may
279.21 establish as internal operating procedures the procedures or requirements for the applicant's
279.22 personal presentation. Upon completion of all other application requirements, a doctor of
279.23 podiatric medicine applying for a temporary military license has six months in which to
279.24 comply with this subdivision.

279.25 (f) The applicant shall pay a fee established by the board by rule. The fee shall not be
279.26 refunded.

279.27 (g) The applicant must not have engaged in conduct warranting disciplinary action
279.28 against a licensee. If the applicant does not satisfy the requirements of this paragraph, the
279.29 board may refuse to issue a license unless it determines that the public will be protected
279.30 through issuance of a license with conditions and limitations the board considers appropriate.

279.31 (h) Upon payment of a fee as the board may require, an applicant who fails to pass an
279.32 examination and is refused a license is entitled to reexamination within one year of the

280.1 board's refusal to issue the license. No more than two reexaminations are allowed without
280.2 a new application for a license.

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

280.4 Sec. 20. **TEMPORARY REQUIREMENTS GOVERNING AMBULANCE SERVICE**
280.5 **OPERATIONS AND THE PROVISION OF EMERGENCY MEDICAL SERVICES.**

280.6 Subdivision 1. **Application.** Notwithstanding any law to the contrary in Minnesota
280.7 Statutes, chapter 144E, an ambulance service may operate according to this section, and
280.8 emergency medical technicians, advanced emergency medical technicians, and paramedics
280.9 may provide emergency medical services according to this section.

280.10 Subd. 2. **Definitions.** (a) The terms defined in this subdivision apply to this section.

280.11 (b) "Advanced emergency medical technician" has the meaning given in Minnesota
280.12 Statutes, section 144E.001, subdivision 5d.

280.13 (c) "Advanced life support" has the meaning given in Minnesota Statutes, section
280.14 144E.001, subdivision 1b.

280.15 (d) "Ambulance" has the meaning given in Minnesota Statutes, section 144E.001,
280.16 subdivision 2.

280.17 (e) "Ambulance service personnel" has the meaning given in Minnesota Statutes, section
280.18 144E.001, subdivision 3a.

280.19 (f) "Basic life support" has the meaning given in Minnesota Statutes, section 144E.001,
280.20 subdivision 4b.

280.21 (g) "Board" means the Emergency Medical Services Regulatory Board.

280.22 (h) "Emergency medical technician" has the meaning given in Minnesota Statutes, section
280.23 144E.001, subdivision 5c.

280.24 (i) "Paramedic" has the meaning given in Minnesota Statutes, section 144E.001,
280.25 subdivision 5e.

280.26 (j) "Primary service area" means the area designated by the board according to Minnesota
280.27 Statutes, section 144E.06, to be served by an ambulance service.

280.28 Subd. 3. **Staffing.** (a) For emergency ambulance calls in an ambulance service's primary
280.29 service area, an ambulance service must staff an ambulance that provides basic life support
280.30 with at least:

281.1 (1) one emergency medical technician, who must be in the patient compartment when
281.2 a patient is being transported; and

281.3 (2) one individual to drive the ambulance. The driver must hold a valid driver's license
281.4 from any state, must have attended an emergency vehicle driving course approved by the
281.5 ambulance service, and must have completed a course on cardiopulmonary resuscitation
281.6 approved by the ambulance service.

281.7 (b) For emergency ambulance calls in an ambulance service's primary service area, an
281.8 ambulance service must staff an ambulance that provides advanced life support with at least:

281.9 (1) one paramedic; one registered nurse who meets the requirements in Minnesota
281.10 Statutes, section 144E.001, subdivision 3a, clause (2); or one physician assistant who meets
281.11 the requirements in Minnesota Statutes, section 144E.001, subdivision 3a, clause (3), and
281.12 who must be in the patient compartment when a patient is being transported; and

281.13 (2) one individual to drive the ambulance. The driver must hold a valid driver's license
281.14 from any state, must have attended an emergency vehicle driving course approved by the
281.15 ambulance service, and must have completed a course on cardiopulmonary resuscitation
281.16 approved by the ambulance service.

281.17 (c) The ambulance service director and medical director must approve the staffing of
281.18 an ambulance according to this subdivision.

281.19 (d) An ambulance service staffing an ambulance according to this subdivision must
281.20 immediately notify the board in writing and in a manner prescribed by the board. The notice
281.21 must specify how the ambulance service is staffing its basic life support or advanced life
281.22 support ambulances and the time period the ambulance service plans to staff the ambulances
281.23 according to this subdivision. If an ambulance service continues to staff an ambulance
281.24 according to this subdivision after the date provided to the board in its initial notice, the
281.25 ambulance service must provide a new notice to the board in a manner that complies with
281.26 this paragraph.

281.27 (e) If an individual serving as a driver under this subdivision commits an act listed in
281.28 Minnesota Statutes, section 144E.27, subdivision 5, paragraph (a), the board may temporarily
281.29 suspend or prohibit the individual from driving an ambulance or place conditions on the
281.30 individual's ability to drive an ambulance using the procedures and authority in Minnesota
281.31 Statutes, section 144E.27, subdivisions 5 and 6.

281.32 **Subd. 4. Use of expired emergency medications and medical supplies.** (a) If an
281.33 ambulance service experiences a shortage of an emergency medication or medical supply,

282.1 ambulance service personnel may use an emergency medication or medical supply for up
282.2 to six months after the emergency medication's or medical supply's specified expiration
282.3 date, provided:

282.4 (1) the ambulance service director and medical director approve the use of the expired
282.5 emergency medication or medical supply;

282.6 (2) ambulance service personnel use an expired emergency medication or medical supply
282.7 only after depleting the ambulance service's supply of that emergency medication or medical
282.8 supply that is unexpired;

282.9 (3) the ambulance service has stored and maintained the expired emergency medication
282.10 or medical supply according to the manufacturer's instructions;

282.11 (4) if possible, ambulance service personnel obtain consent from the patient to use the
282.12 expired emergency medication or medical supply prior to its use; and

282.13 (5) when the ambulance service obtains a supply of that emergency medication or medical
282.14 supply that is unexpired, ambulance service personnel cease use of the expired emergency
282.15 medication or medical supply and instead use the unexpired emergency medication or
282.16 medical supply.

282.17 (b) Before approving the use of an expired emergency medication, an ambulance service
282.18 director and medical director must consult with the Board of Pharmacy regarding the safety
282.19 and efficacy of using the expired emergency medication.

282.20 (c) An ambulance service must keep a record of all expired emergency medications and
282.21 all expired medical supplies used and must submit that record in writing to the board in a
282.22 time and manner specified by the board. The record must list the specific expired emergency
282.23 medications and medical supplies used and the time period during which ambulance service
282.24 personnel used the expired emergency medication or medical supply.

282.25 **Subd. 5. Provision of emergency medical services after certification expires.** (a) At
282.26 the request of an emergency medical technician, advanced emergency medical technician,
282.27 or paramedic, and with the approval of the ambulance service director, an ambulance service
282.28 medical director may authorize the emergency medical technician, advanced emergency
282.29 medical technician, or paramedic to provide emergency medical services for the ambulance
282.30 service for up to three months after the certification of the emergency medical technician,
282.31 advanced emergency medical technician, or paramedic expires.

282.32 (b) An ambulance service must immediately notify the board each time its medical
282.33 director issues an authorization under paragraph (a). The notice must be provided in writing

283.1 and in a manner prescribed by the board and must include information on the time period
283.2 each emergency medical technician, advanced emergency medical technician, or paramedic
283.3 will provide emergency medical services according to an authorization under this subdivision;
283.4 information on why the emergency medical technician, advanced emergency medical
283.5 technician, or paramedic needs the authorization; and an attestation from the medical director
283.6 that the authorization is necessary to help the ambulance service adequately staff its
283.7 ambulances.

283.8 Subd. 6. **Reports.** The board must provide quarterly reports to the chairs and ranking
283.9 minority members of the legislative committees with jurisdiction over the board regarding
283.10 actions taken by ambulance services according to subdivisions 3, 4, and 5. The board must
283.11 submit reports by June 30, September 30, and December 31 of 2022; and by March 31, June
283.12 30, September 30, and December 31 of 2023. Each report must include the following
283.13 information:

283.14 (1) for each ambulance service staffing basic life support or advanced life support
283.15 ambulances according to subdivision 3, the primary service area served by the ambulance
283.16 service, the number of ambulances staffed according to subdivision 3, and the time period
283.17 the ambulance service has staffed and plans to staff the ambulances according to subdivision
283.18 3;

283.19 (2) for each ambulance service that authorized the use of an expired emergency
283.20 medication or medical supply according to subdivision 4, the expired emergency medications
283.21 and medical supplies authorized for use and the time period the ambulance service used
283.22 each expired emergency medication or medical supply; and

283.23 (3) for each ambulance service that authorized the provision of emergency medical
283.24 services according to subdivision 5, the number of emergency medical technicians, advanced
283.25 emergency medical technicians, and paramedics providing emergency medical services
283.26 under an expired certification and the time period each emergency medical technician,
283.27 advanced emergency medical technician, or paramedic provided and will provide emergency
283.28 medical services under an expired certification.

283.29 Subd. 7. **Expiration.** This section expires January 1, 2024.

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

283.31 Sec. 21. **REPEALER.**

283.32 Minnesota Statutes 2020, section 150A.091, subdivisions 3, 15, and 17, are repealed.

ARTICLE 6

PRESCRIPTION DRUGS

284.1

284.2

284.3 Section 1. Minnesota Statutes 2020, section 62A.02, subdivision 1, is amended to read:

284.4 Subdivision 1. **Filing.** For purposes of this section, "health plan" means a health plan
284.5 as defined in section 62A.011 or a policy of accident and sickness insurance as defined in
284.6 section 62A.01. No health plan shall be issued or delivered to any person in this state, nor
284.7 shall any application, rider, or endorsement be used in connection with the health plan, until
284.8 a copy of its form and of the classification of risks and the premium rates pertaining to the
284.9 form have been filed with the commissioner. The filing must include the health plan's
284.10 prescription drug formulary. Proposed revisions to the health plan's prescription drug
284.11 formulary must be filed with the commissioner no later than August 1 of the application
284.12 year. The filing for nongroup health plan forms shall include a statement of actuarial reasons
284.13 and data to support the rate. For health benefit plans as defined in section 62L.02, and for
284.14 health plans to be issued to individuals, the health carrier shall file with the commissioner
284.15 the information required in section 62L.08, subdivision 8. For group health plans for which
284.16 approval is sought for sales only outside of the small employer market as defined in section
284.17 62L.02, this section applies only to policies or contracts of accident and sickness insurance.
284.18 All forms intended for issuance in the individual or small employer market must be
284.19 accompanied by a statement as to the expected loss ratio for the form. Premium rates and
284.20 forms relating to specific insureds or proposed insureds, whether individuals or groups,
284.21 need not be filed, unless requested by the commissioner.

284.22 Sec. 2. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 1, is amended
284.23 to read:

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

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

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

284.31 (d) "Electronic media" has the meaning given under Code of Federal Regulations, title
284.32 45, part 160.103.

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

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

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

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

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

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

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

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

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

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

286.1 (o) "Pharmacy benefit manager" has the meaning given in section 62W.02, subdivision
286.2 15.

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

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

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

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

286.13 Sec. 3. Minnesota Statutes 2021 Supplement, section 62J.497, subdivision 3, is amended
286.14 to read:

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

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

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

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

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

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

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

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

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

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

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

287.9 **EFFECTIVE DATE.** This section is effective January 1, 2023.

287.10 Sec. 4. Minnesota Statutes 2020, section 62J.84, as amended by Laws 2021, chapter 30,
287.11 article 3, sections 5 to 9, is amended to read:

287.12 **62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.**

287.13 Subdivision 1. **Short title.** This section may be cited as the "Prescription Drug Price
287.14 Transparency Act."

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

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

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

287.20 (1) an original, new drug application approved under United States Code, title 21, section
287.21 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
287.22 section 447.502; or

287.23 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section
287.24 262(a)(c).

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

287.26 (e) "Course of treatment" means the total dosage of a single prescription for a prescription
287.27 drug recommended by the Food and Drug Administration (FDA)-approved prescribing
287.28 label. If the FDA-approved prescribing label includes more than one recommended dosage
287.29 for a single course of treatment, the course of treatment is the maximum recommended
287.30 dosage on the FDA-approved prescribing label.

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

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

288.4 (2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42,
288.5 section 447.502; or

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

288.8 ~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

288.9 (h) "National Drug Code" means the three-segment code maintained by the FDA that
288.10 includes a labeler code, a product code, and a package code for a drug product and that has
288.11 been converted to an 11-digit format consisting of five digits in the first segment, four digits
288.12 in the second segment, and two digits in the third segment. A three-segment code shall be
288.13 considered converted to an 11-digit format when, as necessary, at least one "0" has been
288.14 added to the front of each segment containing less than the specified number of digits so
288.15 that each segment contains the specified number of digits.

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

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

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

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

288.27 (m) "Rebate" means a discount, chargeback, or other price concession that affects the
288.28 price of a prescription drug product, regardless of whether conferred through regular
288.29 aggregate payments, on a claim-by-claim basis at the point of sale, as part of retrospective
288.30 financial reconciliations including reconciliations that also reflect other contractual
288.31 arrangements, or by any other method. Rebate does not mean a bona fide service fee, as the
288.32 term is defined in Code of Federal Regulations, title 42, section 447.502.

289.1 (n) "30-day supply" means the total daily dosage units of a prescription drug
289.2 recommended by the prescribing label approved by the FDA for 30 days. If the
289.3 FDA-approved prescribing label includes more than one recommended daily dosage, the
289.4 30-day supply is based on the maximum recommended daily dosage on the FDA-approved
289.5 prescribing label.

289.6 **Subd. 3. Prescription drug price increases reporting.** (a) Beginning January 1, 2022,
289.7 a drug manufacturer must submit to the commissioner the information described in paragraph
289.8 (b) for each prescription drug for which the price was \$100 or greater for a 30-day supply
289.9 or for a course of treatment lasting less than 30 days and:

289.10 (1) for brand name drugs where there is an increase of ten percent or greater in the price
289.11 over the previous 12-month period or an increase of 16 percent or greater in the price over
289.12 the previous 24-month period; and

289.13 (2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in
289.14 the price over the previous 12-month period.

289.15 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
289.16 the commissioner no later than 60 days after the price increase goes into effect, in the form
289.17 and manner prescribed by the commissioner, the following information, if applicable:

289.18 (1) the name, description, and price of the drug and the net increase, expressed as a
289.19 percentage; with the following listed separately:

289.20 (i) National Drug Code;

289.21 (ii) product name;

289.22 (iii) dosage form;

289.23 (iv) strength; and

289.24 (v) package size;

289.25 (2) the factors that contributed to the price increase;

289.26 (3) the name of any generic version of the prescription drug available on the market;

289.27 (4) the introductory price of the prescription drug when it was introduced for sale in the
289.28 United States and the price of the drug on the last day of each of the five calendar years
289.29 preceding the price increase when it was approved for marketing by the Food and Drug
289.30 Administration and the net yearly increase, by calendar year, in the price of the prescription
289.31 drug during the previous five years;

- 290.1 (5) the direct costs incurred during the previous 12-month period by the manufacturer
- 290.2 that are associated with the prescription drug, listed separately:
- 290.3 (i) to manufacture the prescription drug;
- 290.4 (ii) to market the prescription drug, including advertising costs; and
- 290.5 (iii) to distribute the prescription drug;
- 290.6 (6) the number of units of the prescription drug sold during the previous 12-month period;
- 290.7 (7) the total rebate payable amount accrued for the prescription drug during the previous
- 290.8 12-month period;
- 290.9 ~~(6)~~ (8) the total sales revenue for the prescription drug during the previous 12-month
- 290.10 period;
- 290.11 ~~(7)~~ (9) the manufacturer's net profit attributable to the prescription drug during the
- 290.12 previous 12-month period;
- 290.13 ~~(8)~~ (10) the total amount of financial assistance the manufacturer has provided through
- 290.14 patient prescription assistance programs during the previous 12-month period, if applicable;
- 290.15 ~~(9)~~ (11) any agreement between a manufacturer and another entity contingent upon any
- 290.16 delay in offering to market a generic version of the prescription drug;
- 290.17 ~~(10)~~ (12) the patent expiration date of the prescription drug if it is under patent;
- 290.18 ~~(11)~~ (13) the name and location of the company that manufactured the drug; ~~and~~
- 290.19 ~~(12)~~ (14) if a brand name prescription drug, the ten highest prices paid for the prescription
- 290.20 drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding
- 290.21 the United States., that charged the highest single price for the prescription drug; and
- 290.22 (15) if the prescription drug was acquired by the manufacturer during the previous
- 290.23 12-month period, all of the following information:
- 290.24 (i) price at acquisition;
- 290.25 (ii) price in the calendar year prior to acquisition;
- 290.26 (iii) name of the company from which the drug was acquired;
- 290.27 (iv) date of acquisition; and
- 290.28 (v) acquisition price.
- 290.29 (c) The manufacturer may submit any documentation necessary to support the information
- 290.30 reported under this subdivision.

291.1 Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no
 291.2 later than 60 days after a manufacturer introduces a new prescription drug for sale in the
 291.3 United States that is a new brand name drug with a price that is greater than the tier threshold
 291.4 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
 291.5 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
 291.6 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold
 291.7 established by the Centers for Medicare and Medicaid Services for specialty drugs in the
 291.8 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than
 291.9 30 days and is not at least 15 percent lower than the referenced brand name drug when the
 291.10 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,
 291.11 in the form and manner prescribed by the commissioner, the following information, if
 291.12 applicable:

291.13 (1) the description of the drug, with the following listed separately:

291.14 (i) National Drug Code;

291.15 (ii) product name;

291.16 (iii) dosage form;

291.17 (iv) strength; and

291.18 (v) package size

291.19 ~~(1)~~ (2) the price of the prescription drug;

291.20 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a
 291.21 breakthrough therapy designation or a priority review;

291.22 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the
 291.23 prescription drug, listed separately:

291.24 (i) to manufacture the prescription drug;

291.25 (ii) to market the prescription drug, including advertising costs; and

291.26 (iii) to distribute the prescription drug; and

291.27 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

291.28 (b) The manufacturer may submit documentation necessary to support the information
 291.29 reported under this subdivision.

291.30 Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning January
 291.31 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information

292.1 described in paragraph (b) for each newly acquired prescription drug for which the price
292.2 was \$100 or greater for a 30-day supply or for a course of treatment lasting less than 30
292.3 days and:

292.4 (1) for a newly acquired brand name drug where there is an increase of ten percent or
292.5 greater in the price over the previous 12-month period or an increase of 16 percent or greater
292.6 in price over the previous 24-month period; and

292.7 (2) for a newly acquired generic or biosimilar drug where there is an increase of 50
292.8 percent or greater in the price over the previous 12-month period.

292.9 (b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall
292.10 submit to the commissioner no later than 60 days after the acquiring manufacturer begins
292.11 to sell the newly acquired drug, in the form and manner prescribed by the commissioner,
292.12 the following information, if applicable:

292.13 (1) the description of the drug, with the following listed separately:

292.14 (i) National Drug Code;

292.15 (ii) product name;

292.16 (iii) dosage form;

292.17 (iv) strength; and

292.18 (v) package size

292.19 ~~(4)~~ (2) the price of the prescription drug at the time of acquisition and in the calendar
292.20 year prior to acquisition;

292.21 ~~(2)~~ (3) the name of the company from which the prescription drug was acquired, the
292.22 date acquired, and the purchase price;

292.23 ~~(3)~~ (4) the year the prescription drug was introduced to market and the price of the
292.24 prescription drug at the time of introduction;

292.25 ~~(4)~~ (5) the price of the prescription drug for the previous five years;

292.26 ~~(5)~~ (6) any agreement between a manufacturer and another entity contingent upon any
292.27 delay in offering to market a generic version of the manufacturer's drug; and

292.28 ~~(6)~~ (7) the patent expiration date of the drug if it is under patent.

292.29 (c) The manufacturer may submit any documentation necessary to support the information
292.30 reported under this subdivision.

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

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

293.7 (2) information reported to the commissioner under subdivisions 3, 4, and 5.

293.8 (b) The information must be published in an easy-to-read format and in a manner that
293.9 identifies the information that is disclosed on a per-drug basis and must not be aggregated
293.10 in a manner that prevents the identification of the prescription drug.

293.11 (c) The commissioner shall not post to the department's website or a private entity
293.12 contracting with the commissioner shall not post any information described in this section
293.13 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
293.14 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
293.15 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
293.16 1836, as amended. If a manufacturer believes information should be withheld from public
293.17 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
293.18 that information and describe the legal basis in writing when the manufacturer submits the
293.19 information under this section. If the commissioner disagrees with the manufacturer's request
293.20 to withhold information from public disclosure, the commissioner shall provide the
293.21 manufacturer written notice that the information will be publicly posted 30 days after the
293.22 date of the notice.

293.23 (d) If the commissioner withholds any information from public disclosure pursuant to
293.24 this subdivision, the commissioner shall post to the department's website a report describing
293.25 the nature of the information and the commissioner's basis for withholding the information
293.26 from disclosure.

293.27 (e) To the extent the information required to be posted under this subdivision is collected
293.28 and made available to the public by another state, by the University of Minnesota, or through
293.29 an online drug pricing reference and analytical tool, the commissioner may reference the
293.30 availability of this drug price data from another source including, within existing
293.31 appropriations, creating the ability of the public to access the data from the source for
293.32 purposes of meeting the reporting requirements of this subdivision.

293.33 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
293.34 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of

294.1 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
294.2 of the information reported under this section; in posting information pursuant to subdivision
294.3 6; and in taking any other action for the purpose of implementing this section.

294.4 (b) The commissioner may consult with representatives of the manufacturers to establish
294.5 a standard format for reporting information under this section and may use existing reporting
294.6 methodologies to establish a standard format to minimize administrative burdens to the state
294.7 and manufacturers.

294.8 **Subd. 8. Enforcement and penalties.** (a) A manufacturer may be subject to a civil
294.9 penalty, as provided in paragraph (b), for:

294.10 (1) failing to submit timely reports or notices as required by this section;

294.11 (2) failing to provide information required under this section; or

294.12 (3) providing inaccurate or incomplete information under this section.

294.13 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000
294.14 per day of violation, based on the severity of each violation.

294.15 (c) The commissioner shall impose civil penalties under this section as provided in
294.16 section 144.99, subdivision 4.

294.17 (d) The commissioner may remit or mitigate civil penalties under this section upon terms
294.18 and conditions the commissioner considers proper and consistent with public health and
294.19 safety.

294.20 (e) Civil penalties collected under this section shall be deposited in the health care access
294.21 fund.

294.22 **Subd. 9. Legislative report.** (a) No later than May 15, 2022, and by January 15 of each
294.23 year thereafter, the commissioner shall report to the chairs and ranking minority members
294.24 of the legislative committees with jurisdiction over commerce and health and human services
294.25 policy and finance on the implementation of this section, including but not limited to the
294.26 effectiveness in addressing the following goals:

294.27 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

294.28 (2) enhancing the understanding on pharmaceutical spending trends; and

294.29 (3) assisting the state and other payers in the management of pharmaceutical costs.

294.30 (b) The report must include a summary of the information submitted to the commissioner
294.31 under subdivisions 3, 4, and 5.

295.1 Sec. 5. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

295.2 Subd. 2. **Definitions.** (a) For purposes of this section and section 62J.841, the terms
295.3 defined in this subdivision have the meanings given.

295.4 (b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics
295.5 license application approved under United States Code, title 42, section 262(K)(3).

295.6 (c) "Brand name drug" means a drug that is produced or distributed pursuant to:

295.7 (1) an original, new drug application approved under United States Code, title 21, section
295.8 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
295.9 section 447.502; or

295.10 (2) a biologics license application approved under United States Code, title 45, section
295.11 262(a)(c).

295.12 (d) "Commissioner" means the commissioner of health.

295.13 (e) "Generic drug" means a drug that is marketed or distributed pursuant to:

295.14 (1) an abbreviated new drug application approved under United States Code, title 21,
295.15 section 355(j);

295.16 (2) an authorized generic as defined under Code of Federal Regulations, title 45, section
295.17 447.502; or

295.18 (3) a drug that entered the market the year before 1962 and was not originally marketed
295.19 under a new drug application.

295.20 (f) "Manufacturer" means a drug manufacturer licensed under section 151.252, but does
295.21 not include an entity required to be licensed under that section solely because the entity
295.22 repackages or relabels drugs.

295.23 (g) "New prescription drug" or "new drug" means a prescription drug approved for
295.24 marketing by the United States Food and Drug Administration for which no previous
295.25 wholesale acquisition cost has been established for comparison.

295.26 (h) "Patient assistance program" means a program that a manufacturer offers to the public
295.27 in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs
295.28 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other
295.29 means.

295.30 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision
295.31 8.

296.1 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title
296.2 42, section 1395w-3a(c)(6)(B).

296.3 Sec. 6. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

296.4 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision
296.5 have the meanings given.

296.6 (b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics
296.7 license application approved under United States Code, title 42, section 262(K)(3).

296.8 (c) "Brand name drug" means a drug that is produced or distributed pursuant to:

296.9 (1) an original, new drug application approved under United States Code, title 21, section
296.10 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
296.11 section 447.502; or

296.12 (2) a biologics license application approved under United States Code, title 45, section
296.13 262(a)(c).

296.14 (d) "Commissioner" means the commissioner of health.

296.15 (e) "Drug product family" means a group of one or more prescription drugs that share
296.16 a unique generic drug description or nontrade name and dosage form.

296.17 ~~(e)~~ (f) "Generic drug" means a drug that is marketed or distributed pursuant to:

296.18 (1) an abbreviated new drug application approved under United States Code, title 21,
296.19 section 355(j);

296.20 (2) an authorized generic as defined under Code of Federal Regulations, title 45, section
296.21 447.502; or

296.22 (3) a drug that entered the market the year before 1962 and was not originally marketed
296.23 under a new drug application.

296.24 ~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

296.25 ~~(g)~~ (h) "New prescription drug" or "new drug" means a prescription drug approved for
296.26 marketing by the United States Food and Drug Administration for which no previous
296.27 wholesale acquisition cost has been established for comparison.

296.28 ~~(h)~~ (i) "Patient assistance program" means a program that a manufacturer offers to the
296.29 public in which a consumer may reduce the consumer's out-of-pocket costs for prescription
296.30 drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by
296.31 other means.

297.1 (j) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board
297.2 of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded,
297.3 or dispensed under the supervision of a pharmacist.

297.4 (k) "Pharmacy benefits manager (PBM)" means an entity licensed to act as a pharmacy
297.5 benefits manager under section 62W.03.

297.6 ~~(j)~~ (l) "Prescription drug" or "drug" has the meaning provided in section 151.441,
297.7 subdivision 8.

297.8 ~~(j)~~ (m) "Price" means the wholesale acquisition cost as defined in United States Code,
297.9 title 42, section 1395w-3a(c)(6)(B).

297.10 (n) "Pricing Unit" means the smallest dispensable amount of a prescription drug product
297.11 that could be dispensed.

297.12 (o) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager,
297.13 wholesale drug distributor, or any other entity required to submit data under section 62J.84.

297.14 (p) "Wholesale drug distributor" or "wholesaler" means an entity that:

297.15 (1) is licensed to act as a wholesale drug distributor under section 151.47; and

297.16 (2) distributes prescription drugs, of which it is not the manufacturer, to persons or
297.17 entities other than a consumer or patient in the state.

297.18 Sec. 7. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended
297.19 to read:

297.20 Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner
297.21 shall post on the department's website, or may contract with a private entity or consortium
297.22 that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the
297.23 following information:

297.24 (1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the
297.25 manufacturers of those prescription drugs; ~~and~~

297.26 (2) information reported to the commissioner under subdivisions 3, 4, and 5; and

297.27 (3) information reported to the commissioner under section 62J.841, subdivision 2.

297.28 (b) The information must be published in an easy-to-read format and in a manner that
297.29 identifies the information that is disclosed on a per-drug basis and must not be aggregated
297.30 in a manner that prevents the identification of the prescription drug.

298.1 (c) The commissioner shall not post to the department's website or a private entity
298.2 contracting with the commissioner shall not post any information described in this section
298.3 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
298.4 information under section 13.37, subdivision 1, paragraph (b), subject to section 62J.841,
298.5 subdivision 2, paragraph (e); or is trade secret information pursuant to the Defend Trade
298.6 Secrets Act of 2016, United States Code, title 18, section 1836, as amended, subject to
298.7 section 62J.841, subdivision 2, paragraph (e). If a manufacturer believes information should
298.8 be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly
298.9 and specifically identify that information and describe the legal basis in writing when the
298.10 manufacturer submits the information under this section. If the commissioner disagrees
298.11 with the manufacturer's request to withhold information from public disclosure, the
298.12 commissioner shall provide the manufacturer written notice that the information will be
298.13 publicly posted 30 days after the date of the notice.

298.14 (d) If the commissioner withholds any information from public disclosure pursuant to
298.15 this subdivision, the commissioner shall post to the department's website a report describing
298.16 the nature of the information and the commissioner's basis for withholding the information
298.17 from disclosure.

298.18 (e) To the extent the information required to be posted under this subdivision is collected
298.19 and made available to the public by another state, by the University of Minnesota, or through
298.20 an online drug pricing reference and analytical tool, the commissioner may reference the
298.21 availability of this drug price data from another source including, within existing
298.22 appropriations, creating the ability of the public to access the data from the source for
298.23 purposes of meeting the reporting requirements of this subdivision.

298.24 Sec. 8. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended
298.25 to read:

298.26 **Subd. 6. Public posting of prescription drug price information.** (a) The commissioner
298.27 shall post on the department's website, or may contract with a private entity or consortium
298.28 that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the
298.29 following information:

298.30 (1) a list of the prescription drugs reported under subdivisions 3, 4, ~~and 5~~, 11, 12, 13,
298.31 and 14 and the manufacturers of those prescription drugs; and

298.32 (2) information reported to the commissioner under subdivisions 3, 4, ~~and 5~~, 11, 12, 13,
298.33 and 14.

299.1 (b) The information must be published in an easy-to-read format and in a manner that
299.2 identifies the information that is disclosed on a per-drug basis and must not be aggregated
299.3 in a manner that prevents the identification of the prescription drug.

299.4 (c) The commissioner shall not post to the department's website or a private entity
299.5 contracting with the commissioner shall not post any information described in this section
299.6 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
299.7 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
299.8 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
299.9 1836, as amended. If a manufacturer believes information should be withheld from public
299.10 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
299.11 that information and describe the legal basis in writing when the manufacturer submits the
299.12 information under this section. If the commissioner disagrees with the manufacturer's request
299.13 to withhold information from public disclosure, the commissioner shall provide the
299.14 manufacturer written notice that the information will be publicly posted 30 days after the
299.15 date of the notice.

299.16 (d) If the commissioner withholds any information from public disclosure pursuant to
299.17 this subdivision, the commissioner shall post to the department's website a report describing
299.18 the nature of the information and the commissioner's basis for withholding the information
299.19 from disclosure.

299.20 (e) To the extent the information required to be posted under this subdivision is collected
299.21 and made available to the public by another state, by the University of Minnesota, or through
299.22 an online drug pricing reference and analytical tool, the commissioner may reference the
299.23 availability of this drug price data from another source including, within existing
299.24 appropriations, creating the ability of the public to access the data from the source for
299.25 purposes of meeting the reporting requirements of this subdivision.

299.26 Sec. 9. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

299.27 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
299.28 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of
299.29 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
299.30 of the information reported under this section and section 62J.841; in posting information
299.31 pursuant to subdivision 6; and in taking any other action for the purpose of implementing
299.32 this section and section 62J.841.

299.33 (b) The commissioner may consult with representatives of the manufacturers to establish
299.34 a standard format for reporting information under this section and section 62J.841 and may

300.1 use existing reporting methodologies to establish a standard format to minimize
300.2 administrative burdens to the state and manufacturers.

300.3 Sec. 10. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

300.4 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or
300.5 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of
300.6 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format
300.7 of the information reported under this section; in posting information pursuant to subdivision
300.8 6; and in taking any other action for the purpose of implementing this section.

300.9 (b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting
300.10 entities to establish a standard format for reporting information under this section and may
300.11 use existing reporting methodologies to establish a standard format to minimize
300.12 administrative burdens to the state and ~~manufacturers~~ reporting entities.

300.13 Sec. 11. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

300.14 Subd. 8. **Enforcement and penalties.** (a) A manufacturer may be subject to a civil
300.15 penalty, as provided in paragraph (b), for:

300.16 (1) failing to submit timely reports or notices as required by this section and section
300.17 62J.841;

300.18 (2) failing to provide information required under this section and section 62J.841; ~~or~~

300.19 (3) providing inaccurate or incomplete information under this section and section 62J.841;
300.20 or

300.21 (4) failing to comply with section 62J.481, subdivisions 2, paragraph (e), and 4.

300.22 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000
300.23 per day of violation, based on the severity of each violation.

300.24 (c) The commissioner shall impose civil penalties under this section and section 62J.841
300.25 as provided in section 144.99, subdivision 4.

300.26 (d) The commissioner may remit or mitigate civil penalties under this section and section
300.27 62J.481 upon terms and conditions the commissioner considers proper and consistent with
300.28 public health and safety.

300.29 (e) Civil penalties collected under this section and section 62J.841 shall be deposited in
300.30 the health care access fund.

301.1 Sec. 12. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

301.2 Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject
301.3 to a civil penalty, as provided in paragraph (b), for:

301.4 (1) failing to register under subdivision 15;

301.5 ~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

301.6 ~~(2)~~ (3) failing to provide information required under this section; or

301.7 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

301.8 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000
301.9 per day of violation, based on the severity of each violation.

301.10 (c) The commissioner shall impose civil penalties under this section as provided in
301.11 section 144.99, subdivision 4.

301.12 (d) The commissioner may remit or mitigate civil penalties under this section upon terms
301.13 and conditions the commissioner considers proper and consistent with public health and
301.14 safety.

301.15 (e) Civil penalties collected under this section shall be deposited in the health care access
301.16 fund.

301.17 Sec. 13. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended
301.18 to read:

301.19 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each
301.20 year thereafter, the commissioner shall report to the chairs and ranking minority members
301.21 of the legislative committees with jurisdiction over commerce and health and human services
301.22 policy and finance on the implementation of this section and section 62J.841, including but
301.23 not limited to the effectiveness in addressing the following goals:

301.24 (1) promoting transparency in pharmaceutical pricing for the state, health carriers, and
301.25 other payers;

301.26 (2) enhancing the understanding on pharmaceutical spending trends; and

301.27 (3) assisting the state, health carriers, and other payers in the management of
301.28 pharmaceutical costs and limiting formulary changes due to prescription drug cost increases
301.29 during a coverage year.

301.30 (b) The report must include a summary of the information submitted to the commissioner
301.31 under subdivisions 3, 4, and 5, and section 62J.841.

302.1 Sec. 14. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended
302.2 to read:

302.3 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each
302.4 year thereafter, the commissioner shall report to the chairs and ranking minority members
302.5 of the legislative committees with jurisdiction over commerce and health and human services
302.6 policy and finance on the implementation of this section, including but not limited to the
302.7 effectiveness in addressing the following goals:

302.8 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

302.9 (2) enhancing the understanding on pharmaceutical spending trends; and

302.10 (3) assisting the state and other payers in the management of pharmaceutical costs.

302.11 (b) The report must include a summary of the information submitted to the commissioner
302.12 under subdivisions 3, 4, ~~and 5~~, 11, 12, 13, and 14.

302.13 Sec. 15. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
302.14 read:

302.15 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than
302.16 January 31, 2023, and quarterly thereafter, the commissioner shall produce and post on the
302.17 department's website a list of prescription drugs that the department determines to represent
302.18 a substantial public interest and for which the department intends to request data under
302.19 subdivisions 11, 12, 13, and 14, subject to paragraph (c). The department shall base its
302.20 inclusion of prescription drugs on any information the department determines is relevant
302.21 to providing greater consumer awareness of the factors contributing to the cost of prescription
302.22 drugs in the state, and the department shall consider drug product families that include
302.23 prescription drugs:

302.24 (1) that triggered reporting under subdivisions 3, 4, or 5 during the previous calendar
302.25 quarter;

302.26 (2) for which average claims paid amounts exceeded 125 percent of the price as of the
302.27 claim incurred date during the most recent calendar quarter for which claims paid amounts
302.28 are available; or

302.29 (3) that are identified by members of the public during a public comment period process.

302.30 (b) No sooner than 30 days after publicly posting the list of prescription drugs under
302.31 paragraph (a), the department shall notify, via e-mail, reporting entities registered with the
302.32 department of the requirement to report under subdivisions 11, 12, 13, and 14.

303.1 (c) No more than 500 prescription drugs may be designated as having a substantial public
303.2 interest in any one notice.

303.3 Sec. 16. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
303.4 read:

303.5 **Subd. 11. Manufacturer prescription drug substantial public interest reporting. (a)**
303.6 **Beginning January 1, 2023, a manufacturer must submit to the commissioner the information**
303.7 **described in paragraph (b) for any prescription drug:**

303.8 (1) included in a notification to report issued to the manufacturer by the department
303.9 under subdivision 10;

303.10 (2) which the manufacturer manufactures or repackages;

303.11 (3) for which the manufacturer sets the wholesale acquisition cost; and

303.12 (4) for which the manufacturer has not submitted data under subdivisions 3 or 5 during
303.13 the 120-day period prior to the date of the notification to report.

303.14 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to
303.15 the commissioner no later than 60 days after the date of the notification to report, in the
303.16 form and manner prescribed by the commissioner, the following information, if applicable:

303.17 (1) a description of the drug with the following listed separately:

303.18 (i) National Drug Code;

303.19 (ii) product name;

303.20 (iii) dosage form;

303.21 (iv) strength; and

303.22 (v) package size;

303.23 (2) the price of the drug product on the later of:

303.24 (i) the day one year prior to the date of the notification to report;

303.25 (ii) the introduced to market date; or

303.26 (iii) the acquisition date;

303.27 (3) the price of the drug product on the date of the notification to report;

304.1 (4) the introductory price of the prescription drug when it was introduced for sale in the
304.2 United States and the price of the drug on the last day of each of the five calendar years
304.3 preceding the date of the notification to report;

304.4 (5) the direct costs incurred during the 12-month period prior to the date of the notification
304.5 to report by the manufacturer that are associated with the prescription drug, listed separately:

304.6 (i) to manufacture the prescription drug;

304.7 (ii) to market the prescription drug, including advertising costs; and

304.8 (iii) to distribute the prescription drug;

304.9 (6) the number of units of the prescription drug sold during the 12-month period prior
304.10 to the date of the notification to report;

304.11 (7) the total sales revenue for the prescription drug during the 12-month period prior to
304.12 the date of the notification to report;

304.13 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
304.14 period prior to the date of the notification to report;

304.15 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
304.16 period prior to the date of the notification to report;

304.17 (10) the total amount of financial assistance the manufacturer has provided through
304.18 patient prescription assistance programs during the 12-month period prior to the date of the
304.19 notification to report, if applicable;

304.20 (11) any agreement between a manufacturer and another entity contingent upon any
304.21 delay in offering to market a generic version of the prescription drug;

304.22 (12) the patent expiration date of the prescription drug if it is under patent;

304.23 (13) the name and location of the company that manufactured the drug;

304.24 (14) if a brand name prescription drug, the ten countries other than the United States
304.25 that paid the highest prices for the prescription drug during the previous calendar year and
304.26 their prices; and

304.27 (15) if the prescription drug was acquired by the manufacturer within the 12-month
304.28 period prior to the date of the notification to report, all of the following information:

304.29 (i) price at acquisition;

304.30 (ii) price in the calendar year prior to acquisition;

305.1 (iii) name of the company from which the drug was acquired;

305.2 (iv) date of acquisition; and

305.3 (v) acquisition price.

305.4 (c) The manufacturer may submit any documentation necessary to support the information
305.5 reported under this subdivision.

305.6 Sec. 17. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
305.7 read:

305.8 **Subd. 12. Pharmacy prescription drug substantial public interest reporting. (a)**
305.9 Beginning January 1, 2023, a pharmacy must submit to the commissioner the information
305.10 described in paragraph (b) for any prescription drug included in a notification to report
305.11 issued to the pharmacy by the department under subdivision 10.

305.12 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the
305.13 commissioner no later than 60 days after the date of the notification to report in the form
305.14 and manner prescribed by the commissioner the following information, if applicable:

305.15 (1) a description of the drug with the following listed separately:

305.16 (i) National Drug Code;

305.17 (ii) product name;

305.18 (iii) dosage form;

305.19 (iv) strength; and

305.20 (v) package size;

305.21 (2) the number of units of the drug acquired during the 12-month period prior to the date
305.22 of the notification to report;

305.23 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month
305.24 period prior to the date of the notification to report;

305.25 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
305.26 12-month period prior to the date of the notification to report;

305.27 (5) the number of pricing units of the drug dispensed by the pharmacy during the
305.28 12-month period prior to the date of the notification to report;

306.1 (6) the total payment receivable by the pharmacy for dispensing the drug, including
306.2 ingredient cost, dispensing fee, and administrative fees, during the 12-month period prior
306.3 to the date of the notification to report;

306.4 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
306.5 12-month period prior to the date of the notification to report; and

306.6 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
306.7 where no claim was submitted to a health care service plan or health insurer during the
306.8 12-month period prior to the date of the notification to report.

306.9 (c) The pharmacy may submit any documentation necessary to support the information
306.10 reported under this subdivision.

306.11 Sec. 18. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
306.12 read:

306.13 Subd. 13. **Pharmacy benefit manager (PBM) prescription drug substantial public**
306.14 **interest reporting.** (a) Beginning January 1, 2023, a PBM as defined in section 62W.02,
306.15 subdivision 14, must submit to the commissioner the information described in paragraph
306.16 (b) for any prescription drug included in a notification to report issued to the PBM by the
306.17 department under subdivision 10.

306.18 (b) For each of the drugs described in paragraph (a), the PBM shall submit to the
306.19 commissioner no later than 60 days after the date of the notification to report, in the form
306.20 and manner prescribed by the commissioner, the following information, if applicable:

306.21 (1) a description of the drug with the following listed separately:

306.22 (i) National Drug Code;

306.23 (ii) product name;

306.24 (iii) dosage form;

306.25 (iv) strength; and

306.26 (v) package size;

306.27 (2) the number of pricing units of the drug product filled for which the PBM administered
306.28 claims during the 12-month period prior to the date of the notification to report;

306.29 (3) the total reimbursement amount accrued and payable to pharmacies for pricing units
306.30 of the drug product filled for which the PBM administered claims during the 12-month
306.31 period prior to the date of the notification to report;

307.1 (4) the total reimbursement or administrative fee amount or both accrued and receivable
307.2 from payers for pricing units of the drug product filled for which the PBM administered
307.3 claims during the 12-month period prior to the date of the notification to report;

307.4 (5) the total rebate receivable amount accrued by the PBM for the drug product during
307.5 the 12-month period prior to the date of the notification to report; and

307.6 (6) the total rebate payable amount accrued by the PBM for the drug product during the
307.7 12-month period prior to the date of the notification to report.

307.8 (c) The PBM may submit any documentation necessary to support the information
307.9 reported under this subdivision.

307.10 Sec. 19. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
307.11 read:

307.12 Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a)
307.13 Beginning January 1, 2023, a wholesaler must submit to the commissioner the information
307.14 described in paragraph (b) for any prescription drug included in a notification to report
307.15 issued to the wholesaler by the department under subdivision 10.

307.16 (b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the
307.17 commissioner no later than 60 days after the date of the notification to report, in the form
307.18 and manner prescribed by the commissioner, the following information, if applicable:

307.19 (1) a description of the drug with the following listed separately:

307.20 (i) National Drug Code;

307.21 (ii) product name;

307.22 (iii) dosage form;

307.23 (iv) strength; and

307.24 (v) package size;

307.25 (2) the number of units of the drug product acquired by the wholesale drug distributor
307.26 during the 12-month period prior to the date of the notification to report;

307.27 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug
307.28 product during the 12-month period prior to the date of the notification to report;

307.29 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the
307.30 drug product during the 12-month period prior to the date of the notification to report;

308.1 (5) the number of units of the drug product sold by the wholesale drug distributor during
308.2 the 12-month period prior to the date of the notification to report;

308.3 (6) gross revenue from sales in the United States generated by the wholesale drug
308.4 distributor for the drug product during the 12-month period prior to the date of the notification
308.5 to report; and

308.6 (7) total rebate payable amount accrued by the wholesale drug distributor for the drug
308.7 product during the 12-month period prior to the date of the notification to report.

308.8 (c) The wholesaler may submit any documentation necessary to support the information
308.9 reported under this subdivision.

308.10 Sec. 20. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
308.11 read:

308.12 Subd. 15. **Registration requirement.** Beginning January 1, 2023, a reporting entity
308.13 subject to this chapter shall register with the department in a form and manner prescribed
308.14 by the commissioner.

308.15 Sec. 21. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to
308.16 read:

308.17 Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the
308.18 expedited rulemaking process under section 14.389.

308.19 Sec. 22. **[62J.84] REPORTING PRESCRIPTION DRUG PRICES; FORMULARY**
308.20 **DEVELOPMENT AND PRICE STABILITY.**

308.21 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms in this subdivision
308.22 have the meanings given.

308.23 (b) "Average wholesale price" means the customary reference price for sales by a drug
308.24 wholesaler to a retail pharmacy, as established and published by the manufacturer.

308.25 (c) "National drug code" means the numerical code maintained by the United States
308.26 Food and Drug Administration and includes the label code, product code, and package code.

308.27 (d) "Unit" has the meaning given in United States Code, title 42, section 1395w-3a(b)(2).

308.28 (e) "Wholesale acquisition cost" has the meaning given in United States Code, title 42,
308.29 section 1395w-3a(c)(6)(B).

309.1 Subd. 2. Price reporting. (a) Beginning July 31, 2023, and by July 31 each year
309.2 thereafter, a manufacturer must report to the commissioner the information in paragraph
309.3 (b) for every drug with a wholesale acquisition cost of \$100 or more for a 30-day supply
309.4 or for a course of treatment lasting less than 30 days, as applicable to the next calendar year.

309.5 (b) A manufacturer shall report a drug's:

309.6 (1) national drug code, labeler code, and the manufacturer name associated with the
309.7 labeler code;

309.8 (2) brand name, if applicable;

309.9 (3) generic name, if applicable;

309.10 (4) wholesale acquisition cost for one unit;

309.11 (5) measure that constitutes a wholesale acquisition cost unit;

309.12 (6) average wholesale price; and

309.13 (7) status as brand name or generic.

309.14 (c) The effective date of the information described in paragraph (b) must be included in
309.15 the report to the commissioner.

309.16 (d) A manufacturer must report the information described in this subdivision in the form
309.17 and manner specified by the commissioner.

309.18 (e) Information reported under this subdivision is classified as public data not on
309.19 individuals, as defined in section 13.02, subdivision 14, and must not be classified by the
309.20 manufacturer as trade secret information, as defined in section 13.37, subdivision 1, paragraph
309.21 (b).

309.22 (f) A manufacturer's failure to report the information required by this subdivision is
309.23 grounds for disciplinary action under section 151.071, subdivision 2.

309.24 Subd. 3. Public posting of prescription drug price information. By October 1 of each
309.25 year, beginning October 1, 2023, the commissioner must post the information reported
309.26 under subdivision 2 on the department website, as required by section 62J.84, subdivision
309.27 6.

309.28 Subd. 4. Price change. (a) If a drug subject to price reporting under subdivision 2 is
309.29 included in the formulary of a health plan submitted to and approved by the commissioner
309.30 of commerce for the next calendar year under section 62A.02, subdivision 1, the manufacturer

310.1 may increase the wholesale acquisition cost of the drug for the next calendar year only after
310.2 providing the commissioner with at least 90 days' written notice.

310.3 (b) A manufacturer's failure to meet the requirements of paragraph (a) is grounds for
310.4 disciplinary action under section 151.071, subdivision 2.

310.5 Sec. 23. **[62J.841] DEFINITIONS.**

310.6 Subdivision 1. **Scope.** For purposes of sections 62J.841 to 62J.845, the following
310.7 definitions apply.

310.8 Subd. 2. **Consumer Price Index.** "Consumer Price Index" means the Consumer Price
310.9 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,
310.10 reported by the United States Department of Labor, Bureau of Labor Statistics, or its
310.11 successor or, if the index is discontinued, an equivalent index reported by a federal authority
310.12 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen
310.13 by the Bureau of Labor Statistics.

310.14 Subd. 3. **Generic or off-patent drug.** "Generic or off-patent drug" means any prescription
310.15 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and
310.16 Cosmetic Act; section 351 of the federal Public Health Service Act; and federal patent law
310.17 have expired, including any drug-device combination product for the delivery of a generic
310.18 drug.

310.19 Subd. 4. **Manufacturer.** "Manufacturer" has the meaning provided in section 151.01,
310.20 subdivision 14a.

310.21 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject
310.22 to United States Code, title 21, section 353(b)(1).

310.23 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning
310.24 provided in United States Code, title 42, section 1395w-3a.

310.25 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in
310.26 section 151.441, subdivision 14.

310.27 Sec. 24. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

310.28 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an
310.29 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or
310.30 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or
310.31 delivered to any consumer in the state.

311.1 Subd. 2. Excessive price increase. A price increase is excessive for purposes of this
 311.2 section when:

311.3 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

311.4 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar
 311.5 year; or

311.6 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three
 311.7 calendar years; and

311.8 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds
 311.9 \$30 for:

311.10 (i) a 30-day supply of the drug; or

311.11 (ii) a course of treatment lasting less than 30 days.

311.12 Subd. 3. Exemption. It is not a violation of this section for a wholesale distributor or
 311.13 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly
 311.14 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy
 311.15 by the manufacturer of the drug.

311.16 Sec. 25. [62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.

311.17 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or
 311.18 off-patent drug in the state is required to maintain a registered agent and office within the
 311.19 state.

311.20 Sec. 26. [62J.844] ENFORCEMENT.

311.21 Subdivision 1. Notification. The commissioner of management and budget and any
 311.22 other state agency that provides or purchases a pharmacy benefit, except the Department
 311.23 of Human Services, and any entity under contract with a state agency to provide a pharmacy
 311.24 benefit other than an entity under contract with the Department of Human Services, shall
 311.25 notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board
 311.26 of Pharmacy of any price increase in violation of section 62J.842.

311.27 Subd. 2. Submission of drug cost statement and other information by manufacturer;
 311.28 investigation by attorney general. (a) Within 45 days of receiving a notice under subdivision
 311.29 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to
 311.30 the attorney general. The statement must:

311.31 (1) itemize the cost components related to production of the drug;

312.1 (2) identify the circumstances and timing of any increase in materials or manufacturing
312.2 costs that caused any increase during the preceding calendar year, or preceding three calendar
312.3 years as applicable, in the price of the drug; and

312.4 (3) provide any other information that the manufacturer believes to be relevant to a
312.5 determination of whether a violation of section 62J.842 has occurred.

312.6 (b) The attorney general may investigate whether a violation of section 62J.842 has
312.7 occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

312.8 Subd. 3. **Petition to court.** (a) On petition of the attorney general, a court may issue an
312.9 order:

312.10 (1) compelling the manufacturer of a generic or off-patent drug to:

312.11 (i) provide the drug cost statement required under subdivision 2, paragraph (a); and

312.12 (ii) answer interrogatories, produce records or documents, or be examined under oath,
312.13 as required by the attorney general under subdivision 2, paragraph (b);

312.14 (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing
312.15 an order requiring that drug prices be restored to levels that comply with section 62J.842;

312.16 (3) requiring the manufacturer to provide an accounting to the attorney general of all
312.17 revenues resulting from a violation of section 62J.842;

312.18 (4) requiring the manufacturer to repay to all consumers, including any third-party payers,
312.19 any money acquired as a result of a price increase that violates section 62J.842;

312.20 (5) notwithstanding section 16A.151, if a manufacturer is unable to determine the
312.21 individual transactions necessary to provide the repayments described in clause (4), requiring
312.22 that all revenues generated from a violation of section 62J.842 be remitted to the state and
312.23 deposited into a special fund to be used for initiatives to reduce the cost to consumers of
312.24 acquiring prescription drugs;

312.25 (6) imposing a civil penalty of up to \$10,000 per day for each violation of section 62J.842;

312.26 (7) providing for the attorney general's recovery of its costs and disbursements incurred
312.27 in bringing an action against a manufacturer found in violation of section 62J.842, including
312.28 the costs of investigation and reasonable attorney's fees; and

312.29 (8) providing any other appropriate relief, including any other equitable relief as
312.30 determined by the court.

313.1 (b) For purposes of paragraph (a), clause (6), every individual transaction in violation
313.2 of section 62J.842 must be considered a separate violation.

313.3 Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision
313.4 3a, by a person injured by a violation of this section is for the benefit of the public.

313.5 Sec. 27. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR**
313.6 **OFF-PATENT DRUGS FOR SALE.**

313.7 Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited
313.8 from withdrawing that drug from sale or distribution within this state for the purpose of
313.9 avoiding the prohibition on excessive price increases under section 62J.842.

313.10 Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to
313.11 withdraw a generic or off-patent drug from sale or distribution within the state shall provide
313.12 a written notice of withdrawal to the Board of Pharmacy and the attorney general at least
313.13 180 days prior to the withdrawal.

313.14 Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of \$500,000 on
313.15 any manufacturer of a generic or off-patent drug that it determines has failed to comply
313.16 with the requirements of this section.

313.17 Sec. 28. **[62J.846] SEVERABILITY.**

313.18 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person
313.19 or circumstance is held invalid for any reason in a court of competent jurisdiction, the
313.20 invalidity does not affect other provisions or any other application of sections 62J.841 to
313.21 62J.845 that can be given effect without the invalid provision or application.

313.22 Sec. 29. **[62J.85] CITATION.**

313.23 Sections 62J.85 to 62J.95 may be cited as the "Prescription Drug Affordability Act."

313.24 Sec. 30. **[62J.86] DEFINITIONS.**

313.25 Subdivision 1. **Definitions.** For the purposes of sections 62J.85 to 62J.95, the following
313.26 terms have the meanings given.

313.27 Subd. 2. **Advisory council.** "Advisory council" means the Prescription Drug Affordability
313.28 Advisory Council established under section 62J.88.

314.1 Subd. 3. **Biologic.** "Biologic" means a drug that is produced or distributed in accordance
314.2 with a biologics license application approved under Code of Federal Regulations, title 42,
314.3 section 447.502.

314.4 Subd. 4. **Biosimilar.** "Biosimilar" has the meaning provided in section 62J.84, subdivision
314.5 2, paragraph (b).

314.6 Subd. 5. **Board.** "Board" means the Prescription Drug Affordability Board established
314.7 under section 62J.87.

314.8 Subd. 6. **Brand name drug.** "Brand name drug" has the meaning provided in section
314.9 62J.84, subdivision 2, paragraph (c).

314.10 Subd. 7. **Generic drug.** "Generic drug" has the meaning provided in section 62J.84,
314.11 subdivision 2, paragraph (e).

314.12 Subd. 8. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03,
314.13 subdivision 6, and includes pharmacy benefit managers as defined in section 62W.02,
314.14 subdivision 15.

314.15 Subd. 9. **Manufacturer.** "Manufacturer" means an entity that:

314.16 (1) engages in the manufacture of a prescription drug product or enters into a lease with
314.17 another manufacturer to market and distribute a prescription drug product under the entity's
314.18 own name; and

314.19 (2) sets or changes the wholesale acquisition cost of the prescription drug product it
314.20 manufactures or markets.

314.21 Subd. 10. **Prescription drug product.** "Prescription drug product" means a brand name
314.22 drug, a generic drug, a biologic, or a biosimilar.

314.23 Subd. 11. **Wholesale acquisition cost or WAC.** "Wholesale acquisition cost" or "WAC"
314.24 has the meaning given in United States Code, title 42, section 1395W-3a(c)(6)(B).

314.25 Sec. 31. **[62J.87] PRESCRIPTION DRUG AFFORDABILITY BOARD.**

314.26 Subdivision 1. **Establishment.** The commissioner of commerce shall establish the
314.27 Prescription Drug Affordability Board, which shall be governed as a board under section
314.28 15.012, paragraph (a), to protect consumers, state and local governments, health plan
314.29 companies, providers, pharmacies, and other health care system stakeholders from
314.30 unaffordable costs of certain prescription drugs.

315.1 Subd. 2. **Membership.** (a) The Prescription Drug Affordability Board consists of nine
315.2 members appointed as follows:

315.3 (1) seven voting members appointed by the governor;

315.4 (2) one nonvoting member appointed by the majority leader of the senate; and

315.5 (3) one nonvoting member appointed by the speaker of the house.

315.6 (b) All members appointed must have knowledge and demonstrated expertise in
315.7 pharmaceutical economics and finance or health care economics and finance. A member
315.8 must not be an employee of, a board member of, or a consultant to a manufacturer or trade
315.9 association for manufacturers or a pharmacy benefit manager or trade association for
315.10 pharmacy benefit managers.

315.11 (c) Initial appointments must be made by January 1, 2023.

315.12 Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms, except that initial
315.13 appointees shall serve staggered terms of two, three, or four years as determined by lot by
315.14 the secretary of state. A board member shall serve no more than two consecutive terms.

315.15 (b) A board member may resign at any time by giving written notice to the board.

315.16 Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from
315.17 the members appointed by the governor. The acting chair shall convene the first meeting
315.18 of the board.

315.19 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
315.20 board by a majority of the members. The chair shall serve for one year.

315.21 (c) The board shall elect a vice-chair and other officers from its membership as it deems
315.22 necessary.

315.23 Subd. 5. **Staff; technical assistance.** (a) The board shall hire an executive director and
315.24 other staff, who shall serve in the unclassified service. The executive director must have
315.25 knowledge and demonstrated expertise in pharmacoeconomics, pharmacology, health policy,
315.26 health services research, medicine, or a related field or discipline. The board may employ
315.27 or contract for professional and technical assistance as the board deems necessary to perform
315.28 the board's duties.

315.29 (b) The attorney general shall provide legal services to the board.

315.30 Subd. 6. **Compensation.** The board members shall not receive compensation but may
315.31 receive reimbursement for expenses as authorized under section 15.059, subdivision 3.

316.1 Subd. 7. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall
316.2 meet publicly at least every three months to review prescription drug product information
316.3 submitted to the board under section 62J.90. If there are no pending submissions, the chair
316.4 of the board may cancel or postpone the required meeting. The board may meet in closed
316.5 session when reviewing proprietary information as determined under the standards developed
316.6 in accordance with section 62J.91, subdivision 4.

316.7 (b) The board shall announce each public meeting at least two weeks prior to the
316.8 scheduled date of the meeting. Any materials for the meeting must be made public at least
316.9 one week prior to the scheduled date of the meeting.

316.10 (c) At each public meeting, the board shall provide the opportunity for comments from
316.11 the public, including the opportunity for written comments to be submitted to the board
316.12 prior to a decision by the board.

316.13 Sec. 32. **[62J.88] PRESCRIPTION DRUG AFFORDABILITY ADVISORY**
316.14 **COUNCIL.**

316.15 Subdivision 1. **Establishment.** The governor shall appoint a 12-member stakeholder
316.16 advisory council to provide advice to the board on drug cost issues and to represent
316.17 stakeholders' views. The members of the advisory council shall be appointed based on their
316.18 knowledge and demonstrated expertise in one or more of the following areas: the
316.19 pharmaceutical business; practice of medicine; patient perspectives; health care cost trends
316.20 and drivers; clinical and health services research; and the health care marketplace.

316.21 Subd. 2. **Membership.** The council's membership shall consist of the following:

316.22 (1) two members representing patients and health care consumers;

316.23 (2) two members representing health care providers;

316.24 (3) one member representing health plan companies;

316.25 (4) two members representing employers, with one member representing large employers
316.26 and one member representing small employers;

316.27 (5) one member representing government employee benefit plans;

316.28 (6) one member representing pharmaceutical manufacturers;

316.29 (7) one member who is a health services clinical researcher;

316.30 (8) one member who is a pharmacologist; and

317.1 (9) one member representing the commissioner of health with expertise in health
317.2 economics.

317.3 Subd. 3. **Terms.** (a) The initial appointments to the advisory council must be made by
317.4 January 1, 2023. The initial appointed advisory council members shall serve staggered terms
317.5 of two, three, or four years determined by lot by the secretary of state. Following the initial
317.6 appointments, the advisory council members shall serve four-year terms.

317.7 (b) Removal and vacancies of advisory council members are governed by section 15.059.

317.8 Subd. 4. **Compensation.** Advisory council members may be compensated according to
317.9 section 15.059.

317.10 Subd. 5. **Meetings.** Meetings of the advisory council are subject to chapter 13D. The
317.11 advisory council shall meet publicly at least every three months to advise the board on drug
317.12 cost issues related to the prescription drug product information submitted to the board under
317.13 section 62J.90.

317.14 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not
317.15 expire.

317.16 **Sec. 33. [62J.89] CONFLICTS OF INTEREST.**

317.17 Subdivision 1. **Definition.** (a) For purposes of this section, "conflict of interest" means
317.18 a financial or personal association that has the potential to bias or have the appearance of
317.19 biasing a person's decisions in matters related to the board or the advisory council, or in the
317.20 conduct of the board's or council's activities.

317.21 (b) A conflict of interest includes any instance in which a person or a person's immediate
317.22 family member has received or could receive a direct or indirect financial benefit of any
317.23 amount deriving from the result or findings of a decision or determination of the board.

317.24 (c) For purposes of this section, a person's immediate family member includes a spouse,
317.25 parent, child, or other legal dependent, or an in-law of any of the preceding individuals.

317.26 (d) For purposes of this section, a financial benefit includes honoraria, fees, stock, the
317.27 value of stock holdings, and any direct financial benefit deriving from the finding of a review
317.28 conducted under sections 62J.85 to 62J.95.

317.29 (e) Ownership of securities is not a conflict of interest if the securities are: (1) part of a
317.30 diversified mutual or exchange traded fund; or (2) in a tax-deferred or tax-exempt retirement
317.31 account that is administered by an independent trustee.

318.1 Subd. 2. **General.** (a) A board or advisory council member, board staff member, or
 318.2 third-party contractor must disclose any conflicts of interest to the appointing authority or
 318.3 the board prior to the acceptance of an appointment, an offer of employment, or a contractual
 318.4 agreement. The information disclosed must include the type, nature, and magnitude of the
 318.5 interests involved.

318.6 (b) A board member, board staff member, or third-party contractor with a conflict of
 318.7 interest relating to any prescription drug product under review must recuse themselves from
 318.8 any discussion, review, decision, or determination made by the board relating to the
 318.9 prescription drug product.

318.10 (c) Any conflict of interest must be disclosed in advance of the first meeting after the
 318.11 conflict is identified or within five days after the conflict is identified, whichever is earlier.

318.12 Subd. 3. **Prohibitions.** Board members, board staff, or third-party contractors are
 318.13 prohibited from accepting gifts, bequeaths, or donations of services or property that raise
 318.14 the specter of a conflict of interest or have the appearance of injecting bias into the activities
 318.15 of the board.

318.16 Sec. 34. **[62J.90] PRESCRIPTION DRUG PRICE INFORMATION; DECISION**
 318.17 **TO CONDUCT COST REVIEW.**

318.18 Subdivision 1. **Drug price information from the commissioner of health and other**
 318.19 **sources.** (a) The commissioner of health shall provide to the board the information reported
 318.20 to the commissioner by drug manufacturers under section 62J.84, subdivisions 3, 4, and 5.
 318.21 The commissioner shall provide this information to the board within 30 days of the date the
 318.22 information is received from drug manufacturers.

318.23 (b) The board shall subscribe to one or more prescription drug pricing files, such as
 318.24 Medispan or FirstDatabank, or as otherwise determined by the board.

318.25 Subd. 2. **Identification of certain prescription drug products.** (a) The board, in
 318.26 consultation with the advisory council, shall identify the following prescription drug products:

318.27 (1) brand name drugs or biologics for which the WAC increases by more than ten percent
 318.28 or by more than \$10,000 during any 12-month period or course of treatment if less than 12
 318.29 months, after adjusting for changes in the consumer price index (CPI);

318.30 (2) brand name drugs or biologics introduced at a WAC of \$30,000 or more per calendar
 318.31 year or per course of treatment;

- 319.1 (3) biosimilar drugs introduced at a WAC that is not at least 15 percent lower than the
319.2 referenced brand name biologic at the time the biosimilar is introduced; and
- 319.3 (4) generic drugs for which the WAC:
- 319.4 (i) is \$100 or more, after adjusting for changes in the CPI, for:
- 319.5 (A) a 30-day supply lasting a patient for a period of 30 consecutive days based on the
319.6 recommended dosage approved for labeling by the United States Food and Drug
319.7 Administration (FDA);
- 319.8 (B) a supply lasting a patient for fewer than 30 days based on recommended dosage
319.9 approved for labeling by the FDA; or
- 319.10 (C) one unit of the drug if the labeling approved by the FDA does not recommend a
319.11 finite dosage; and
- 319.12 (ii) has increased by 200 percent or more during the immediate preceding 12-month
319.13 period, as determined by the difference between the resulting WAC and the average of the
319.14 WAC reported over the preceding 12 months, after adjusting for changes in the CPI.
- 319.15 (b) The board, in consultation with the advisory council, shall identify prescription drug
319.16 products not described in paragraph (a) that may impose costs that create significant
319.17 affordability challenges for the state health care system or for patients, including but not
319.18 limited to drugs to address public health emergencies.
- 319.19 (c) The board shall make available to the public the names and related price information
319.20 of the prescription drug products identified under this subdivision, with the exception of
319.21 information determined by the board to be proprietary under the standards developed by
319.22 the board under section 62J.91, subdivision 4.
- 319.23 Subd. 3. **Determination to proceed with review.** (a) The board may initiate a cost
319.24 review of a prescription drug product identified by the board under this section.
- 319.25 (b) The board shall consider requests by the public for the board to proceed with a cost
319.26 review of any prescription drug product identified under this section.
- 319.27 (c) If there is no consensus among the members of the board on whether or not to initiate
319.28 a cost review of a prescription drug product, any member of the board may request a vote
319.29 to determine whether or not to review the cost of the prescription drug product.

320.1 **Sec. 35. [62J.91] PRESCRIPTION DRUG PRODUCT REVIEWS.**

320.2 Subdivision 1. **General.** Once the board decides to proceed with a cost review of a
320.3 prescription drug product, the board shall conduct the review and make a determination as
320.4 to whether appropriate utilization of the prescription drug under review, based on utilization
320.5 that is consistent with the United States Food and Drug Administration (FDA) label or
320.6 standard medical practice, has led or will lead to affordability challenges for the state health
320.7 care system or for patients.

320.8 Subd. 2. **Review considerations.** In reviewing the cost of a prescription drug product,
320.9 the board may consider the following factors:

320.10 (1) the price at which the prescription drug product has been and will be sold in the state;

320.11 (2) the average monetary price concession, discount, or rebate the manufacturer provides
320.12 to a group purchaser in this state as reported by the manufacturer and the group purchaser,
320.13 expressed as a percent of the WAC for the prescription drug product under review;

320.14 (3) the price at which therapeutic alternatives have been or will be sold in the state;

320.15 (4) the average monetary price concession, discount, or rebate the manufacturer provides
320.16 or is expected to provide to a group purchaser or group purchasers in the state for therapeutic
320.17 alternatives;

320.18 (5) the cost to group purchasers based on patient access consistent with the FDA-labeled
320.19 indications;

320.20 (6) the impact on patient access resulting from the cost of the prescription drug product
320.21 relative to insurance benefit design;

320.22 (7) the current or expected dollar value of drug-specific patient access programs supported
320.23 by manufacturers;

320.24 (8) the relative financial impacts to health, medical, or other social services costs that
320.25 can be quantified and compared to baseline effects of existing therapeutic alternatives;

320.26 (9) the average patient co-pay or other cost-sharing for the prescription drug product in
320.27 the state;

320.28 (10) any information a manufacturer chooses to provide; and

320.29 (11) any other factors as determined by the board.

321.1 Subd. 3. Further review factors. If, after considering the factors described in subdivision
321.2 2, the board is unable to determine whether a prescription drug product will produce or has
321.3 produced an affordability challenge, the board may consider:

321.4 (1) manufacturer research and development costs, as indicated on the manufacturer's
321.5 federal tax filing for the most recent tax year, in proportion to the manufacturer's sales in
321.6 the state;

321.7 (2) the portion of direct-to-consumer marketing costs eligible for favorable federal tax
321.8 treatment in the most recent tax year that is specific to the prescription drug product under
321.9 review, multiplied by the ratio of total manufacturer in-state sales to total manufacturer
321.10 sales in the United States for the product under review;

321.11 (3) gross and net manufacturer revenues for the most recent tax year;

321.12 (4) any information and research related to the manufacturer's selection of the introductory
321.13 price or price increase, including but not limited to:

321.14 (i) life cycle management;

321.15 (ii) market competition and context; and

321.16 (iii) projected revenue; and

321.17 (5) any additional factors determined by the board to be relevant.

321.18 Subd. 4. Public data; proprietary information. (a) Any submission made to the board
321.19 related to a drug cost review must be made available to the public with the exception of
321.20 information determined by the board to be proprietary.

321.21 (b) The board shall establish the standards for the information to be considered proprietary
321.22 under paragraph (a) and section 62J.90, subdivision 2, including standards for heightened
321.23 consideration of proprietary information for submissions for a cost review of a drug that is
321.24 not yet approved by the FDA.

321.25 (c) Prior to the board establishing the standards under paragraph (b), the public must be
321.26 provided notice and the opportunity to submit comments.

321.27 Sec. 36. [62J.92] DETERMINATIONS; COMPLIANCE; REMEDIES.

321.28 Subdivision 1. Upper payment limit. (a) In the event the board finds that the spending
321.29 on a prescription drug product reviewed under section 62J.91 creates an affordability
321.30 challenge for the state health care system or for patients, the board shall establish an upper
321.31 payment limit after considering:

- 322.1 (1) the cost of administering the drug;
- 322.2 (2) the cost of delivering the drug to consumers;
- 322.3 (3) the range of prices at which the drug is sold in the United States according to one or
- 322.4 more pricing files accessed under section 62J.90, subdivision 1, and the range at which
- 322.5 pharmacies are reimbursed in Canada; and
- 322.6 (4) any other relevant pricing and administrative cost information for the drug.
- 322.7 (b) The upper payment limit must apply to all public and private purchases, payments,
- 322.8 and payer reimbursements for the prescription drug products received by an individual in
- 322.9 the state in person, by mail, or by other means.
- 322.10 Subd. 2. **Noncompliance.** (a) The failure of an entity to comply with an upper payment
- 322.11 limit established by the board under this section shall be referred to the Office of the Attorney
- 322.12 General.
- 322.13 (b) If the Office of the Attorney General finds that an entity was noncompliant with the
- 322.14 upper payment limit requirements, the attorney general may pursue remedies consistent
- 322.15 with chapter 8 or appropriate criminal charges if there is evidence of intentional profiteering.
- 322.16 (c) An entity that obtains price concessions from a drug manufacturer that result in a
- 322.17 lower net cost to the stakeholder than the upper payment limit established by the board must
- 322.18 not be considered to be in noncompliance.
- 322.19 (d) The Office of the Attorney General may provide guidance to stakeholders concerning
- 322.20 activities that could be considered noncompliant.
- 322.21 Subd. 3. **Appeals.** (a) Persons affected by a decision of the board may request an appeal
- 322.22 of the board's decision within 30 days of the date of the decision. The board shall hear the
- 322.23 appeal and render a decision within 60 days of the hearing.
- 322.24 (b) All appeal decisions are subject to judicial review in accordance with chapter 14.
- 322.25 Sec. 37. **[62J.93] REPORTS.**
- 322.26 Beginning March 1, 2023, and each March 1 thereafter, the board shall submit a report
- 322.27 to the governor and legislature on general price trends for prescription drug products and
- 322.28 the number of prescription drug products that were subject to the board's cost review and
- 322.29 analysis, including the result of any analysis and the number and disposition of appeals and
- 322.30 judicial reviews.

323.1 Sec. 38. **[62J.94] ERISA PLANS AND MEDICARE DRUG PLANS.**

323.2 (a) Nothing in sections 62J.85 to 62J.95 shall be construed to require ERISA plans or
323.3 Medicare Part D plans to comply with decisions of the board. ERISA plans or Medicare
323.4 Part D plans may choose to exceed the upper payment limit established by the board under
323.5 section 62J.92.

323.6 (b) Providers who dispense and administer drugs in the state must bill all payers no more
323.7 than the upper payment limit without regard to whether or not an ERISA plan or Medicare
323.8 Part D plan chooses to reimburse the provider in an amount greater than the upper payment
323.9 limit established by the board.

323.10 (c) For purposes of this section, an ERISA plan or group health plan is an employee
323.11 welfare benefit plan established or maintained by an employer or an employee organization,
323.12 or both, that provides employer sponsored health coverage to employees and the employee's
323.13 dependents and is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

323.14 Sec. 39. **[62J.95] SEVERABILITY.**

323.15 If any provision of sections 62J.85 to 62J.94 or the application thereof to any person or
323.16 circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity
323.17 does not affect other provisions or any other application of sections 62J.85 to 62J.94 that
323.18 can be given effect without the invalid provision or application.

323.19 Sec. 40. **[62Q.1842] PROHIBITION ON USE OF STEP THERAPY FOR**
323.20 **ANTIRETROVIRAL DRUGS.**

323.21 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
323.22 apply.

323.23 (b) "Health plan" has the meaning given in section 62Q.01, subdivision 3, and includes
323.24 health coverage provided by a managed care plan or a county-based purchasing plan
323.25 participating in a public program under chapter 256B or 256L or an integrated health
323.26 partnership under section 256B.0755.

323.27 (c) "Step therapy protocol" has the meaning given in section 62Q.184.

323.28 Subd. 2. **Prohibition on use of step therapy protocols.** A health plan that covers
323.29 antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including
323.30 preexposure prophylaxis and postexposure prophylaxis, must not limit or exclude coverage
323.31 for the antiretroviral drugs by requiring prior authorization or by requiring an enrollee to
323.32 follow a step therapy protocol.

324.1 Sec. 41. [62Q.481] COST-SHARING FOR PRESCRIPTION DRUGS AND RELATED
324.2 MEDICAL SUPPLIES TO TREAT CHRONIC DISEASE.

324.3 Subdivision 1. Cost-sharing limits. (a) A health plan must limit the amount of any
324.4 enrollee cost-sharing for prescription drugs prescribed to treat a chronic disease to no more
324.5 than \$25 per one-month supply for each prescription drug and to no more than \$50 per
324.6 month in total for all related medical supplies. Coverage under this section must not be
324.7 subject to any deductible.

324.8 (b) If application of this section before an enrollee has met their plan's deductible would
324.9 result in health savings account ineligibility under United States Code, title 26, section 223,
324.10 then this section must apply to that specific prescription drug or related medical supply only
324.11 after the enrollee has met their plan's deductible.

324.12 Subd. 2. Definitions. (a) For purposes of this section, the following terms have the
324.13 meanings given.

324.14 (b) "Chronic disease" means diabetes, asthma, and allergies requiring the use of
324.15 epinephrine auto-injectors.

324.16 (c) "Cost-sharing" means co-payments and coinsurance.

324.17 (d) "Related medical supplies" means syringes, insulin pens, insulin pumps, epinephrine
324.18 auto-injectors, test strips, glucometers, continuous glucose monitors, and other medical
324.19 supply items necessary to effectively and appropriately administer a prescription drug
324.20 prescribed to treat a chronic disease.

324.21 EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health
324.22 plans offered, issued, or renewed on or after that date.

324.23 Sec. 42. [62Q.524] COVERAGE FOR DRUGS TO PREVENT THE ACQUISITION
324.24 OF HUMAN IMMUNODEFICIENCY VIRUS.

324.25 (a) A health plan that provides prescription drug coverage must provide coverage in
324.26 accordance with this section for:

324.27 (1) any antiretroviral drug approved by the United States Food and Drug Administration
324.28 (FDA) for preventing the acquisition of human immunodeficiency virus (HIV) that is
324.29 prescribed, dispensed, or administered by a pharmacist who meets the requirements described
324.30 in section 151.37, subdivision 17; and

325.1 (2) any laboratory testing necessary for therapy that uses the drugs described in clause
325.2 (1) that is ordered, performed, and interpreted by a pharmacist who meets the requirements
325.3 described in section 151.37, subdivision 17.

325.4 (b) A health plan must provide the same terms of prescription drug coverage for drugs
325.5 to prevent the acquisition of HIV that are prescribed or administered by a pharmacist if the
325.6 pharmacist meets the requirements described in section 151.37, subdivision 17, as would
325.7 apply had the drug been prescribed or administered by a physician, physician assistant, or
325.8 advanced practice registered nurse. The health plan may require pharmacists or pharmacies
325.9 to meet reasonable medical management requirements when providing the services described
325.10 in paragraph (a) if other providers are required to meet the same requirements.

325.11 (c) A health plan must reimburse an in-network pharmacist or pharmacy for the drugs
325.12 and testing described in paragraph (a) at a rate equal to the rate of reimbursement provided
325.13 to a physician, physician assistant, or advanced practice registered nurse if providing similar
325.14 services.

325.15 (d) A health plan is not required to cover the drugs and testing described in paragraph
325.16 (a) if provided by a pharmacist or pharmacy that is out-of-network unless the health plan
325.17 covers similar services provided by out-of-network providers. A health plan must ensure
325.18 that the health plan's provider network includes in-network pharmacies that provide the
325.19 services described in paragraph (a).

325.20 **Sec. 43. [62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**
325.21 **MANAGEMENT.**

325.22 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
325.23 the meanings given.

325.24 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

325.25 (c) "Enrollee contract term" means the 12-month term during which benefits associated
325.26 with health plan company products are in effect. For managed care plans and county-based
325.27 purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a
325.28 single calendar quarter.

325.29 (d) "Formulary" means a list of prescription drugs developed by clinical and pharmacy
325.30 experts that represents the health plan company's medically appropriate and cost-effective
325.31 prescription drugs approved for use.

325.32 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
325.33 includes an entity that performs pharmacy benefits management for the health plan company.

326.1 For purposes of this paragraph, "pharmacy benefits management" means the administration
326.2 or management of prescription drug benefits provided by the health plan company for the
326.3 benefit of the plan's enrollees and may include but is not limited to procurement of
326.4 prescription drugs, clinical formulary development and management services, claims
326.5 processing, and rebate contracting and administration.

326.6 (f) "Prescription" has the meaning given in section 151.01, subdivision 16a.

326.7 Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides
326.8 prescription drug benefit coverage and uses a formulary must make the plan's formulary
326.9 and related benefit information available by electronic means and, upon request, in writing
326.10 at least 30 days before annual renewal dates.

326.11 (b) Formularies must be organized and disclosed consistent with the most recent version
326.12 of the United States Pharmacopeia's (USP) Model Guidelines.

326.13 (c) For each item or category of items on the formulary, the specific enrollee benefit
326.14 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

326.15 Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan
326.16 company may, at any time during the enrollee's contract term:

326.17 (1) expand its formulary by adding drugs to the formulary;

326.18 (2) reduce co-payments or coinsurance; or

326.19 (3) move a drug to a benefit category that reduces an enrollee's cost.

326.20 (b) A health plan company may remove a brand name drug from the plan's formulary
326.21 or place a brand name drug in a benefit category that increases an enrollee's cost only upon
326.22 the addition to the formulary of a generic or multisource brand name drug rated as
326.23 therapeutically equivalent according to the FDA Orange Book or a biologic drug rated as
326.24 interchangeable according to the FDA Purple Book at a lower cost to the enrollee, and upon
326.25 at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

326.26 (c) A health plan company may change utilization review requirements or move drugs
326.27 to a benefit category that increases an enrollee's cost during the enrollee's contract term
326.28 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
326.29 that these changes do not apply to enrollees who are currently taking the drugs affected by
326.30 these changes for the duration of the enrollee's contract term.

326.31 (d) A health plan company may remove any drugs from the plan's formulary that have
326.32 been deemed unsafe by the Food and Drug Administration; that have been withdrawn by

327.1 either the Food and Drug Administration or the product manufacturer; or when an
327.2 independent source of research, clinical guidelines, or evidence-based standards has issued
327.3 drug-specific warnings or recommended changes in drug usage.

327.4 (e) The state employee group insurance program and coverage offered through that
327.5 program are exempt from the requirements of this subdivision.

327.6 Subd. 4. **Not severable.** (a) The provisions of this section are not severable from the
327.7 amendments and enactments in this act to sections 62A.02, subdivision 1; 62J.84,
327.8 subdivisions 2, 6, 7, 8, and 9; 62J.841; and 151.071, subdivision 2.

327.9 (b) If any amendment or enactment listed in paragraph (a) or its application to any
327.10 individual, entity, or circumstance is found to be void for any reason, this section is also
327.11 void.

327.12 **EFFECTIVE DATE.** This section is effective January 1, 2024, and applies to health
327.13 plans offered, sold, issued, or renewed on or after that date.

327.14 Sec. 44. **[62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.**

327.15 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
327.16 the meanings given.

327.17 (b) "Biological product" has the meaning given in section 151.01, subdivision 40.

327.18 (c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01,
327.19 subdivision 43.

327.20 (d) "Interchangeable biological product" has the meaning given in section 151.01,
327.21 subdivision 41.

327.22 (e) "Reference biological product" has the meaning given in section 151.01, subdivision
327.23 44.

327.24 Subd. 2. **Pharmacy and provider choice related to dispensing reference biological**
327.25 **products, interchangeable biological products, or biosimilar products.** (a)
327.26 Notwithstanding paragraph (b), a pharmacy benefit manager or health carrier must not
327.27 require or demonstrate a preference for a reference biological product administered to a
327.28 patient by a physician or health care provider or any product that is biosimilar to the reference
327.29 biological product or an interchangeable biological product administered to a patient by a
327.30 physician or health care provider.

327.31 (b) If a pharmacy benefit manager or health carrier elects coverage of a product listed
327.32 in paragraph (a), and there are two or less biosimilar products available relative to the

328.1 reference product, the pharmacy benefit manager or health carrier must elect equivalent
 328.2 coverage for all of the products that are biosimilar to the reference biological product or
 328.3 interchangeable biological product.

328.4 (c) If a pharmacy benefit manager or health carrier elects coverage of a product listed
 328.5 in paragraph (a), and there are greater than two biosimilar products available relative to the
 328.6 reference product, the pharmacy benefit manager or health carrier must elect preferential
 328.7 coverage for all of the products that are biosimilar to the reference biological or
 328.8 interchangeable biological products.

328.9 (d) A pharmacy benefit manager or health carrier must not impose limits on access to a
 328.10 product required to be covered under paragraph (b) that are more restrictive than limits
 328.11 imposed on access to a product listed in paragraph (a), or that otherwise have the same
 328.12 effect as giving preferred status to a product listed in paragraph (a) over the product required
 328.13 to be covered under paragraph (b).

328.14 (e) This section only applies to new administrations of a reference biological product.
 328.15 Nothing in this section requires switching from a prescribed reference biological product
 328.16 for a patient on an active course of treatment.

328.17 Subd. 3. **Exemption.** The state employee group insurance program, and coverage offered
 328.18 through that program, are exempt from the requirements of this section.

328.19 **EFFECTIVE DATE.** This section is effective January 1, 2023.

328.20 Sec. 45. **[62W.15] CLINICIAN-ADMINISTERED DRUGS.**

328.21 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
 328.22 the meanings given.

328.23 (b) "Affiliated pharmacy" means a pharmacy in which a pharmacy benefit manager or
 328.24 health carrier has an ownership interest either directly or indirectly, or through an affiliate
 328.25 or subsidiary.

328.26 (c) "Clinician-administered drug" means an outpatient prescription drug other than a
 328.27 vaccine that:

328.28 (1) cannot reasonably be self-administered by the patient to whom the drug is prescribed
 328.29 or by an individual assisting the patient with self-administration; and

328.30 (2) is typically administered:

328.31 (i) by a health care provider authorized to administer the drug, including when acting
 328.32 under a physician's delegation and supervision; and

329.1 (ii) in a physician's office, hospital outpatient infusion center, or other clinical setting.

329.2 Subd. 2. Prohibition on requiring coverage as a pharmacy benefit. A pharmacy
329.3 benefit manager or health carrier shall not require that a clinician-administered drug or the
329.4 administration of a clinician-administered drug be covered as a pharmacy benefit.

329.5 Subd. 3. Enrollee choice. A pharmacy benefit manager or health carrier:

329.6 (1) shall permit an enrollee to obtain a clinician-administered drug from a health care
329.7 provider authorized to administer the drug, or a pharmacy;

329.8 (2) shall not interfere with the enrollee's right to obtain a clinician-administered drug
329.9 from their provider or pharmacy of choice, and shall not offer financial or other incentives
329.10 to influence the enrollee's choice of a provider or pharmacy;

329.11 (3) shall not require clinician-administered drugs to be dispensed by a pharmacy selected
329.12 by the pharmacy benefit manager or health carrier; and

329.13 (4) shall not limit or exclude coverage for a clinician-administered drug when it is not
329.14 dispensed by a pharmacy selected by the pharmacy benefit manager or health carrier, if the
329.15 drug would otherwise be covered.

329.16 Subd. 4. Cost-sharing and reimbursement. A pharmacy benefit manager or health
329.17 carrier:

329.18 (1) may impose coverage or benefit limitations on an enrollee who obtains a
329.19 clinician-administered drug from a health care provider authorized to administer the drug,
329.20 or a pharmacy, only if these limitations would also be imposed were the drug to be obtained
329.21 from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or
329.22 health carrier; and

329.23 (2) may impose cost-sharing requirements on an enrollee who obtains a
329.24 clinician-administered drug from a health care provider authorized to administer the drug,
329.25 or a pharmacy, only if these requirements would also be imposed were the drug to be obtained
329.26 from an affiliated pharmacy or a pharmacy selected by the pharmacy benefit manager or
329.27 health carrier.

329.28 Subd. 5. Other requirements. A pharmacy benefit manager or health carrier:

329.29 (1) shall not require or encourage the dispensing of a clinician-administered drug to an
329.30 enrollee in a manner that is inconsistent with the supply chain security controls and chain
329.31 of distribution set by the federal Drug Supply Chain Security Act, United States Code, title
329.32 21, section 360eee, et seq.;

330.1 (2) shall not require a specialty pharmacy to dispense a clinician-administered medication
330.2 directly to a patient with the intention that the patient will transport the medication to a
330.3 health care provider for administration; and

330.4 (3) may offer, but shall not require:

330.5 (i) the use of a home infusion pharmacy to dispense or administer clinician-administered
330.6 drugs to enrollees; and

330.7 (ii) the use of an infusion site external to the enrollee's provider office or clinic.

330.8 **EFFECTIVE DATE.** This section is effective January 1, 2023.

330.9 Sec. 46. Minnesota Statutes 2020, section 151.01, subdivision 23, is amended to read:

330.10 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
330.11 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
330.12 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed
330.13 advanced practice registered nurse, or licensed physician assistant. For purposes of sections
330.14 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision
330.15 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to
330.16 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision
330.17 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe
330.18 self-administered hormonal contraceptives, nicotine replacement medications, or opiate
330.19 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs
330.20 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,
330.21 subdivision 17.

330.22 Sec. 47. Minnesota Statutes 2020, section 151.01, subdivision 27, is amended to read:

330.23 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

330.24 (1) interpretation and evaluation of prescription drug orders;

330.25 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
330.26 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
330.27 and devices);

330.28 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
330.29 of safe and effective use of drugs, including the performance of laboratory tests that are
330.30 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,
330.31 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory

331.1 tests but may modify drug therapy only pursuant to a protocol or collaborative practice
331.2 agreement;

331.3 (4) participation in drug and therapeutic device selection; drug administration for first
331.4 dosage and medical emergencies; intramuscular and subcutaneous administration used for
331.5 the treatment of alcohol or opioid dependence; drug regimen reviews; and drug or
331.6 drug-related research;

331.7 (5) drug administration, through intramuscular and subcutaneous administration used
331.8 to treat mental illnesses as permitted under the following conditions:

331.9 (i) upon the order of a prescriber and the prescriber is notified after administration is
331.10 complete; or

331.11 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
331.12 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
331.13 modification, administration, and discontinuation of drug therapy is according to the protocol
331.14 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
331.15 physician, podiatrist, or veterinarian, or an advanced practice registered nurse authorized
331.16 to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy
331.17 or medication administration made pursuant to a protocol or collaborative practice agreement
331.18 must be documented by the pharmacist in the patient's medical record or reported by the
331.19 pharmacist to a practitioner responsible for the patient's care;

331.20 (6) participation in administration of influenza vaccines and vaccines approved by the
331.21 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all
331.22 eligible individuals six years of age and older and all other vaccines to patients 13 years of
331.23 age and older by written protocol with a physician licensed under chapter 147, a physician
331.24 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered
331.25 nurse authorized to prescribe drugs under section 148.235, provided that:

331.26 (i) the protocol includes, at a minimum:

331.27 (A) the name, dose, and route of each vaccine that may be given;

331.28 (B) the patient population for whom the vaccine may be given;

331.29 (C) contraindications and precautions to the vaccine;

331.30 (D) the procedure for handling an adverse reaction;

331.31 (E) the name, signature, and address of the physician, physician assistant, or advanced
331.32 practice registered nurse;

332.1 (F) a telephone number at which the physician, physician assistant, or advanced practice
332.2 registered nurse can be contacted; and

332.3 (G) the date and time period for which the protocol is valid;

332.4 (ii) the pharmacist has successfully completed a program approved by the Accreditation
332.5 Council for Pharmacy Education specifically for the administration of immunizations or a
332.6 program approved by the board;

332.7 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to
332.8 assess the immunization status of individuals prior to the administration of vaccines, except
332.9 when administering influenza vaccines to individuals age nine and older;

332.10 (iv) the pharmacist reports the administration of the immunization to the Minnesota
332.11 Immunization Information Connection; and

332.12 (v) the pharmacist complies with guidelines for vaccines and immunizations established
332.13 by the federal Advisory Committee on Immunization Practices, except that a pharmacist
332.14 does not need to comply with those portions of the guidelines that establish immunization
332.15 schedules when administering a vaccine pursuant to a valid, patient-specific order issued
332.16 by a physician licensed under chapter 147, a physician assistant authorized to prescribe
332.17 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe
332.18 drugs under section 148.235, provided that the order is consistent with the United States
332.19 Food and Drug Administration approved labeling of the vaccine;

332.20 (7) participation in the initiation, management, modification, and discontinuation of
332.21 drug therapy according to a written protocol or collaborative practice agreement between:

332.22 (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists,
332.23 or veterinarians; or (ii) one or more pharmacists and one or more physician assistants
332.24 authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice
332.25 registered nurses authorized to prescribe, dispense, and administer under section 148.235.
332.26 Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement
332.27 must be documented by the pharmacist in the patient's medical record or reported by the
332.28 pharmacist to a practitioner responsible for the patient's care;

332.29 (8) participation in the storage of drugs and the maintenance of records;

332.30 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
332.31 devices;

332.32 (10) offering or performing those acts, services, operations, or transactions necessary
332.33 in the conduct, operation, management, and control of a pharmacy;

333.1 (11) participation in the initiation, management, modification, and discontinuation of
333.2 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

333.3 (i) a written protocol as allowed under clause (7); or

333.4 (ii) a written protocol with a community health board medical consultant or a practitioner
333.5 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;
333.6 ~~and~~

333.7 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
333.8 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
333.9 to section 151.37, subdivision 14, 15, or 16;

333.10 (13) prescribing, dispensing, and administering drugs for preventing the acquisition of
333.11 human immunodeficiency virus (HIV) if the pharmacist meets the requirements under
333.12 section 151.37, subdivision 17; and

333.13 (14) ordering, conducting, and interpreting laboratory tests necessary for therapies that
333.14 use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements
333.15 under section 151.37, subdivision 17.

333.16 Sec. 48. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
333.17 read:

333.18 Subd. 43. **Biosimilar product.** "Biosimilar product" or "interchangeable biologic product"
333.19 means a biological product that the United States Food and Drug Administration has licensed
333.20 and determined to be biosimilar under United States Code, title 42, section 262(i)(2).

333.21 **EFFECTIVE DATE.** This section is effective January 1, 2023.

333.22 Sec. 49. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
333.23 read:

333.24 Subd. 44. **Reference biological product.** "Reference biological product" means the
333.25 single biological product for which the United States Food and Drug Administration has
333.26 approved an initial biological product license application, against which other biological
333.27 products are evaluated for licensure as biosimilar products or interchangeable biological
333.28 products.

333.29 **EFFECTIVE DATE.** This section is effective January 1, 2023.

334.1 Sec. 50. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

334.2 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,
334.3 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do
334.4 one or more of the following:

334.5 (1) deny the issuance of a license or registration;

334.6 (2) refuse to renew a license or registration;

334.7 (3) revoke the license or registration;

334.8 (4) suspend the license or registration;

334.9 (5) impose limitations, conditions, or both on the license or registration, including but
334.10 not limited to: the limitation of practice to designated settings; the limitation of the scope
334.11 of practice within designated settings; the imposition of retraining or rehabilitation
334.12 requirements; the requirement of practice under supervision; the requirement of participation
334.13 in a diversion program such as that established pursuant to section 214.31 or the conditioning
334.14 of continued practice on demonstration of knowledge or skills by appropriate examination
334.15 or other review of skill and competence;

334.16 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that
334.17 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section
334.18 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant
334.19 of any economic advantage gained by reason of the violation, to discourage similar violations
334.20 by the licensee or registrant or any other licensee or registrant, or to reimburse the board
334.21 for the cost of the investigation and proceeding, including but not limited to, fees paid for
334.22 services provided by the Office of Administrative Hearings, legal and investigative services
334.23 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of
334.24 records, board members' per diem compensation, board staff time, and travel costs and
334.25 expenses incurred by board staff and board members; and

334.26 (7) reprimand the licensee or registrant.

334.27 Sec. 51. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

334.28 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
334.29 grounds for disciplinary action:

334.30 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
334.31 registration contained in this chapter or the rules of the board. The burden of proof is on
334.32 the applicant to demonstrate such qualifications or satisfaction of such requirements;

335.1 (2) obtaining a license by fraud or by misleading the board in any way during the
335.2 application process or obtaining a license by cheating, or attempting to subvert the licensing
335.3 examination process. Conduct that subverts or attempts to subvert the licensing examination
335.4 process includes, but is not limited to: (i) conduct that violates the security of the examination
335.5 materials, such as removing examination materials from the examination room or having
335.6 unauthorized possession of any portion of a future, current, or previously administered
335.7 licensing examination; (ii) conduct that violates the standard of test administration, such as
335.8 communicating with another examinee during administration of the examination, copying
335.9 another examinee's answers, permitting another examinee to copy one's answers, or
335.10 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
335.11 impersonator to take the examination on one's own behalf;

335.12 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
335.13 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
335.14 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
335.15 in this subdivision includes a conviction of an offense that if committed in this state would
335.16 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
335.17 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
335.18 withheld or not entered thereon. The board may delay the issuance of a new license or
335.19 registration if the applicant has been charged with a felony until the matter has been
335.20 adjudicated;

335.21 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
335.22 or applicant is convicted of a felony reasonably related to the operation of the facility. The
335.23 board may delay the issuance of a new license or registration if the owner or applicant has
335.24 been charged with a felony until the matter has been adjudicated;

335.25 (5) for a controlled substance researcher, conviction of a felony reasonably related to
335.26 controlled substances or to the practice of the researcher's profession. The board may delay
335.27 the issuance of a registration if the applicant has been charged with a felony until the matter
335.28 has been adjudicated;

335.29 (6) disciplinary action taken by another state or by one of this state's health licensing
335.30 agencies:

335.31 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
335.32 license or registration in another state or jurisdiction, failure to report to the board that
335.33 charges or allegations regarding the person's license or registration have been brought in
335.34 another state or jurisdiction, or having been refused a license or registration by any other

336.1 state or jurisdiction. The board may delay the issuance of a new license or registration if an
336.2 investigation or disciplinary action is pending in another state or jurisdiction until the
336.3 investigation or action has been dismissed or otherwise resolved; and

336.4 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
336.5 license or registration issued by another of this state's health licensing agencies, failure to
336.6 report to the board that charges regarding the person's license or registration have been
336.7 brought by another of this state's health licensing agencies, or having been refused a license
336.8 or registration by another of this state's health licensing agencies. The board may delay the
336.9 issuance of a new license or registration if a disciplinary action is pending before another
336.10 of this state's health licensing agencies until the action has been dismissed or otherwise
336.11 resolved;

336.12 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
336.13 any order of the board, of any of the provisions of this chapter or any rules of the board or
336.14 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
336.15 pharmacy;

336.16 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
336.17 of the board, of any of the provisions of this chapter or the rules of the board or violation
336.18 of any federal, state, or local law relating to the operation of the facility;

336.19 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
336.20 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
336.21 a patient; or pharmacy practice that is professionally incompetent, in that it may create
336.22 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
336.23 actual injury need not be established;

336.24 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
336.25 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
336.26 technician or pharmacist intern if that person is performing duties allowed by this chapter
336.27 or the rules of the board;

336.28 (11) for an individual licensed or registered by the board, adjudication as mentally ill
336.29 or developmentally disabled, or as a chemically dependent person, a person dangerous to
336.30 the public, a sexually dangerous person, or a person who has a sexual psychopathic
336.31 personality, by a court of competent jurisdiction, within or without this state. Such
336.32 adjudication shall automatically suspend a license for the duration thereof unless the board
336.33 orders otherwise;

337.1 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
337.2 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
337.3 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
337.4 intern or performing duties specifically reserved for pharmacists under this chapter or the
337.5 rules of the board;

337.6 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
337.7 duty except as allowed by a variance approved by the board;

337.8 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
337.9 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
337.10 of material or as a result of any mental or physical condition, including deterioration through
337.11 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
337.12 pharmacist interns, or controlled substance researchers, the inability to carry out duties
337.13 allowed under this chapter or the rules of the board with reasonable skill and safety to
337.14 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
337.15 of material or as a result of any mental or physical condition, including deterioration through
337.16 the aging process or loss of motor skills;

337.17 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
337.18 dispenser, or controlled substance researcher, revealing a privileged communication from
337.19 or relating to a patient except when otherwise required or permitted by law;

337.20 (16) for a pharmacist or pharmacy, improper management of patient records, including
337.21 failure to maintain adequate patient records, to comply with a patient's request made pursuant
337.22 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

337.23 (17) fee splitting, including without limitation:

337.24 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
337.25 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

337.26 (ii) referring a patient to any health care provider as defined in sections 144.291 to
337.27 144.298 in which the licensee or registrant has a financial or economic interest as defined
337.28 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
337.29 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
337.30 and

337.31 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
337.32 does not have a significant ownership interest, fills a prescription drug order and the
337.33 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price

338.1 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
338.2 benefit manager, or other person paying for the prescription or, in the case of veterinary
338.3 patients, the price for the filled prescription that is charged to the client or other person
338.4 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
338.5 an arrangement provided that the client or other person paying for the prescription is notified,
338.6 in writing and with each prescription dispensed, about the arrangement, unless such
338.7 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
338.8 production systems, in which case client notification would not be required;

338.9 (18) engaging in abusive or fraudulent billing practices, including violations of the
338.10 federal Medicare and Medicaid laws or state medical assistance laws or rules;

338.11 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
338.12 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
338.13 to a patient;

338.14 (20) failure to make reports as required by section 151.072 or to cooperate with an
338.15 investigation of the board as required by section 151.074;

338.16 (21) knowingly providing false or misleading information that is directly related to the
338.17 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
338.18 administration of a placebo;

338.19 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
338.20 established by any of the following:

338.21 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
338.22 of section 609.215, subdivision 1 or 2;

338.23 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
338.24 issued under section 609.215, subdivision 4;

338.25 (iii) a copy of the record of a judgment assessing damages under section 609.215,
338.26 subdivision 5; or

338.27 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
338.28 The board must investigate any complaint of a violation of section 609.215, subdivision 1
338.29 or 2;

338.30 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
338.31 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
338.32 duties permitted to such individuals by this chapter or the rules of the board under a lapsed

339.1 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
339.2 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

339.3 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
339.4 from the health professionals services program for reasons other than the satisfactory
339.5 completion of the program; and

339.6 (25) for a drug manufacturer, failure to comply with section 62J.841.

339.7 Sec. 52. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

339.8 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
339.9 grounds for disciplinary action:

339.10 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
339.11 registration contained in this chapter or the rules of the board. The burden of proof is on
339.12 the applicant to demonstrate such qualifications or satisfaction of such requirements;

339.13 (2) obtaining a license by fraud or by misleading the board in any way during the
339.14 application process or obtaining a license by cheating, or attempting to subvert the licensing
339.15 examination process. Conduct that subverts or attempts to subvert the licensing examination
339.16 process includes, but is not limited to: (i) conduct that violates the security of the examination
339.17 materials, such as removing examination materials from the examination room or having
339.18 unauthorized possession of any portion of a future, current, or previously administered
339.19 licensing examination; (ii) conduct that violates the standard of test administration, such as
339.20 communicating with another examinee during administration of the examination, copying
339.21 another examinee's answers, permitting another examinee to copy one's answers, or
339.22 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
339.23 impersonator to take the examination on one's own behalf;

339.24 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
339.25 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
339.26 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
339.27 in this subdivision includes a conviction of an offense that if committed in this state would
339.28 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
339.29 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
339.30 withheld or not entered thereon. The board may delay the issuance of a new license or
339.31 registration if the applicant has been charged with a felony until the matter has been
339.32 adjudicated;

340.1 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
340.2 or applicant is convicted of a felony reasonably related to the operation of the facility. The
340.3 board may delay the issuance of a new license or registration if the owner or applicant has
340.4 been charged with a felony until the matter has been adjudicated;

340.5 (5) for a controlled substance researcher, conviction of a felony reasonably related to
340.6 controlled substances or to the practice of the researcher's profession. The board may delay
340.7 the issuance of a registration if the applicant has been charged with a felony until the matter
340.8 has been adjudicated;

340.9 (6) disciplinary action taken by another state or by one of this state's health licensing
340.10 agencies:

340.11 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
340.12 license or registration in another state or jurisdiction, failure to report to the board that
340.13 charges or allegations regarding the person's license or registration have been brought in
340.14 another state or jurisdiction, or having been refused a license or registration by any other
340.15 state or jurisdiction. The board may delay the issuance of a new license or registration if an
340.16 investigation or disciplinary action is pending in another state or jurisdiction until the
340.17 investigation or action has been dismissed or otherwise resolved; and

340.18 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
340.19 license or registration issued by another of this state's health licensing agencies, failure to
340.20 report to the board that charges regarding the person's license or registration have been
340.21 brought by another of this state's health licensing agencies, or having been refused a license
340.22 or registration by another of this state's health licensing agencies. The board may delay the
340.23 issuance of a new license or registration if a disciplinary action is pending before another
340.24 of this state's health licensing agencies until the action has been dismissed or otherwise
340.25 resolved;

340.26 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
340.27 any order of the board, of any of the provisions of this chapter or any rules of the board or
340.28 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
340.29 pharmacy;

340.30 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
340.31 of the board, of any of the provisions of this chapter or the rules of the board or violation
340.32 of any federal, state, or local law relating to the operation of the facility;

340.33 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
340.34 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of

341.1 a patient; or pharmacy practice that is professionally incompetent, in that it may create
341.2 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
341.3 actual injury need not be established;

341.4 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
341.5 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
341.6 technician or pharmacist intern if that person is performing duties allowed by this chapter
341.7 or the rules of the board;

341.8 (11) for an individual licensed or registered by the board, adjudication as mentally ill
341.9 or developmentally disabled, or as a chemically dependent person, a person dangerous to
341.10 the public, a sexually dangerous person, or a person who has a sexual psychopathic
341.11 personality, by a court of competent jurisdiction, within or without this state. Such
341.12 adjudication shall automatically suspend a license for the duration thereof unless the board
341.13 orders otherwise;

341.14 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
341.15 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
341.16 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
341.17 intern or performing duties specifically reserved for pharmacists under this chapter or the
341.18 rules of the board;

341.19 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
341.20 duty except as allowed by a variance approved by the board;

341.21 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
341.22 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
341.23 of material or as a result of any mental or physical condition, including deterioration through
341.24 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
341.25 pharmacist interns, or controlled substance researchers, the inability to carry out duties
341.26 allowed under this chapter or the rules of the board with reasonable skill and safety to
341.27 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
341.28 of material or as a result of any mental or physical condition, including deterioration through
341.29 the aging process or loss of motor skills;

341.30 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
341.31 dispenser, or controlled substance researcher, revealing a privileged communication from
341.32 or relating to a patient except when otherwise required or permitted by law;

342.1 (16) for a pharmacist or pharmacy, improper management of patient records, including
342.2 failure to maintain adequate patient records, to comply with a patient's request made pursuant
342.3 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

342.4 (17) fee splitting, including without limitation:

342.5 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
342.6 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

342.7 (ii) referring a patient to any health care provider as defined in sections 144.291 to
342.8 144.298 in which the licensee or registrant has a financial or economic interest as defined
342.9 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
342.10 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
342.11 and

342.12 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
342.13 does not have a significant ownership interest, fills a prescription drug order and the
342.14 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
342.15 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
342.16 benefit manager, or other person paying for the prescription or, in the case of veterinary
342.17 patients, the price for the filled prescription that is charged to the client or other person
342.18 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
342.19 an arrangement provided that the client or other person paying for the prescription is notified,
342.20 in writing and with each prescription dispensed, about the arrangement, unless such
342.21 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
342.22 production systems, in which case client notification would not be required;

342.23 (18) engaging in abusive or fraudulent billing practices, including violations of the
342.24 federal Medicare and Medicaid laws or state medical assistance laws or rules;

342.25 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
342.26 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
342.27 to a patient;

342.28 (20) failure to make reports as required by section 151.072 or to cooperate with an
342.29 investigation of the board as required by section 151.074;

342.30 (21) knowingly providing false or misleading information that is directly related to the
342.31 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
342.32 administration of a placebo;

343.1 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
 343.2 established by any of the following:

343.3 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
 343.4 of section 609.215, subdivision 1 or 2;

343.5 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
 343.6 issued under section 609.215, subdivision 4;

343.7 (iii) a copy of the record of a judgment assessing damages under section 609.215,
 343.8 subdivision 5; or

343.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
 343.10 The board must investigate any complaint of a violation of section 609.215, subdivision 1
 343.11 or 2;

343.12 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
 343.13 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
 343.14 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
 343.15 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
 343.16 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

343.17 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
 343.18 from the health professionals services program for reasons other than the satisfactory
 343.19 completion of the program; and

343.20 (25) for a manufacturer, a violation of section 62J.842 or 62J.845.

343.21 Sec. 53. Minnesota Statutes 2021 Supplement, section 151.335, is amended to read:

343.22 **151.335 DELIVERY THROUGH COMMON CARRIER; COMPLIANCE WITH**
 343.23 **TEMPERATURE REQUIREMENTS.**

343.24 In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a
 343.25 mail order or specialty pharmacy that employs the United States Postal Service or other
 343.26 common carrier to deliver a filled prescription directly to a patient must ensure that the drug
 343.27 is delivered in compliance with temperature requirements established by the manufacturer
 343.28 of the drug. The methods used to ensure compliance must include but are not limited to
 343.29 enclosing in each medication's packaging a device recognized by the United States
 343.30 Pharmacopeia by which the patient can easily detect improper storage or temperature
 343.31 variations. The pharmacy must develop written policies and procedures that are consistent
 343.32 with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized

344.1 standards issued by standard-setting or accreditation organizations recognized by the board
344.2 through guidance. The policies and procedures must be provided to the board upon request.

344.3 Sec. 54. Minnesota Statutes 2020, section 151.37, is amended by adding a subdivision to
344.4 read:

344.5 Subd. 17. **Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized
344.6 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency
344.7 virus (HIV) in accordance with this subdivision.

344.8 (b) By January 1, 2023, the board of pharmacy shall develop a standardized protocol
344.9 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing
344.10 the protocol, the board may consult with community health advocacy groups, the board of
344.11 medical practice, the board of nursing, the commissioner of health, professional pharmacy
344.12 associations, and professional associations for physicians, physician assistants, and advanced
344.13 practice registered nurses.

344.14 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the
344.15 pharmacist must successfully complete a training program specifically developed for
344.16 prescribing drugs for preventing the acquisition of HIV that is offered by a college of
344.17 pharmacy, a continuing education provider that is accredited by the Accreditation Council
344.18 for Pharmacy Education, or a program approved by the board. To maintain authorization
344.19 to prescribe, the pharmacist shall complete continuing education requirements as specified
344.20 by the board.

344.21 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the
344.22 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may
344.23 dispense to a patient a drug described in paragraph (a).

344.24 (e) Before dispensing a drug described under paragraph (a) that is prescribed by the
344.25 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs
344.26 and must provide the patient with a fact sheet that includes the indications and
344.27 contraindications for the use of these drugs, the appropriate method for using these drugs,
344.28 the need for medical follow up, and any other additional information listed in Minnesota
344.29 Rules, part 6800.0910, subpart 2, that is required to be provided to a patient during the
344.30 counseling process.

344.31 (f) A pharmacist is prohibited from delegating the prescribing authority provided under
344.32 this subdivision to any other person. A pharmacist intern registered under section 151.101
344.33 may prepare the prescription, but before the prescription is processed or dispensed, a

345.1 pharmacist authorized to prescribe under this subdivision must review, approve, and sign
345.2 the prescription.

345.3 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
345.4 management, modification, and discontinuation of drug therapy according to a protocol as
345.5 authorized in this section and in section 151.01, subdivision 27.

345.6 Sec. 55. Minnesota Statutes 2020, section 151.555, as amended by Laws 2021, chapter
345.7 30, article 5, sections 2 to 5, is amended to read:

345.8 **151.555 ~~PRESCRIPTION DRUG~~ MEDICATION REPOSITORY PROGRAM.**

345.9 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
345.10 subdivision have the meanings given.

345.11 (b) "Central repository" means a wholesale distributor that meets the requirements under
345.12 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
345.13 section.

345.14 (c) "Distribute" means to deliver, other than by administering or dispensing.

345.15 (d) "Donor" means:

345.16 (1) a health care facility as defined in this subdivision;

345.17 (2) a skilled nursing facility licensed under chapter 144A;

345.18 (3) an assisted living facility licensed under chapter 144G;

345.19 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
345.20 the state;

345.21 (5) a drug wholesaler licensed under section 151.47;

345.22 (6) a drug manufacturer licensed under section 151.252; or

345.23 (7) an individual at least 18 years of age, provided that the drug or medical supply that
345.24 is donated was obtained legally and meets the requirements of this section for donation.

345.25 (e) "Drug" means any prescription drug that has been approved for medical use in the
345.26 United States, is listed in the United States Pharmacopoeia or National Formulary, and
345.27 meets the criteria established under this section for donation; or any over-the-counter
345.28 medication that meets the criteria established under this section for donation. This definition
345.29 includes cancer drugs and antirejection drugs, but does not include controlled substances,
345.30 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed

346.1 to a patient registered with the drug's manufacturer in accordance with federal Food and
 346.2 Drug Administration requirements.

346.3 (f) "Health care facility" means:

346.4 (1) a physician's office or health care clinic where licensed practitioners provide health
 346.5 care to patients;

346.6 (2) a hospital licensed under section 144.50;

346.7 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

346.8 (4) a nonprofit community clinic, including a federally qualified health center; a rural
 346.9 health clinic; public health clinic; or other community clinic that provides health care utilizing
 346.10 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

346.11 (g) "Local repository" means a health care facility that elects to accept donated drugs
 346.12 and medical supplies and meets the requirements of subdivision 4.

346.13 (h) "Medical supplies" or "supplies" means any prescription ~~and~~ or nonprescription
 346.14 medical supplies needed to administer a ~~prescription~~ drug.

346.15 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
 346.16 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
 346.17 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
 346.18 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
 346.19 part 6800.3750.

346.20 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
 346.21 it does not include a veterinarian.

346.22 Subd. 2. **Establishment; contract and oversight.** (a) By January 1, 2020, the Board of
 346.23 Pharmacy shall establish a ~~drug~~ medication repository program, through which donors may
 346.24 donate a drug or medical supply for use by an individual who meets the eligibility criteria
 346.25 specified under subdivision 5.

346.26 (b) The board shall contract with a central repository that meets the requirements of
 346.27 subdivision 3 to implement and administer the ~~prescription drug~~ medication repository
 346.28 program. The contract must:

346.29 (1) require the board to transfer to the central repository any money appropriated by the
 346.30 legislature for the purpose of operating the medication repository program and require the
 346.31 central repository to spend any money transferred only for purposes specified in the contract;

347.1 (2) require the central repository to report the following performance measures to the
347.2 board:

347.3 (i) the number of individuals served and the types of medications these individuals
347.4 received;

347.5 (ii) the number of clinics, pharmacies, and long-term care facilities with which the central
347.6 repository partnered;

347.7 (iii) the number and cost of medications accepted for inventory, disposed of, and
347.8 dispensed to individuals in need; and

347.9 (iv) locations within the state to which medications are shipped or delivered; and

347.10 (3) require the board to annually audit the expenditure by the central repository of any
347.11 funds appropriated by the legislature and transferred by the board to ensure that this funding
347.12 is used only for purposes specified in the contract.

347.13 **Subd. 3. Central repository requirements.** (a) The board may publish a request for
347.14 proposal for participants who meet the requirements of this subdivision and are interested
347.15 in acting as the central repository for the ~~drug~~ medication repository program. If the board
347.16 publishes a request for proposal, it shall follow all applicable state procurement procedures
347.17 in the selection process. The board may also work directly with the University of Minnesota
347.18 to establish a central repository.

347.19 (b) To be eligible to act as the central repository, the participant must be a wholesale
347.20 drug distributor located in Minnesota, licensed pursuant to section 151.47, and in compliance
347.21 with all applicable federal and state statutes, rules, and regulations.

347.22 (c) The central repository shall be subject to inspection by the board pursuant to section
347.23 151.06, subdivision 1.

347.24 (d) The central repository shall comply with all applicable federal and state laws, rules,
347.25 and regulations pertaining to the ~~drug~~ medication repository program, drug storage, and
347.26 dispensing. The facility must maintain in good standing any state license or registration that
347.27 applies to the facility.

347.28 **Subd. 4. Local repository requirements.** (a) To be eligible for participation in the ~~drug~~
347.29 medication repository program, a health care facility must agree to comply with all applicable
347.30 federal and state laws, rules, and regulations pertaining to the ~~drug~~ medication repository
347.31 program, drug storage, and dispensing. The facility must also agree to maintain in good
347.32 standing any required state license or registration that may apply to the facility.

348.1 (b) A local repository may elect to participate in the program by submitting the following
348.2 information to the central repository on a form developed by the board and made available
348.3 on the board's website:

348.4 (1) the name, street address, and telephone number of the health care facility and any
348.5 state-issued license or registration number issued to the facility, including the issuing state
348.6 agency;

348.7 (2) the name and telephone number of a responsible pharmacist or practitioner who is
348.8 employed by or under contract with the health care facility; and

348.9 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
348.10 that the health care facility meets the eligibility requirements under this section and agrees
348.11 to comply with this section.

348.12 (c) Participation in the ~~drug~~ medication repository program is voluntary. A local
348.13 repository may withdraw from participation in the ~~drug~~ medication repository program at
348.14 any time by providing written notice to the central repository on a form developed by the
348.15 board and made available on the board's website. The central repository shall provide the
348.16 board with a copy of the withdrawal notice within ten business days from the date of receipt
348.17 of the withdrawal notice.

348.18 Subd. 5. **Individual eligibility and application requirements.** (a) To be eligible for
348.19 the ~~drug~~ medication repository program, an individual must submit to a local repository an
348.20 intake application form that is signed by the individual and attests that the individual:

348.21 (1) is a resident of Minnesota;

348.22 (2) is uninsured and is not enrolled in the medical assistance program under chapter
348.23 256B or the MinnesotaCare program under chapter 256L, has no prescription drug coverage,
348.24 or is underinsured;

348.25 (3) acknowledges that the drugs or medical supplies to be received through the program
348.26 may have been donated; and

348.27 (4) consents to a waiver of the child-resistant packaging requirements of the federal
348.28 Poison Prevention Packaging Act.

348.29 (b) Upon determining that an individual is eligible for the program, the local repository
348.30 shall furnish the individual with an identification card. The card shall be valid for one year
348.31 from the date of issuance and may be used at any local repository. A new identification card
348.32 may be issued upon expiration once the individual submits a new application form.

349.1 (c) The local repository shall send a copy of the intake application form to the central
349.2 repository by regular mail, facsimile, or secured e-mail within ten days from the date the
349.3 application is approved by the local repository.

349.4 (d) The board shall develop and make available on the board's website an application
349.5 form and the format for the identification card.

349.6 **Subd. 6. Standards and procedures for accepting donations of drugs and supplies.** (a)
349.7 A donor may donate ~~prescription~~ drugs or medical supplies to the central repository or a
349.8 local repository if the drug or supply meets the requirements of this section as determined
349.9 by a pharmacist or practitioner who is employed by or under contract with the central
349.10 repository or a local repository.

349.11 (b) A ~~prescription~~ drug is eligible for donation under the drug medication repository
349.12 program if the following requirements are met:

349.13 (1) the donation is accompanied by a drug medication repository donor form described
349.14 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
349.15 to the donor's knowledge in accordance with paragraph (d);

349.16 (2) the drug's expiration date is at least six months after the date the drug was donated.
349.17 If a donated drug bears an expiration date that is less than six months from the donation
349.18 date, the drug may be accepted and distributed if the drug is in high demand and can be
349.19 dispensed for use by a patient before the drug's expiration date;

349.20 (3) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
349.21 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
349.22 is unopened;

349.23 (4) the drug or the packaging does not have any physical signs of tampering, misbranding,
349.24 deterioration, compromised integrity, or adulteration;

349.25 (5) the drug does not require storage temperatures other than normal room temperature
349.26 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
349.27 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
349.28 in Minnesota; and

349.29 (6) the ~~prescription~~ drug is not a controlled substance.

349.30 (c) A medical supply is eligible for donation under the drug medication repository
349.31 program if the following requirements are met:

350.1 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
350.2 is no reason to believe it has been adulterated, tampered with, or misbranded;

350.3 (2) the supply is in its original, unopened, sealed packaging;

350.4 (3) the donation is accompanied by a ~~drug~~ medication repository donor form described
350.5 under paragraph (d) that is signed by an individual who is authorized by the donor to attest
350.6 to the donor's knowledge in accordance with paragraph (d); and

350.7 (4) if the supply bears an expiration date, the date is at least six months later than the
350.8 date the supply was donated. If the donated supply bears an expiration date that is less than
350.9 six months from the date the supply was donated, the supply may be accepted and distributed
350.10 if the supply is in high demand and can be dispensed for use by a patient before the supply's
350.11 expiration date.

350.12 (d) The board shall develop the ~~drug~~ medication repository donor form and make it
350.13 available on the board's website. The form must state that to the best of the donor's knowledge
350.14 the donated drug or supply has been properly stored under appropriate temperature and
350.15 humidity conditions and that the drug or supply has never been opened, used, tampered
350.16 with, adulterated, or misbranded.

350.17 (e) Donated drugs and supplies may be shipped or delivered to the premises of the central
350.18 repository or a local repository, and shall be inspected by a pharmacist or an authorized
350.19 practitioner who is employed by or under contract with the repository and who has been
350.20 designated by the repository to accept donations. A drop box must not be used to deliver
350.21 or accept donations.

350.22 (f) The central repository and local repository shall inventory all drugs and supplies
350.23 donated to the repository. For each drug, the inventory must include the drug's name, strength,
350.24 quantity, manufacturer, expiration date, and the date the drug was donated. For each medical
350.25 supply, the inventory must include a description of the supply, its manufacturer, the date
350.26 the supply was donated, and, if applicable, the supply's brand name and expiration date.

350.27 **Subd. 7. Standards and procedures for inspecting and storing donated ~~prescription~~**
350.28 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
350.29 under contract with the central repository or a local repository shall inspect all donated
350.30 ~~prescription~~ drugs and supplies before the drug or supply is dispensed to determine, to the
350.31 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
350.32 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
350.33 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
350.34 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an

351.1 inspection record stating that the requirements for donation have been met. If a local
351.2 repository receives drugs and supplies from the central repository, the local repository does
351.3 not need to reinspect the drugs and supplies.

351.4 (b) The central repository and local repositories shall store donated drugs and supplies
351.5 in a secure storage area under environmental conditions appropriate for the drug or supply
351.6 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

351.7 (c) The central repository and local repositories shall dispose of all ~~prescription~~ drugs
351.8 and medical supplies that are not suitable for donation in compliance with applicable federal
351.9 and state statutes, regulations, and rules concerning hazardous waste.

351.10 (d) In the event that controlled substances or ~~prescription~~ drugs that can only be dispensed
351.11 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
351.12 local repository for donation, the shipment delivery must be documented by the repository
351.13 and returned immediately to the donor or the donor's representative that provided the drugs.

351.14 (e) Each repository must develop drug and medical supply recall policies and procedures.
351.15 If a repository receives a recall notification, the repository shall destroy all of the drug or
351.16 medical supply in its inventory that is the subject of the recall and complete a record of
351.17 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
351.18 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
351.19 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
351.20 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
351.21 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

351.22 (f) A record of destruction of donated drugs and supplies that are not dispensed under
351.23 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
351.24 shall be maintained by the repository for at least two years. For each drug or supply destroyed,
351.25 the record shall include the following information:

351.26 (1) the date of destruction;

351.27 (2) the name, strength, and quantity of the drug destroyed; and

351.28 (3) the name of the person or firm that destroyed the drug.

351.29 **Subd. 8. Dispensing requirements.** (a) Donated drugs and supplies may be dispensed
351.30 if the drugs or supplies are prescribed by a practitioner for use by an eligible individual and
351.31 are dispensed by a pharmacist or practitioner. A repository shall dispense drugs and supplies
351.32 to eligible individuals in the following priority order: (1) individuals who are uninsured;
351.33 (2) individuals with no prescription drug coverage; and (3) individuals who are underinsured.

352.1 A repository shall dispense donated ~~prescription~~ drugs in compliance with applicable federal
352.2 and state laws and regulations for dispensing ~~prescription~~ drugs, including all requirements
352.3 relating to packaging, labeling, record keeping, drug utilization review, and patient
352.4 counseling.

352.5 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
352.6 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
352.7 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
352.8 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

352.9 (c) Before a drug or supply is dispensed or administered to an individual, the individual
352.10 must sign a drug repository recipient form acknowledging that the individual understands
352.11 the information stated on the form. The board shall develop the form and make it available
352.12 on the board's website. The form must include the following information:

352.13 (1) that the drug or supply being dispensed or administered has been donated and may
352.14 have been previously dispensed;

352.15 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
352.16 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
352.17 its original, unopened packaging; and

352.18 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
352.19 central repository or local repository, the Board of Pharmacy, and any other participant of
352.20 the ~~drug~~ medication repository program cannot guarantee the safety of the drug or medical
352.21 supply being dispensed or administered and that the pharmacist or practitioner has determined
352.22 that the drug or supply is safe to dispense or administer based on the accuracy of the donor's
352.23 form submitted with the donated drug or medical supply and the visual inspection required
352.24 to be performed by the pharmacist or practitioner before dispensing or administering.

352.25 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
352.26 receiving a drug or supply a handling fee of no more than 250 percent of the medical
352.27 assistance program dispensing fee for each drug or medical supply dispensed or administered
352.28 by that repository.

352.29 (b) A repository that dispenses or administers a drug or medical supply through the drug
352.30 repository program shall not receive reimbursement under the medical assistance program
352.31 or the MinnesotaCare program for that dispensed or administered drug or supply.

353.1 Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and
 353.2 local repositories may distribute drugs and supplies donated under the drug repository
 353.3 program to other participating repositories for use pursuant to this program.

353.4 (b) A local repository that elects not to dispense donated drugs or supplies must transfer
 353.5 all donated drugs and supplies to the central repository. A copy of the donor form that was
 353.6 completed by the original donor under subdivision 6 must be provided to the central
 353.7 repository at the time of transfer.

353.8 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
 353.9 for the administration of this program shall be utilized by the participants of the program
 353.10 and shall be available on the board's website:

353.11 (1) intake application form described under subdivision 5;

353.12 (2) local repository participation form described under subdivision 4;

353.13 (3) local repository withdrawal form described under subdivision 4;

353.14 (4) ~~drug~~ medication repository donor form described under subdivision 6;

353.15 (5) record of destruction form described under subdivision 7; and

353.16 (6) ~~drug~~ medication repository recipient form described under subdivision 8.

353.17 (b) All records, including drug inventory, inspection, and disposal of donated ~~prescription~~
 353.18 drugs and medical supplies, must be maintained by a repository for a minimum of two years.
 353.19 Records required as part of this program must be maintained pursuant to all applicable
 353.20 practice acts.

353.21 (c) Data collected by the ~~drug~~ medication repository program from all local repositories
 353.22 shall be submitted quarterly or upon request to the central repository. Data collected may
 353.23 consist of the information, records, and forms required to be collected under this section.

353.24 (d) The central repository shall submit reports to the board as required by the contract
 353.25 or upon request of the board.

353.26 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
 353.27 or civil liability for injury, death, or loss to a person or to property for causes of action
 353.28 described in clauses (1) and (2). A manufacturer is not liable for:

353.29 (1) the intentional or unintentional alteration of the drug or supply by a party not under
 353.30 the control of the manufacturer; or

354.1 (2) the failure of a party not under the control of the manufacturer to transfer or
354.2 communicate product or consumer information or the expiration date of the donated drug
354.3 or supply.

354.4 (b) A health care facility participating in the program, a pharmacist dispensing a drug
354.5 or supply pursuant to the program, a practitioner dispensing or administering a drug or
354.6 supply pursuant to the program, or a donor of a drug or medical supply is immune from
354.7 civil liability for an act or omission that causes injury to or the death of an individual to
354.8 whom the drug or supply is dispensed and no disciplinary action by a health-related licensing
354.9 board shall be taken against a pharmacist or practitioner so long as the drug or supply is
354.10 donated, accepted, distributed, and dispensed according to the requirements of this section.
354.11 This immunity does not apply if the act or omission involves reckless, wanton, or intentional
354.12 misconduct, or malpractice unrelated to the quality of the drug or medical supply.

354.13 Subd. 13. **Drug returned for credit.** Nothing in this section allows a long-term care
354.14 facility to donate a drug to a central or local repository when federal or state law requires
354.15 the drug to be returned to the pharmacy that initially dispensed it, so that the pharmacy can
354.16 credit the payer for the amount of the drug returned.

354.17 Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy,
354.18 may enter into an agreement with another state that has an established drug repository or
354.19 drug donation program if the other state's program includes regulations to ensure the purity,
354.20 integrity, and safety of the drugs and supplies donated, to permit the central repository to
354.21 offer to another state program inventory that is not needed by a Minnesota resident and to
354.22 accept inventory from another state program to be distributed to local repositories and
354.23 dispensed to Minnesota residents in accordance with this program.

354.24 Subd. 15. **Funding.** The central repository may seek grants and other funds from nonprofit
354.25 charitable organizations, the federal government, and other sources to fund the ongoing
354.26 operations of the medication repository program.

354.27 Sec. 56. Minnesota Statutes 2020, section 152.125, is amended to read:

354.28 **152.125 INTRACTABLE PAIN.**

354.29 Subdivision 1. ~~Definition~~ **Definitions.** (a) For purposes of this section, the terms in this
354.30 subdivision have the meanings given.

354.31 (b) "Drug diversion" means the unlawful transfer of prescription drugs from their licit
354.32 medical purpose to the illicit marketplace.

355.1 (c) "Intractable pain" means a pain state in which the cause of the pain cannot be removed
355.2 or otherwise treated with the consent of the patient and in which, in the generally accepted
355.3 course of medical practice, no relief or cure of the cause of the pain is possible, or none has
355.4 been found after reasonable efforts. Conditions associated with intractable pain include but
355.5 are not limited to cancer and the recovery period, sickle cell disease, noncancer pain, rare
355.6 diseases, orphan diseases, severe injuries, and health conditions requiring the provision of
355.7 palliative care or hospice care. Reasonable efforts for relieving or curing the cause of the
355.8 pain may be determined on the basis of, but are not limited to, the following:

355.9 (1) when treating a nonterminally ill patient for intractable pain, an evaluation conducted
355.10 by the attending physician and one or more physicians specializing in pain medicine or the
355.11 treatment of the area, system, or organ of the body confirmed or perceived as the source of
355.12 the intractable pain; or

355.13 (2) when treating a terminally ill patient, an evaluation conducted by the attending
355.14 physician who does so in accordance with the standard of care and the level of care, skill,
355.15 and treatment that would be recognized by a reasonably prudent physician under similar
355.16 conditions and circumstances.

355.17 (d) "Palliative care" has the meaning provided in section 144A.75, subdivision 12.

355.18 (e) "Rare disease" means a disease, disorder, or condition that affects fewer than 200,000
355.19 individuals in the United States and is chronic, serious, life altering, or life threatening.

355.20 **Subd. 1a. Criteria for the evaluation and treatment of intractable pain.** The evaluation
355.21 and treatment of intractable pain when treating a nonterminally ill patient is governed by
355.22 the following criteria:

355.23 (1) a diagnosis of intractable pain by the treating physician and either by a physician
355.24 specializing in pain medicine or a physician treating the area, system, or organ of the body
355.25 that is the source of the pain is sufficient to meet the definition of intractable pain; and

355.26 (2) the cause of the diagnosis of intractable pain must not interfere with medically
355.27 necessary treatment including but not limited to prescribing or administering a controlled
355.28 substance in Schedules II to V of section 152.02.

355.29 **Subd. 2. Prescription and administration of controlled substances for intractable**
355.30 **pain.** (a) Notwithstanding any other provision of this chapter, a physician, advanced practice
355.31 registered nurse, or physician assistant may prescribe or administer a controlled substance
355.32 in Schedules II to V of section 152.02 to an individual a patient in the course of the
355.33 physician's, advanced practice registered nurse's, or physician assistant's treatment of the

356.1 ~~individual patient~~ for a diagnosed condition causing intractable pain. No physician, advanced
356.2 practice registered nurse, or physician assistant shall be subject to disciplinary action by
356.3 the Board of Medical Practice or Board of Nursing for appropriately prescribing or
356.4 administering a controlled substance in Schedules II to V of section 152.02 in the course
356.5 of treatment of ~~an individual~~ a patient for intractable pain, provided the physician, advanced
356.6 practice registered nurse, or physician assistant:

356.7 (1) keeps accurate records of the purpose, use, prescription, and disposal of controlled
356.8 substances, writes accurate prescriptions, and prescribes medications in conformance with
356.9 chapter 147- ~~or 148~~ or in accordance with the current standard of care; and

356.10 (2) enters into a patient-provider agreement that meets the criteria in subdivision 5.

356.11 (b) No physician, advanced practice registered nurse, or physician assistant, acting in
356.12 good faith and based on the needs of the patient, shall be subject to any civil or criminal
356.13 action or investigation, disenrollment, or termination by the commissioner of health or
356.14 human services solely for prescribing a dosage that equates to an upward deviation from
356.15 morphine milligram equivalent dosage recommendations or thresholds specified in state or
356.16 federal opioid prescribing guidelines or policies, including but not limited to the Guideline
356.17 for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and
356.18 Prevention, Minnesota opioid prescribing guidelines, the Minnesota opioid prescribing
356.19 improvement program, and the Minnesota quality improvement program established under
356.20 section 256B.0638.

356.21 (c) A physician, advanced practice registered nurse, or physician assistant treating
356.22 intractable pain by prescribing, dispensing, or administering a controlled substance in
356.23 Schedules II to V of section 152.02 that includes but is not opioid analgesics must not taper
356.24 a patient's medication dosage solely to meet a predetermined morphine milligram equivalent
356.25 dosage recommendation or threshold if the patient is stable and compliant with the treatment
356.26 plan, is experiencing no serious harm from the level of medication currently being prescribed
356.27 or previously prescribed, and is in compliance with the patient-provider agreement as
356.28 described in subdivision 5.

356.29 (d) A physician's, advanced practice registered nurse's, or physician assistant's decision
356.30 to taper a patient's medication dosage must be based on factors other than a morphine
356.31 milligram equivalent recommendation or threshold.

356.32 (e) No pharmacist, health plan company, or pharmacy benefit manager shall refuse to
356.33 fill a prescription for an opiate issued by a licensed practitioner with the authority to prescribe

357.1 opiates solely based on the prescription exceeding a predetermined morphine milligram
357.2 equivalent dosage recommendation or threshold.

357.3 Subd. 3. **Limits on applicability.** This section does not apply to:

357.4 (1) a physician's, advanced practice registered nurse's, or physician assistant's treatment
357.5 of an individual a patient for chemical dependency resulting from the use of controlled
357.6 substances in Schedules II to V of section 152.02;

357.7 (2) the prescription or administration of controlled substances in Schedules II to V of
357.8 section 152.02 to an individual a patient whom the physician, advanced practice registered
357.9 nurse, or physician assistant knows to be using the controlled substances for nontherapeutic
357.10 or drug diversion purposes;

357.11 (3) the prescription or administration of controlled substances in Schedules II to V of
357.12 section 152.02 for the purpose of terminating the life of an individual a patient having
357.13 intractable pain; or

357.14 (4) the prescription or administration of a controlled substance in Schedules II to V of
357.15 section 152.02 that is not a controlled substance approved by the United States Food and
357.16 Drug Administration for pain relief.

357.17 Subd. 4. **Notice of risks.** Prior to treating an individual a patient for intractable pain in
357.18 accordance with subdivision 2, a physician, advanced practice registered nurse, or physician
357.19 assistant shall discuss with the individual patient or the patient's legal guardian, if applicable,
357.20 the risks associated with the controlled substances in Schedules II to V of section 152.02
357.21 to be prescribed or administered in the course of the physician's, advanced practice registered
357.22 nurse's, or physician assistant's treatment of an individual a patient, and document the
357.23 discussion in the individual's patient's record as required in the patient-provider agreement
357.24 described in subdivision 5.

357.25 Subd. 5. **Patient-provider agreement.** (a) Before treating a patient for intractable pain,
357.26 a physician, advanced practice registered nurse, or physician assistant and the patient or the
357.27 patient's legal guardian, if applicable, must mutually agree to the treatment and enter into
357.28 a provider-patient agreement. The agreement must include a description of the prescriber's
357.29 and the patient's expectations, responsibilities, and rights according to best practices and
357.30 current standards of care.

357.31 (b) The agreement must be signed by the patient or the patient's legal guardian, if
357.32 applicable, and the physician, advanced practice registered nurse, or physician assistant and

358.1 included in the patient's medical records. A copy of the signed agreement must be provided
358.2 to the patient.

358.3 (c) The agreement must be reviewed by the patient and the physician, advanced practice
358.4 registered nurse, or physician assistant annually. If there is a change in the patient's treatment
358.5 plan, the agreement must be updated and a revised agreement must be signed by the patient
358.6 or the patient's legal guardian. A copy of the revised agreement must be included in the
358.7 patient's medical record and a copy must be provided to the patient.

358.8 (d) A patient-provider agreement is not required in an emergency or inpatient hospital
358.9 setting.

358.10 Sec. 57. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 13, is
358.11 amended to read:

358.12 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
358.13 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
358.14 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
358.15 dispensing physician, or by a physician, a physician assistant, or an advanced practice
358.16 registered nurse employed by or under contract with a community health board as defined
358.17 in section 145A.02, subdivision 5, for the purposes of communicable disease control.

358.18 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
358.19 unless authorized by the commissioner or the drug appears on the 90-day supply list published
358.20 by the commissioner. The 90-day supply list shall be published by the commissioner on the
358.21 department's website. The commissioner may add to, delete from, and otherwise modify
358.22 the 90-day supply list after providing public notice and the opportunity for a 15-day public
358.23 comment period. The 90-day supply list may include cost-effective generic drugs and shall
358.24 not include controlled substances.

358.25 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
358.26 ingredient" is defined as a substance that is represented for use in a drug and when used in
358.27 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
358.28 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
358.29 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
358.30 excipients which are included in the medical assistance formulary. Medical assistance covers
358.31 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
358.32 when the compounded combination is specifically approved by the commissioner or when
358.33 a commercially available product:

359.1 (1) is not a therapeutic option for the patient;

359.2 (2) does not exist in the same combination of active ingredients in the same strengths
359.3 as the compounded prescription; and

359.4 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
359.5 prescription.

359.6 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
359.7 a licensed practitioner or by a licensed pharmacist who meets standards established by the
359.8 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
359.9 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
359.10 with documented vitamin deficiencies, vitamins for children under the age of seven and
359.11 pregnant or nursing women, and any other over-the-counter drug identified by the
359.12 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
359.13 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
359.14 disorders, and this determination shall not be subject to the requirements of chapter 14. A
359.15 pharmacist may prescribe over-the-counter medications as provided under this paragraph
359.16 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
359.17 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
359.18 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
359.19 and make referrals as needed to other health care professionals.

359.20 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
359.21 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
359.22 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
359.23 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
359.24 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
359.25 individuals, medical assistance may cover drugs from the drug classes listed in United States
359.26 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
359.27 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
359.28 not be covered.

359.29 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
359.30 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
359.31 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
359.32 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

359.33 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
359.34 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section

360.1 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
360.2 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
360.3 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
360.4 pharmacist in accordance with section 151.37, subdivision 16.

360.5 (h) Medical assistance coverage of, and reimbursement for, antiretroviral drugs to prevent
360.6 the acquisition of human immunodeficiency virus (HIV) and any laboratory testing necessary
360.7 for therapy that uses these drugs must meet the requirements that would otherwise apply to
360.8 a health plan under section 62Q.524.

360.9 Sec. 58. Minnesota Statutes 2020, section 256B.0625, subdivision 13f, is amended to read:

360.10 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
360.11 recommend drugs which require prior authorization. The Formulary Committee shall
360.12 establish general criteria to be used for the prior authorization of brand-name drugs for
360.13 which generically equivalent drugs are available, but the committee is not required to review
360.14 each brand-name drug for which a generically equivalent drug is available.

360.15 (b) Prior authorization may be required by the commissioner before certain formulary
360.16 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
360.17 authorization directly to the commissioner. The commissioner may also request that the
360.18 Formulary Committee review a drug for prior authorization. Before the commissioner may
360.19 require prior authorization for a drug:

360.20 (1) the commissioner must provide information to the Formulary Committee on the
360.21 impact that placing the drug on prior authorization may have on the quality of patient care
360.22 and on program costs, information regarding whether the drug is subject to clinical abuse
360.23 or misuse, and relevant data from the state Medicaid program if such data is available;

360.24 (2) the Formulary Committee must review the drug, taking into account medical and
360.25 clinical data and the information provided by the commissioner; and

360.26 (3) the Formulary Committee must hold a public forum and receive public comment for
360.27 an additional 15 days.

360.28 The commissioner must provide a 15-day notice period before implementing the prior
360.29 authorization.

360.30 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
360.31 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
360.32 if:

- 361.1 (1) there is no generically equivalent drug available; and
- 361.2 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or
- 361.3 (3) the drug is part of the recipient's current course of treatment.

361.4 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
361.5 program established or administered by the commissioner. Prior authorization shall
361.6 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
361.7 illness within 60 days of when a generically equivalent drug becomes available, provided
361.8 that the brand name drug was part of the recipient's course of treatment at the time the
361.9 generically equivalent drug became available.

361.10 (d) The commissioner may require prior authorization for brand name drugs whenever
361.11 a generically equivalent product is available, even if the prescriber specifically indicates
361.12 "dispense as written-brand necessary" on the prescription as required by section 151.21,
361.13 subdivision 2.

361.14 (e) Notwithstanding this subdivision, the commissioner may automatically require prior
361.15 authorization, for a period not to exceed 180 days, for any drug that is approved by the
361.16 United States Food and Drug Administration on or after July 1, 2005. The 180-day period
361.17 begins no later than the first day that a drug is available for shipment to pharmacies within
361.18 the state. The Formulary Committee shall recommend to the commissioner general criteria
361.19 to be used for the prior authorization of the drugs, but the committee is not required to
361.20 review each individual drug. In order to continue prior authorizations for a drug after the
361.21 180-day period has expired, the commissioner must follow the provisions of this subdivision.

361.22 (f) Prior authorization under this subdivision shall comply with ~~section~~ sections 62Q.184
361.23 and 62Q.1842.

361.24 (g) Any step therapy protocol requirements established by the commissioner must comply
361.25 with ~~section~~ sections 62Q.1841 and 62Q.1842.

361.26 **Sec. 59. STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL**
361.27 **PRODUCTS.**

361.28 The commissioner of health, within the limits of existing resources, shall analyze the
361.29 effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of
361.30 biological products, interchangeable biological products, and biosimilar products. The
361.31 commissioner of health shall report findings to the chairs and ranking minority members
361.32 of the legislative committees with jurisdiction over health and human services finance and
361.33 policy and insurance by December 15, 2024.

ARTICLE 7

HEALTH INSURANCE

362.1

362.2

362.3 Section 1. Minnesota Statutes 2020, section 62A.25, subdivision 2, is amended to read:

362.4 Subd. 2. **Required coverage.** (a) Every policy, plan, certificate or contract to which this
362.5 section applies shall provide benefits for reconstructive surgery when such service is
362.6 incidental to or follows surgery resulting from injury, sickness or other diseases of the
362.7 involved part or when such service is performed on a covered dependent child because of
362.8 congenital disease or anomaly which has resulted in a functional defect as determined by
362.9 the attending physician.

362.10 (b) The coverage limitations on reconstructive surgery in paragraph (a) do not apply to
362.11 reconstructive breast surgery: (1) following mastectomies; or (2) if the patient has been
362.12 diagnosed with ectodermal dysplasia and has congenitally absent breast tissue or nipples.
362.13 ~~In these cases, Coverage for reconstructive surgery must be provided if the mastectomy is~~
362.14 ~~medically necessary as determined by the attending physician.~~

362.15 (c) Reconstructive surgery benefits include all stages of reconstruction ~~of the breast on~~
362.16 ~~which the mastectomy has been performed,~~ including surgery and reconstruction of the
362.17 other breast to produce a symmetrical appearance, and prosthesis and physical complications
362.18 at all stages ~~of a mastectomy,~~ including lymphedemas, in a manner determined in consultation
362.19 with the attending physician and patient. Coverage may be subject to annual deductible,
362.20 co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent
362.21 with those established for other benefits under the plan or coverage. Coverage may not:

362.22 (1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage
362.23 under the terms of the plan, solely for the purpose of avoiding the requirements of this
362.24 section; and

362.25 (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or
362.26 provide monetary or other incentives to an attending provider to induce the provider to
362.27 provide care to an individual participant or beneficiary in a manner inconsistent with this
362.28 section.

362.29 Written notice of the availability of the coverage must be delivered to the participant upon
362.30 enrollment and annually thereafter.

362.31 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
362.32 plans offered, issued, or sold on or after that date.

363.1 Sec. 2. [62A.255] COVERAGE OF LYMPHEDEMA TREATMENT.

363.2 Subdivision 1. Scope of coverage. This section applies to all health plans that are sold,
363.3 issued, or renewed to a Minnesota resident.

363.4 Subd. 2. Required coverage. (a) Each health plan must provide coverage for lymphedema
363.5 treatment, including coverage for compression treatment items, complex decongestive
363.6 therapy, and outpatient self-management training and education during lymphedema treatment
363.7 if prescribed by a licensed health care professional. Lymphedema compression treatment
363.8 items include: (1) compression garments, stockings, and sleeves; (2) compression devices;
363.9 and (3) bandaging systems, components, and supplies that are primarily and customarily
363.10 used in the treatment of lymphedema.

363.11 (b) If applicable to the enrollee's health plan, a health carrier may require the prescribing
363.12 health care professional to be within the enrollee's health plan provider network if the
363.13 provider network meets network adequacy requirements under section 62K.10.

363.14 (c) A health plan must not apply any cost-sharing requirements, benefit limitations, or
363.15 service limitations for lymphedema treatment and compression treatment items that place
363.16 a greater financial burden on the enrollee or are more restrictive than cost-sharing
363.17 requirements or limitations applied by the health plan to other similar services or benefits.

363.18 EFFECTIVE DATE. This section is effective January 1, 2023, and applies to any health
363.19 plan issued, sold, or renewed on or after that date.

363.20 Sec. 3. Minnesota Statutes 2020, section 62A.28, subdivision 2, is amended to read:

363.21 Subd. 2. Required coverage. Every policy, plan, certificate, or contract referred to in
363.22 subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp hair
363.23 prostheses worn for hair loss suffered as a result of alopecia areata or ectodermal dysplasias.

363.24 The coverage required by this section is subject to the co-payment, coinsurance,
363.25 deductible, and other enrollee cost-sharing requirements that apply to similar types of items
363.26 under the policy, plan, certificate, or contract and may be limited to one prosthesis per
363.27 benefit year.

363.28 EFFECTIVE DATE. This section is effective January 1, 2023, and applies to health
363.29 plans offered, issued, or sold on or after that date.

364.1 Sec. 4. Minnesota Statutes 2020, section 62A.30, is amended by adding a subdivision to
364.2 read:

364.3 Subd. 5. **Mammogram; diagnostic services and testing.** If a health care provider
364.4 determines an enrollee requires additional diagnostic services or testing after a mammogram,
364.5 a health plan must provide coverage for the additional diagnostic services or testing with
364.6 no cost sharing, including co-pay, deductible, or coinsurance.

364.7 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
364.8 plans offered, issued, or sold on or after that date.

364.9 Sec. 5. **[62A.3096] COVERAGE FOR ECTODERMAL DYSPLASIAS.**

364.10 Subdivision 1. **Definition.** For purposes of this chapter, "ectodermal dysplasias" means
364.11 a genetic disorder involving the absence or deficiency of tissues and structures derived from
364.12 the embryonic ectoderm.

364.13 Subd. 2. **Coverage.** A health plan must provide coverage for the treatment of ectodermal
364.14 dysplasias.

364.15 Subd. 3. **Dental coverage.** (a) A health plan must provide coverage for dental treatments
364.16 related to ectodermal dysplasias. Covered dental treatments must include but are not limited
364.17 to bone grafts, dental implants, orthodontia, dental prosthodontics, and dental maintenance.

364.18 (b) If a dental treatment is eligible for coverage under a dental insurance plan or other
364.19 health plan, the coverage under this subdivision is secondary.

364.20 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
364.21 plans offered, issued, or sold on or after that date.

364.22 Sec. 6. **[62Q.451] UNRESTRICTED ACCESS TO SERVICES FOR THE**
364.23 **DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES.**

364.24 (a) No health plan company may restrict the choice of an enrollee as to where the enrollee
364.25 receives services from a licensed health care provider related to the diagnosis, monitoring,
364.26 and treatment of a rare disease or condition. Except as provided in paragraph (b), for purposes
364.27 of this section, "rare disease or condition" means any disease or condition:

364.28 (1) that affects less than 200,000 persons in the United States;

364.29 (2) that affects more than 200,000 persons in the United States and a drug for treatment
364.30 has been designated as such pursuant to United States Code, title 21, section 360bb;

365.1 (3) for which a pediatric patient has received two or more clinical consultations with no
365.2 definitive diagnosis or with conflicting diagnoses, and the pediatric patient has a delay in
365.3 skill acquisition and development, regression in skill acquisition and development, or rapid
365.4 progression of symptoms; or

365.5 (4) for which a pediatric patient has received at least one clinical consultation from a
365.6 primary care provider, more than 90 days have elapsed since the initial consultation with
365.7 no definitive diagnosis, and the pediatric patient has a delay in skill acquisition and
365.8 development, regression in skill acquisition and development, or rapid progression of
365.9 symptoms.

365.10 (b) A rare disease or condition does not include an infectious disease that has widely
365.11 available and known protocols for diagnosis and treatment and that is commonly treated in
365.12 a primary care setting, even if it affects less than 200,000 persons in the United States.

365.13 (c) Cost-sharing requirements and benefit or services limitations for the diagnosis and
365.14 treatment of a rare disease or condition must not place a greater financial burden on the
365.15 enrollee or be more restrictive than those requirements for in-network medical treatment.

365.16 (d) This section does not apply to health plan coverage provided through the State
365.17 Employee Group Insurance Program (SEGIP) under chapter 43A.

365.18 **EFFECTIVE DATE.** This section is effective January 1, 2023, and applies to health
365.19 plans offered, issued, or renewed on or after that date.

365.20 Sec. 7. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
365.21 to read:

365.22 Subd. 68. **Services for the diagnosis, monitoring, and treatment of rare**
365.23 **diseases.** Medical assistance coverage for services related to the diagnosis, monitoring, and
365.24 treatment of a rare disease or condition must meet the requirements in section 62Q.451.

365.25 **EFFECTIVE DATE.** This section is effective January 1, 2023.

365.26 Sec. 8. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
365.27 to read:

365.28 Subd. 69. **Ectodermal dysplasias.** Medical assistance and MinnesotaCare cover treatment
365.29 for ectodermal dysplasias. Coverage must meet the requirements of sections 62A.25, 62A.28,
365.30 and 62A.3096.

365.31 **EFFECTIVE DATE.** This section is effective January 1, 2023.

366.1 Sec. 9. Minnesota Statutes 2020, section 256B.0631, subdivision 2, is amended to read:

366.2 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
366.3 exceptions:

366.4 (1) children under the age of 21;

366.5 (2) pregnant women for services that relate to the pregnancy or any other medical
366.6 condition that may complicate the pregnancy;

366.7 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
366.8 intermediate care facility for the developmentally disabled;

366.9 (4) recipients receiving hospice care;

366.10 (5) 100 percent federally funded services provided by an Indian health service;

366.11 (6) emergency services;

366.12 (7) family planning services;

366.13 (8) services that are paid by Medicare, resulting in the medical assistance program paying
366.14 for the coinsurance and deductible;

366.15 (9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses,
366.16 and nonemergency visits to a hospital-based emergency room;

366.17 (10) services, fee-for-service payments subject to volume purchase through competitive
366.18 bidding;

366.19 (11) American Indians who meet the requirements in Code of Federal Regulations, title
366.20 42, sections 447.51 and 447.56;

366.21 (12) persons needing treatment for breast or cervical cancer as described under section
366.22 256B.057, subdivision 10; ~~and~~

366.23 (13) services that currently have a rating of A or B from the United States Preventive
366.24 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee
366.25 on Immunization Practices of the Centers for Disease Control and Prevention, and preventive
366.26 services and screenings provided to women as described in Code of Federal Regulations,
366.27 title 45, section 147.130-; and

366.28 (14) additional diagnostic services or testing that a health care provider determines an
366.29 enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

366.30 **EFFECTIVE DATE.** This section is effective January 1, 2023.

367.1 Sec. 10. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

367.2 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
367.3 children under the age of 21 and to American Indians as defined in Code of Federal
367.4 Regulations, title 42, section 600.5.

367.5 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
367.6 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
367.7 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
367.8 services exempt from cost-sharing under state law. The cost-sharing changes described in
367.9 this paragraph shall not be implemented prior to January 1, 2016.

367.10 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
367.11 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
367.12 title 42, sections 600.510 and 600.520.

367.13 (d) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic
367.14 services or testing that a health care provider determines an enrollee requires after a
367.15 mammogram, as specified under section 62A.30, subdivision 5.

367.16 **EFFECTIVE DATE.** This section is effective January 1, 2023.

367.17 **ARTICLE 8**

367.18 **MISCELLANEOUS**

367.19 Section 1. Minnesota Statutes 2020, section 34A.01, subdivision 4, is amended to read:

367.20 Subd. 4. **Food.** "Food" means every ingredient used for, entering into the consumption
367.21 of, or used or intended for use in the preparation of food, drink, confectionery, or condiment
367.22 for humans or other animals, whether simple, mixed, or compound; and articles used as
367.23 components of these ingredients, except that edible cannabinoid products, as defined in
367.24 section 151.72, subdivision 1, paragraph (c), are not food.

367.25 Sec. 2. Minnesota Statutes 2020, section 137.68, is amended to read:

367.26 **137.68 MINNESOTA RARE DISEASE ADVISORY COUNCIL ON RARE**
367.27 **DISEASES.**

367.28 Subdivision 1. **Establishment.** ~~The University of Minnesota is requested to establish~~
367.29 There is established an advisory council on rare diseases to provide advice on policies,
367.30 access, equity, research, diagnosis, treatment, and education related to rare diseases. The
367.31 advisory council is established in honor of Chloe Barnes and her experiences in the health

368.1 care system. For purposes of this section, "rare disease" has the meaning given in United
 368.2 States Code, title 21, section 360bb. The council shall be called the ~~Chloe Barnes Advisory~~
 368.3 ~~Council on Rare Diseases~~ Minnesota Rare Disease Advisory Council. The Council on
 368.4 Disability shall house the advisory council.

368.5 Subd. 2. **Membership.** (a) The advisory council ~~may~~ shall consist of at least 17 public
 368.6 members who reflect statewide representation and are appointed by the Board of Regents
 368.7 ~~or a designee~~ the governor according to paragraph (b) and four members of the legislature
 368.8 appointed according to paragraph (c).

368.9 (b) ~~The Board of Regents or a designee is requested to~~ The governor shall appoint at
 368.10 least the following public members according to section 15.059:

368.11 (1) three physicians licensed and practicing in the state with experience researching,
 368.12 diagnosing, or treating rare diseases, including one specializing in pediatrics;

368.13 (2) one registered nurse or advanced practice registered nurse licensed and practicing
 368.14 in the state with experience treating rare diseases;

368.15 (3) at least two hospital administrators, or their designees, from hospitals in the state
 368.16 that provide care to persons diagnosed with a rare disease. One administrator or designee
 368.17 appointed under this clause must represent a hospital in which the scope of service focuses
 368.18 on rare diseases of pediatric patients;

368.19 (4) three persons age 18 or older who either have a rare disease or are a caregiver of a
 368.20 person with a rare disease. One person appointed under this clause must reside in rural
 368.21 Minnesota;

368.22 (5) a representative of a rare disease patient organization that operates in the state;

368.23 (6) a social worker with experience providing services to persons diagnosed with a rare
 368.24 disease;

368.25 (7) a pharmacist with experience with drugs used to treat rare diseases;

368.26 (8) a dentist licensed and practicing in the state with experience treating rare diseases;

368.27 (9) a representative of the biotechnology industry;

368.28 (10) a representative of health plan companies;

368.29 (11) a medical researcher with experience conducting research on rare diseases; ~~and~~

368.30 (12) a genetic counselor with experience providing services to persons diagnosed with
 368.31 a rare disease or caregivers of those persons; and

369.1 (13) representatives with other areas of expertise as identified by the advisory council.

369.2 (c) The advisory council shall include two members of the senate, one appointed by the
369.3 majority leader and one appointed by the minority leader; and two members of the house
369.4 of representatives, one appointed by the speaker of the house and one appointed by the
369.5 minority leader.

369.6 (d) The commissioner of health or a designee, a representative of Mayo Medical School,
369.7 and a representative of the University of Minnesota Medical School shall serve as ex officio,
369.8 nonvoting members of the advisory council.

369.9 (e) ~~Initial appointments to the advisory council shall be made no later than September~~
369.10 ~~1, 2019.~~ Notwithstanding section 15.059, members appointed according to paragraph (b)
369.11 shall serve for a term of three years, except that the initial members appointed according to
369.12 paragraph (b) shall have an initial term of two, three, or four years determined by lot by the
369.13 chairperson. Members appointed according to paragraph (b) shall serve until their successors
369.14 have been appointed.

369.15 (f) Members may be reappointed for additional terms according to the advisory council's
369.16 operating procedures.

369.17 Subd. 3. **Meetings.** ~~The Board of Regents or a designee is requested to convene the first~~
369.18 ~~meeting of the advisory council no later than October 1, 2019.~~ The advisory council shall
369.19 meet at the call of the chairperson or at the request of a majority of advisory council members.
369.20 Meetings of the advisory council are subject to section 13D.01, and notice of its meetings
369.21 is governed by section 13D.04.

369.22 Subd. 3a. **Chairperson; executive director; staff; executive committee.** (a) The
369.23 advisory council shall elect a chairperson and other officers as it deems necessary and in
369.24 accordance with the advisory council's operating procedures.

369.25 (b) The advisory council shall be governed by an executive committee elected by the
369.26 members of the advisory council. One member of the executive committee must be the
369.27 advisory council chairperson.

369.28 (c) The advisory council shall appoint an executive director. The executive director
369.29 serves as an ex officio nonvoting member of the executive committee. The advisory council
369.30 may delegate to the executive director any powers and duties under this section that do not
369.31 require advisory council approval. The executive director serves in the unclassified service
369.32 and may be removed at any time by a majority vote of the advisory council. The executive

370.1 director may employ and direct staff necessary to carry out advisory council mandates,
370.2 policies, activities, and objectives.

370.3 (d) The executive committee may appoint additional subcommittees and work groups
370.4 as necessary to fulfill the duties of the advisory council.

370.5 Subd. 4. **Duties.** (a) The advisory council's duties may include, but are not limited to:

370.6 (1) in conjunction with the state's medical schools, the state's schools of public health,
370.7 and hospitals in the state that provide care to persons diagnosed with a rare disease,
370.8 developing resources or recommendations relating to quality of and access to treatment and
370.9 services in the state for persons with a rare disease, including but not limited to:

370.10 (i) a list of existing, publicly accessible resources on research, diagnosis, treatment, and
370.11 education relating to rare diseases;

370.12 (ii) identifying best practices for rare disease care implemented in other states, at the
370.13 national level, and at the international level that will improve rare disease care in the state
370.14 and seeking opportunities to partner with similar organizations in other states and countries;

370.15 (iii) identifying and addressing problems faced by patients with a rare disease when
370.16 changing health plans, including recommendations on how to remove obstacles faced by
370.17 these patients to finding a new health plan and how to improve the ease and speed of finding
370.18 a new health plan that meets the needs of patients with a rare disease; ~~and~~

370.19 (iv) identifying and addressing barriers faced by patients with a rare disease to obtaining
370.20 care, caused by prior authorization requirements in private and public health plans; and

370.21 ~~(iv)~~ (v) identifying, recommending, and implementing best practices to ensure health
370.22 care providers are adequately informed of the most effective strategies for recognizing and
370.23 treating rare diseases; ~~and~~

370.24 (2) advising, consulting, and cooperating with the Department of Health, including the
370.25 Advisory Committee on Heritable and Congenital Disorders; the Department of Human
370.26 Services, including the Drug Utilization Review Board and the Drug Formulary Committee;
370.27 and other agencies of state government in developing recommendations, information, and
370.28 programs for the public and the health care community relating to diagnosis, treatment, and
370.29 awareness of rare diseases;

370.30 (3) advising on policy issues and advancing policy initiatives at the state and federal
370.31 levels; and

370.32 (4) receiving funds and issuing grants.

371.1 (b) The advisory council shall collect additional topic areas for study and evaluation
 371.2 from the general public. In order for the advisory council to study and evaluate a topic, the
 371.3 topic must be approved for study and evaluation by the advisory council.

371.4 Subd. 5. **Conflict of interest.** Advisory council members are subject to the ~~Board of~~
 371.5 ~~Regents policy on conflicts~~ advisory council's conflict of interest policy as outlined in the
 371.6 advisory council's operating procedures.

371.7 Subd. 6. **Annual report.** By January 1 of each year, beginning January 1, 2020, the
 371.8 advisory council shall report to the chairs and ranking minority members of the legislative
 371.9 committees with jurisdiction over higher education and health care policy on the advisory
 371.10 council's activities under subdivision 4 and other issues on which the advisory council may
 371.11 choose to report.

371.12 Sec. 3. Minnesota Statutes 2020, section 151.72, subdivision 1, is amended to read:

371.13 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
 371.14 the meanings given.

371.15 (b) "Certified hemp" means hemp plants that have been tested and found to meet the
 371.16 requirements of chapter 18K and the rules adopted thereunder.

371.17 (c) "Edible cannabinoid product" means any product that is intended to be eaten or
 371.18 consumed as a beverage by humans, contains a cannabinoid in combination with food
 371.19 ingredients, and is not a drug.

371.20 ~~(b)~~ (d) "Hemp" has the meaning given to "industrial hemp" in section 18K.02, subdivision
 371.21 3.

371.22 (e) "Label" has the meaning given in section 151.01, subdivision 18.

371.23 ~~(e)~~ (f) "Labeling" means all labels and other written, printed, or graphic matter that are:

371.24 (1) affixed to the immediate container in which a product regulated under this section
 371.25 is sold; ~~or~~

371.26 (2) provided, in any manner, with the immediate container, including but not limited to
 371.27 outer containers, wrappers, package inserts, brochures, or pamphlets; ~~or~~ or

371.28 (3) provided on that portion of a manufacturer's website that is linked by a scannable
 371.29 barcode or matrix barcode.

372.1 (g) "Matrix barcode" means a code that stores data in a two-dimensional array of
372.2 geometrically shaped dark and light cells capable of being read by the camera on a
372.3 smartphone or other mobile device.

372.4 (h) "Nonintoxicating cannabinoid" means substances extracted from certified hemp
372.5 plants that do not produce intoxicating effects when consumed by any route of administration.

372.6 Sec. 4. Minnesota Statutes 2020, section 151.72, subdivision 2, is amended to read:

372.7 Subd. 2. **Scope.** (a) This section applies to the sale of any product that contains
372.8 ~~nonintoxicating~~ cannabinoids extracted from hemp ~~other than food~~ and that is an edible
372.9 cannabinoid product or is intended for human or animal consumption by any route of
372.10 administration.

372.11 (b) This section does not apply to any product dispensed by a registered medical cannabis
372.12 manufacturer pursuant to sections 152.22 to 152.37.

372.13 (c) The board must have no authority over food products, as defined in section 34A.01,
372.14 subdivision 4, that do not contain cannabinoids extracted or derived from hemp.

372.15 Sec. 5. Minnesota Statutes 2020, section 151.72, subdivision 3, is amended to read:

372.16 Subd. 3. **Sale of cannabinoids derived from hemp.** (a) Notwithstanding any other
372.17 section of this chapter, a product containing nonintoxicating cannabinoids, including an
372.18 edible cannabinoid product, may be sold for human or animal consumption only if all of
372.19 the requirements of this section are met, provided that a product sold for human or animal
372.20 consumption does not contain more than 0.3 percent of any tetrahydrocannabinol and an
372.21 edible cannabinoid product does not contain an amount of any tetrahydrocannabinol that
372.22 exceeds the limits established in subdivision 5a, paragraph (f).

372.23 (b) No other substance extracted or otherwise derived from hemp may be sold for human
372.24 consumption if the substance is intended:

372.25 (1) for external or internal use in the diagnosis, cure, mitigation, treatment, or prevention
372.26 of disease in humans or other animals; or

372.27 (2) to affect the structure or any function of the bodies of humans or other animals.

372.28 (c) No product containing any cannabinoid or tetrahydrocannabinol extracted or otherwise
372.29 derived from hemp may be sold to any individual who is under the age of 21.

372.30 (d) Products that meet the requirements of this section are not controlled substances
372.31 under section 152.02.

373.1 Sec. 6. Minnesota Statutes 2020, section 151.72, subdivision 4, is amended to read:

373.2 Subd. 4. **Testing requirements.** (a) A manufacturer of a product regulated under this
373.3 section must submit representative samples of the product to an independent, accredited
373.4 laboratory in order to certify that the product complies with the standards adopted by the
373.5 board. Testing must be consistent with generally accepted industry standards for herbal and
373.6 botanical substances, and, at a minimum, the testing must confirm that the product:

373.7 (1) contains the amount or percentage of cannabinoids that is stated on the label of the
373.8 product;

373.9 (2) does not contain more than trace amounts of any mold, residual solvents, pesticides,
373.10 fertilizers, or heavy metals; and

373.11 (3) does not contain a ~~delta-9 tetrahydrocannabinol concentration that exceeds the~~
373.12 ~~concentration permitted for industrial hemp as defined in section 18K.02, subdivision 3.~~
373.13 more than 0.3 percent of any tetrahydrocannabinol.

373.14 (b) Upon the request of the board, the manufacturer of the product must provide the
373.15 board with the results of the testing required in this section.

373.16 (c) Testing of the hemp from which the nonintoxicating cannabinoid was derived, or
373.17 possession of a certificate of analysis for such hemp, does not meet the testing requirements
373.18 of this section.

373.19 Sec. 7. Minnesota Statutes 2021 Supplement, section 151.72, subdivision 5, is amended
373.20 to read:

373.21 Subd. 5. **Labeling requirements.** (a) A product regulated under this section must bear
373.22 a label that contains, at a minimum:

373.23 (1) the name, location, contact phone number, and website of the manufacturer of the
373.24 product;

373.25 (2) the name and address of the independent, accredited laboratory used by the
373.26 manufacturer to test the product; and

373.27 (3) an accurate statement of the amount or percentage of cannabinoids found in each
373.28 unit of the product meant to be consumed; ~~or.~~

373.29 (4) ~~instead of the information required in clauses (1) to (3), a scannable bar code or QR~~
373.30 ~~code that links to the manufacturer's website.~~

374.1 (b) The information in paragraph (a) may be provided on an outer package if the
 374.2 immediate container that holds the product is too small to contain all of the information.

374.3 (c) The information required in paragraph (a) may be provided through the use of a
 374.4 scannable barcode or matrix barcode that links to a page on the manufacturer's website if
 374.5 that page contains all of the information required by this subdivision.

374.6 (d) The label must also include a statement stating that ~~this~~ the product does not claim
 374.7 to diagnose, treat, cure, or prevent any disease and has not been evaluated or approved by
 374.8 the United States Food and Drug Administration (FDA) unless the product has been so
 374.9 approved.

374.10 ~~(b)~~ (e) The information required to be on the label by this subdivision must be prominently
 374.11 and conspicuously placed ~~and~~ on the label or displayed on the website in terms that can be
 374.12 easily read and understood by the consumer.

374.13 ~~(e)~~ (f) The ~~label~~ labeling must not contain any claim that the product may be used or is
 374.14 effective for the prevention, treatment, or cure of a disease or that it may be used to alter
 374.15 the structure or function of human or animal bodies, unless the claim has been approved by
 374.16 the FDA.

374.17 Sec. 8. Minnesota Statutes 2020, section 151.72, is amended by adding a subdivision to
 374.18 read:

374.19 Subd. 5a. **Additional requirements for edible cannabinoid products.** (a) In addition
 374.20 to the testing and labeling requirements under subdivisions 4 and 5, an edible cannabinoid
 374.21 must meet the requirements of this subdivision.

374.22 (b) An edible cannabinoid product must not:

374.23 (1) bear the likeness or contain cartoon-like characteristics of a real or fictional person,
 374.24 animal, or fruit that appeals to children;

374.25 (2) be modeled after a brand of products primarily consumed by or marketed to children;

374.26 (3) be made by applying an extracted or concentrated hemp-derived cannabinoid to a
 374.27 commercially available candy or snack food item;

374.28 (4) contain an ingredient, other than a hemp-derived cannabinoid, that is not approved
 374.29 by the United States Food and Drug Administration for use in food;

374.30 (5) be packaged in a way that resembles the trademarked, characteristic, or
 374.31 product-specialized packaging of any commercially available food product; or

375.1 (6) be packaged in a container that includes a statement, artwork, or design that could
375.2 reasonably mislead any person to believe that the package contains anything other than an
375.3 edible cannabinoid product.

375.4 (c) An edible cannabinoid product must be prepackaged in packaging or a container that
375.5 is child-resistant, tamper-evident, and opaque or placed in packaging or a container that is
375.6 child-resistant, tamper-evident, and opaque at the final point of sale to a customer. The
375.7 requirement that packaging be child-resistant does not apply to an edible cannabinoid product
375.8 that is intended to be consumed as a beverage and which contains no more than a trace
375.9 amount of any tetrahydrocannabinol.

375.10 (d) If an edible cannabinoid product is intended for more than a single use or contains
375.11 multiple servings, each serving must be indicated by scoring, wrapping, or other indicators
375.12 designating the individual serving size.

375.13 (e) A label containing at least the following information must be affixed to the packaging
375.14 or container of all edible cannabinoid products sold to consumers:

375.15 (1) the serving size;

375.16 (2) the cannabinoid profile per serving and in total;

375.17 (3) a list of ingredients, including identification of any major food allergens declared
375.18 by name; and

375.19 (4) the following statement: "Keep this product out of reach of children."

375.20 (f) An edible cannabinoid product must not contain more than five milligrams of any
375.21 tetrahydrocannabinol in a single serving, or more than a total of 50 milligrams of any
375.22 tetrahydrocannabinol per package.

375.23 Sec. 9. Minnesota Statutes 2020, section 151.72, subdivision 6, is amended to read:

375.24 Subd. 6. **Enforcement.** (a) A product ~~sold~~ regulated under this section, including an
375.25 edible cannabinoid product, shall be considered an adulterated drug if:

375.26 (1) it consists, in whole or in part, of any filthy, putrid, or decomposed substance;

375.27 (2) it has been produced, prepared, packed, or held under unsanitary conditions where
375.28 it may have been rendered injurious to health, or where it may have been contaminated with
375.29 filth;

375.30 (3) its container is composed, in whole or in part, of any poisonous or deleterious
375.31 substance that may render the contents injurious to health;

376.1 (4) it contains any food additives, color additives, or excipients that have been found by
376.2 the FDA to be unsafe for human or animal consumption; ~~or~~

376.3 (5) it contains an amount or percentage of nonintoxicating cannabinoids that is different
376.4 than the amount or percentage stated on the label;

376.5 (6) it contains more than 0.3 percent of any tetrahydrocannabinol or, if the product is
376.6 an edible cannabinoid product, an amount of tetrahydrocannabinol that exceeds the limits
376.7 established in subdivision 5a, paragraph (f); or

376.8 (7) it contains more than trace amounts of mold, residual solvents, pesticides, fertilizers,
376.9 or heavy metals.

376.10 (b) A product ~~sold~~ regulated under this section shall be considered a misbranded drug
376.11 if the product's labeling is false or misleading in any manner or in violation of the
376.12 requirements of this section.

376.13 (c) The board's authority to issue cease and desist orders under section 151.06; to embargo
376.14 adulterated and misbranded drugs under section 151.38; and to seek injunctive relief under
376.15 section 214.11, extends to any violation of this section.

376.16 Sec. 10. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

376.17 Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance,
376.18 the chemical structure of which is substantially similar to the chemical structure of a
376.19 controlled substance in Schedule I or II:

376.20 (1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system
376.21 that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic
376.22 effect on the central nervous system of a controlled substance in Schedule I or II; or

376.23 (2) with respect to a particular person, if the person represents or intends that the substance
376.24 have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is
376.25 substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect
376.26 on the central nervous system of a controlled substance in Schedule I or II.

376.27 (b) "Analog" does not include:

376.28 (1) a controlled substance;

376.29 (2) any substance for which there is an approved new drug application under the Federal
376.30 Food, Drug, and Cosmetic Act; ~~or~~

377.1 (3) with respect to a particular person, any substance, if an exemption is in effect for
377.2 investigational use, for that person, as provided by United States Code, title 21, section 355,
377.3 and the person is registered as a controlled substance researcher as required under section
377.4 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the
377.5 exemption and registration; or

377.6 (4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus
377.7 cannabis or in the resinous extractives of the plant.

377.8 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes
377.9 committed on or after that date.

377.10 Sec. 11. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

377.11 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

377.12 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
377.13 following substances, including their analogs, isomers, esters, ethers, salts, and salts of
377.14 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
377.15 and salts is possible:

377.16 (1) acetylmethadol;

377.17 (2) allylprodine;

377.18 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
377.19 acetate);

377.20 (4) alphameprodine;

377.21 (5) alphamethadol;

377.22 (6) alpha-methylfentanyl benzethidine;

377.23 (7) betacetylmethadol;

377.24 (8) betameprodine;

377.25 (9) betamethadol;

377.26 (10) betaprodine;

377.27 (11) clonitazene;

377.28 (12) dextromoramide;

377.29 (13) diampromide;

- 378.1 (14) diethylambutene;
- 378.2 (15) difenoxin;
- 378.3 (16) dimenoxadol;
- 378.4 (17) dimepheptanol;
- 378.5 (18) dimethylambutene;
- 378.6 (19) dioxaphetyl butyrate;
- 378.7 (20) dipipanone;
- 378.8 (21) ethylmethylthiambutene;
- 378.9 (22) etonitazene;
- 378.10 (23) etoxeridine;
- 378.11 (24) furethidine;
- 378.12 (25) hydroxypethidine;
- 378.13 (26) ketobemidone;
- 378.14 (27) levomoramide;
- 378.15 (28) levophenacylmorphane;
- 378.16 (29) 3-methylfentanyl;
- 378.17 (30) acetyl-alpha-methylfentanyl;
- 378.18 (31) alpha-methylthiofentanyl;
- 378.19 (32) benzylfentanyl beta-hydroxyfentanyl;
- 378.20 (33) beta-hydroxy-3-methylfentanyl;
- 378.21 (34) 3-methylthiofentanyl;
- 378.22 (35) thenylfentanyl;
- 378.23 (36) thiofentanyl;
- 378.24 (37) para-fluorofentanyl;
- 378.25 (38) morpheridine;
- 378.26 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- 378.27 (40) noracymethadol;

- 379.1 (41) norlevorphanol;
- 379.2 (42) normethadone;
- 379.3 (43) norpipanone;
- 379.4 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- 379.5 (45) phenadoxone;
- 379.6 (46) phenampromide;
- 379.7 (47) phenomorphan;
- 379.8 (48) phenoperidine;
- 379.9 (49) piritramide;
- 379.10 (50) proheptazine;
- 379.11 (51) properidine;
- 379.12 (52) propiram;
- 379.13 (53) racemoramide;
- 379.14 (54) tilidine;
- 379.15 (55) trimeperidine;
- 379.16 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);
- 379.17 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
- 379.18 methylbenzamide(U47700);
- 379.19 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);
- 379.20 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);
- 379.21 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropyl
- 379.22 fentanyl);
- 379.23 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);
- 379.24 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);
- 379.25 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
- 379.26 fentanyl);
- 379.27 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);
- 379.28 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);

- 380.1 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
380.2 (para-chloroisobutyryl fentanyl);
- 380.3 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
380.4 fentanyl);
- 380.5 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
380.6 (para-methoxybutyryl fentanyl);
- 380.7 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);
- 380.8 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
380.9 fentanyl or para-fluoroisobutyryl fentanyl);
- 380.10 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
380.11 acryloylfentanyl);
- 380.12 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
380.13 fentanyl);
- 380.14 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
380.15 or 2-fluorofentanyl);
- 380.16 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
380.17 (tetrahydrofuranyl fentanyl); and
- 380.18 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
380.19 esters and ethers, meaning any substance not otherwise listed under another federal
380.20 Administration Controlled Substance Code Number or not otherwise listed in this section,
380.21 and for which no exemption or approval is in effect under section 505 of the Federal Food,
380.22 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
380.23 to fentanyl by one or more of the following modifications:
- 380.24 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
380.25 or not further substituted in or on the monocycle;
- 380.26 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo,
380.27 haloalkyl, amino, or nitro groups;
- 380.28 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether,
380.29 hydroxyl, halo, haloalkyl, amino, or nitro groups;
- 380.30 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
380.31 substituted in or on the aromatic monocycle; or

- 381.1 (v) replacement of the N-propionyl group by another acyl group.
- 381.2 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
381.3 and salts of isomers, unless specifically excepted or unless listed in another schedule,
381.4 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 381.5 (1) acetorphine;
- 381.6 (2) acetyldihydrocodeine;
- 381.7 (3) benzylmorphine;
- 381.8 (4) codeine methylbromide;
- 381.9 (5) codeine-n-oxide;
- 381.10 (6) cyprenorphine;
- 381.11 (7) desomorphine;
- 381.12 (8) dihydromorphine;
- 381.13 (9) drotebanol;
- 381.14 (10) etorphine;
- 381.15 (11) heroin;
- 381.16 (12) hydromorphenol;
- 381.17 (13) methyl-desorphine;
- 381.18 (14) methyldihydromorphine;
- 381.19 (15) morphine methylbromide;
- 381.20 (16) morphine methylsulfonate;
- 381.21 (17) morphine-n-oxide;
- 381.22 (18) myrophine;
- 381.23 (19) nicocodeine;
- 381.24 (20) nicomorphine;
- 381.25 (21) normorphine;
- 381.26 (22) pholcodine; and
- 381.27 (23) thebacon.

382.1 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
382.2 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
382.3 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
382.4 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
382.5 possible:

- 382.6 (1) methylenedioxy amphetamine;
- 382.7 (2) methylenedioxymethamphetamine;
- 382.8 (3) methylenedioxy-N-ethylamphetamine (MDEA);
- 382.9 (4) n-hydroxy-methylenedioxyamphetamine;
- 382.10 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);
- 382.11 (6) 2,5-dimethoxyamphetamine (2,5-DMA);
- 382.12 (7) 4-methoxyamphetamine;
- 382.13 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;
- 382.14 (9) alpha-ethyltryptamine;
- 382.15 (10) bufotenine;
- 382.16 (11) diethyltryptamine;
- 382.17 (12) dimethyltryptamine;
- 382.18 (13) 3,4,5-trimethoxyamphetamine;
- 382.19 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);
- 382.20 (15) ibogaine;
- 382.21 (16) lysergic acid diethylamide (LSD);
- 382.22 (17) mescaline;
- 382.23 (18) parahexyl;
- 382.24 (19) N-ethyl-3-piperidyl benzilate;
- 382.25 (20) N-methyl-3-piperidyl benzilate;
- 382.26 (21) psilocybin;
- 382.27 (22) psilocyn;
- 382.28 (23) tenocyclidine (TPCP or TCP);

- 383.1 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- 383.2 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- 383.3 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- 383.4 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- 383.5 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- 383.6 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- 383.7 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- 383.8 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- 383.9 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- 383.10 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- 383.11 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- 383.12 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- 383.13 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- 383.14 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);
- 383.15 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
- 383.16 (2-CB-FLY);
- 383.17 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- 383.18 (40) alpha-methyltryptamine (AMT);
- 383.19 (41) N,N-diisopropyltryptamine (DiPT);
- 383.20 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);
- 383.21 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);
- 383.22 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- 383.23 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- 383.24 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- 383.25 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- 383.26 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);
- 383.27 (49) 5-methoxy- α -methyltryptamine (5-MeO-AMT);

- 384.1 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- 384.2 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- 384.3 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);
- 384.4 (53) 5-methoxy- α -ethyltryptamine (5-MeO-AET);
- 384.5 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- 384.6 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- 384.7 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- 384.8 (57) methoxetamine (MXE);
- 384.9 (58) 5-iodo-2-aminoindane (5-IAI);
- 384.10 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- 384.11 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- 384.12 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- 384.13 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- 384.14 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);
- 384.15 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- 384.16 (65) N,N-Dipropyltryptamine (DPT);
- 384.17 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- 384.18 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- 384.19 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- 384.20 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);
- 384.21 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylorketamine,
- 384.22 ethketamine, NENK);
- 384.23 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);
- 384.24 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and
- 384.25 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).
- 384.26 (e) Peyote. All parts of the plant presently classified botanically as *Lophophora williamsii*
- 384.27 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,
- 384.28 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,

385.1 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
385.2 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
385.3 Church, and members of the American Indian Church are exempt from registration. Any
385.4 person who manufactures peyote for or distributes peyote to the American Indian Church,
385.5 however, is required to obtain federal registration annually and to comply with all other
385.6 requirements of law.

385.7 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
385.8 another schedule, any material compound, mixture, or preparation which contains any
385.9 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
385.10 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

385.11 (1) mecloqualone;

385.12 (2) methaqualone;

385.13 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

385.14 (4) flunitrazepam;

385.15 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
385.16 methoxyketamine);

385.17 (6) tianeptine;

385.18 (7) clonazepam;

385.19 (8) etizolam;

385.20 (9) flubromazolam; and

385.21 (10) flubromazepam.

385.22 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
385.23 material compound, mixture, or preparation which contains any quantity of the following
385.24 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
385.25 analogs, salts, isomers, and salts of isomers is possible:

385.26 (1) aminorex;

385.27 (2) cathinone;

385.28 (3) fenethylamine;

385.29 (4) methcathinone;

385.30 (5) methylaminorex;

- 386.1 (6) N,N-dimethylamphetamine;
- 386.2 (7) N-benzylpiperazine (BZP);
- 386.3 (8) methylmethcathinone (mephedrone);
- 386.4 (9) 3,4-methylenedioxy-N-methylcathinone (methydone);
- 386.5 (10) methoxymethcathinone (methedrone);
- 386.6 (11) methylenedioxypropylone (MDPV);
- 386.7 (12) 3-fluoro-N-methylcathinone (3-FMC);
- 386.8 (13) methylethcathinone (MEC);
- 386.9 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- 386.10 (15) dimethylmethcathinone (DMMC);
- 386.11 (16) fluoroamphetamine;
- 386.12 (17) fluoromethamphetamine;
- 386.13 (18) α -methylaminobutyrophenone (MABP or buphedrone);
- 386.14 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);
- 386.15 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- 386.16 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
386.17 naphyrone);
- 386.18 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- 386.19 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);
- 386.20 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- 386.21 (25) 4-methyl-N-ethylcathinone (4-MEC);
- 386.22 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- 386.23 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- 386.24 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentydone);
- 386.25 (29) 4-fluoro-N-methylcathinone (4-FMC);
- 386.26 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);
- 386.27 (31) alpha-pyrrolidinobutiophenone (α -PBP);

- 387.1 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- 387.2 (33) 1-phenyl-2-(1-pyrrolidiny)-1-heptanone (PV8);
- 387.3 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);
- 387.4 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);
- 387.5 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);
- 387.6 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);
- 387.7 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);
- 387.8 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
- 387.9 and
- 387.10 (40) any other substance, except bupropion or compounds listed under a different
- 387.11 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
- 387.12 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
- 387.13 compound is further modified in any of the following ways:
- 387.14 (i) by substitution in the ring system to any extent with alkyl, alkylendioxy, alkoxy,
- 387.15 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
- 387.16 system by one or more other univalent substituents;
- 387.17 (ii) by substitution at the 3-position with an acyclic alkyl substituent;
- 387.18 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
- 387.19 methoxybenzyl groups; or
- 387.20 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.
- 387.21 (h) ~~Marijuana~~, Synthetic tetrahydrocannabinols, and synthetic cannabinoids. Unless
- 387.22 specifically excepted or unless listed in another schedule, any ~~natural~~ or synthetic material,
- 387.23 compound, mixture, or preparation that contains any quantity of the following substances,
- 387.24 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
- 387.25 the existence of the isomers, esters, ethers, or salts is possible:
- 387.26 ~~(1) marijuana;~~
- 387.27 ~~(2) (1) synthetic~~ tetrahydrocannabinols ~~naturally contained in a plant of the genus~~
- 387.28 ~~Cannabis~~, that are the synthetic equivalents of the substances contained in the cannabis
- 387.29 plant or in the resinous extractives of the plant, or synthetic substances with similar chemical
- 387.30 structure and pharmacological activity to those substances contained in the plant or resinous

388.1 extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans
388.2 tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol; and

388.3 ~~(3)~~ (2) synthetic cannabinoids, including the following substances:

388.4 (i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole
388.5 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
388.6 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
388.7 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
388.8 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
388.9 naphthoylindoles include, but are not limited to:

388.10 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

388.11 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

388.12 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

388.13 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

388.14 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

388.15 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

388.16 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

388.17 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

388.18 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

388.19 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

388.20 (ii) Naphthylmethylindoles, which are any compounds containing a
388.21 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the
388.22 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
388.23 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further
388.24 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
388.25 ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

388.26 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

388.27 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

388.28 (iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole
388.29 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
388.30 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
388.31 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any

389.1 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
389.2 naphthoylpyrroles include, but are not limited to,
389.3 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

389.4 (iv) Naphthylmethylenes, which are any compounds containing a naphthylideneindene
389.5 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
389.6 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
389.7 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
389.8 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
389.9 naphthylmethylenes include, but are not limited to,
389.10 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

389.11 (v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole
389.12 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
389.13 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
389.14 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
389.15 extent, whether or not substituted in the phenyl ring to any extent. Examples of
389.16 phenylacetylindoles include, but are not limited to:

389.17 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

389.18 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

389.19 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

389.20 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

389.21 (vi) Cyclohexylphenols, which are compounds containing a
389.22 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
389.23 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
389.24 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted
389.25 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
389.26 limited to:

389.27 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

389.28 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol
389.29 (Cannabicyclohexanol or CP 47,497 C8 homologue);

389.30 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
389.31 -phenol (CP 55,940).

390.1 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
390.2 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
390.3 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or
390.4 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
390.5 extent and whether or not substituted in the phenyl ring to any extent. Examples of
390.6 benzoylindoles include, but are not limited to:

390.7 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

390.8 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

390.9 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
390.10 48,098 or Pravadoline).

390.11 (viii) Others specifically named:

390.12 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
390.13 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);

390.14 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
390.15 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);

390.16 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
390.17 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);

390.18 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);

390.19 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
390.20 (XLR-11);

390.21 (F) 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
390.22 (AKB-48(APINACA));

390.23 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
390.24 (5-Fluoro-AKB-48);

390.25 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);

390.26 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);

390.27 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
390.28 (AB-PINACA);

390.29 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
390.30 1H-indazole-3-carboxamide (AB-FUBINACA);

- 391.1 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
 391.2 indazole-3-carboxamide(AB-CHMINACA);
- 391.3 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate
 391.4 (5-fluoro-AMB);
- 391.5 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);
- 391.6 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone
 391.7 (FUBIMINA);
- 391.8 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
 391.9 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);
- 391.10 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
 391.11 -1H-indole-3-carboxamide (5-fluoro-ABICA);
- 391.12 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
 391.13 -1H-indole-3-carboxamide;
- 391.14 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
 391.15 -1H-indazole-3-carboxamide;
- 391.16 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;
- 391.17 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
 391.18 H-indazole-3-carboxamide (MAB-CHMINACA);
- 391.19 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
 391.20 (ADB-PINACA);
- 391.21 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);
- 391.22 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
 391.23 3-carboxamide. (APP-CHMINACA);
- 391.24 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and
- 391.25 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).
- 391.26 (ix) Additional substances specifically named:
- 391.27 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
 391.28 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);
- 391.29 (B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide
 391.30 (4-CN-Cumyl-Butinaca);

- 392.1 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);
- 392.2 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1-
- 392.3 H-indazole-3-carboxamide (5F-ABPINACA);
- 392.4 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
- 392.5 (MDMB CHMICA);
- 392.6 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
- 392.7 (5F-ADB; 5F-MDMB-PINACA); and
- 392.8 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
- 392.9 1H-indazole-3-carboxamide (ADB-FUBINACA).
- 392.10 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
- 392.11 for human consumption.

392.12 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes

392.13 committed on or after that date.

392.14 Sec. 12. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:

392.15 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.

392.16 (b) Unless specifically excepted or unless listed in another schedule, any of the following

392.17 substances whether produced directly or indirectly by extraction from substances of vegetable

392.18 origin or independently by means of chemical synthesis, or by a combination of extraction

392.19 and chemical synthesis:

392.20 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or

392.21 opiate.

392.22 (i) Excluding:

392.23 (A) apomorphine;

392.24 (B) thebaine-derived butorphanol;

392.25 (C) dextrophan;

392.26 (D) nalbuphine;

392.27 (E) nalmefene;

392.28 (F) naloxegol;

392.29 (G) naloxone;

- 393.1 (H) naltrexone; and
- 393.2 (I) their respective salts;
- 393.3 (ii) but including the following:
- 393.4 (A) opium, in all forms and extracts;
- 393.5 (B) codeine;
- 393.6 (C) dihydroetorphine;
- 393.7 (D) ethylmorphine;
- 393.8 (E) etorphine hydrochloride;
- 393.9 (F) hydrocodone;
- 393.10 (G) hydromorphone;
- 393.11 (H) metopon;
- 393.12 (I) morphine;
- 393.13 (J) oxycodone;
- 393.14 (K) oxymorphone;
- 393.15 (L) thebaine;
- 393.16 (M) oripavine;
- 393.17 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
- 393.18 or identical with any of the substances referred to in clause (1), except that these substances
- 393.19 shall not include the isoquinoline alkaloids of opium;
- 393.20 (3) opium poppy and poppy straw;
- 393.21 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
- 393.22 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
- 393.23 and derivatives), and any salt, compound, derivative, or preparation thereof which is
- 393.24 chemically equivalent or identical with any of these substances, except that the substances
- 393.25 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
- 393.26 do not contain cocaine or ecgonine;
- 393.27 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
- 393.28 or powder form which contains the phenanthrene alkaloids of the opium poppy).

- 394.1 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
394.2 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
394.3 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
394.4 chemical designation:
- 394.5 (1) alfentanil;
 - 394.6 (2) alphaprodine;
 - 394.7 (3) anileridine;
 - 394.8 (4) bezitramide;
 - 394.9 (5) bulk dextropropoxyphene (nondosage forms);
 - 394.10 (6) carfentanil;
 - 394.11 (7) dihydrocodeine;
 - 394.12 (8) dihydromorphinone;
 - 394.13 (9) diphenoxylate;
 - 394.14 (10) fentanyl;
 - 394.15 (11) isomethadone;
 - 394.16 (12) levo-alpha-acetylmethadol (LAAM);
 - 394.17 (13) levomethorphan;
 - 394.18 (14) levorphanol;
 - 394.19 (15) metazocine;
 - 394.20 (16) methadone;
 - 394.21 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;
 - 394.22 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
394.23 acid;
 - 394.24 (19) pethidine;
 - 394.25 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;
 - 394.26 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;
 - 394.27 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;
 - 394.28 (23) phenazocine;

395.1 (24) piminodine;

395.2 (25) racemethorphan;

395.3 (26) racemorphan;

395.4 (27) remifentanil;

395.5 (28) sufentanil;

395.6 (29) tapentadol;

395.7 (30) 4-Anilino-N-phenethylpiperidine.

395.8 (d) Unless specifically excepted or unless listed in another schedule, any material,
395.9 compound, mixture, or preparation which contains any quantity of the following substances
395.10 having a stimulant effect on the central nervous system:

395.11 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;

395.12 (2) methamphetamine, its salts, isomers, and salts of its isomers;

395.13 (3) phenmetrazine and its salts;

395.14 (4) methylphenidate;

395.15 (5) lisdexamfetamine.

395.16 (e) Unless specifically excepted or unless listed in another schedule, any material,
395.17 compound, mixture, or preparation which contains any quantity of the following substances
395.18 having a depressant effect on the central nervous system, including its salts, isomers, and
395.19 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
395.20 within the specific chemical designation:

395.21 (1) amobarbital;

395.22 (2) glutethimide;

395.23 (3) secobarbital;

395.24 (4) pentobarbital;

395.25 (5) phencyclidine;

395.26 (6) phencyclidine immediate precursors:

395.27 (i) 1-phenylcyclohexylamine;

395.28 (ii) 1-piperidinocyclohexanecarbonitrile;

395.29 (7) phenylacetone.

396.1 (f) Cannabis and cannabinoids:

396.2 (1) nabilone;

396.3 (2) unless specifically excepted or unless listed in another schedule, any natural material,
396.4 compound, mixture, or preparation that contains any quantity of the following substances,
396.5 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
396.6 the existence of the isomers, esters, ethers, or salts is possible:

396.7 (i) marijuana; and

396.8 (ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the
396.9 resinous extractives of the plant, except that a product containing tetrahydrocannabinols is
396.10 not included if it meets the requirements of section 151.72; and

396.11 ~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral
396.12 solution in a drug product approved for marketing by the United States Food and Drug
396.13 Administration.

396.14 **EFFECTIVE DATE.** This section is effective August 1, 2022, and applies to crimes
396.15 committed on or after that date.

396.16 Sec. 13. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to
396.17 read:

396.18 **Subd. 5. Exception.** References in this section to Schedule II controlled substances do
396.19 not extend to marijuana or tetrahydrocannabinols.

396.20 Sec. 14. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to
396.21 read:

396.22 **Subd. 6. Exception.** References in this section to Schedule II controlled substances do
396.23 not extend to marijuana or tetrahydrocannabinols.

396.24 Sec. 15. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

396.25 Subd. 3. **Limits on applicability.** This section does not apply to:

396.26 (1) a physician's treatment of an individual for chemical dependency resulting from the
396.27 use of controlled substances in Schedules II to V of section 152.02;

396.28 (2) the prescription or administration of controlled substances in Schedules II to V of
396.29 section 152.02 to an individual whom the physician knows to be using the controlled
396.30 substances for nontherapeutic purposes;

397.1 (3) the prescription or administration of controlled substances in Schedules II to V of
 397.2 section 152.02 for the purpose of terminating the life of an individual having intractable
 397.3 pain; ~~or~~

397.4 (4) the prescription or administration of a controlled substance in Schedules II to V of
 397.5 section 152.02 that is not a controlled substance approved by the United States Food and
 397.6 Drug Administration for pain relief; or

397.7 (5) the administration of medical cannabis under sections 152.22 to 152.37.

397.8 Sec. 16. Minnesota Statutes 2020, section 152.32, subdivision 1, is amended to read:

397.9 Subdivision 1. **Presumption Presumptions.** (a) There is a presumption that a patient
 397.10 enrolled in the registry program under sections 152.22 to 152.37 is engaged in the authorized
 397.11 use of medical cannabis.

397.12 (b) The presumption in paragraph (a) may be rebutted by evidence that conduct related
 397.13 to use of medical cannabis was not for the purpose of treating or alleviating the patient's
 397.14 qualifying medical condition or symptoms associated with the patient's qualifying medical
 397.15 condition.

397.16 (c) Sections 152.22 to 152.37 do not create any positive conflict with federal drug laws
 397.17 or regulations and are consistent with United States Code, title 21, section 903.

397.18 Sec. 17. Minnesota Statutes 2020, section 152.32, subdivision 2, is amended to read:

397.19 Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following
 397.20 are not violations under this chapter:

397.21 (1) use or possession of medical cannabis or medical cannabis products by a patient
 397.22 enrolled in the registry program, or possession by a registered designated caregiver or the
 397.23 parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed
 397.24 on the registry verification;

397.25 (2) possession, dosage determination, or sale of medical cannabis or medical cannabis
 397.26 products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory
 397.27 conducting testing on medical cannabis, or employees of the laboratory; and

397.28 (3) possession of medical cannabis or medical cannabis products by any person while
 397.29 carrying out the duties required under sections 152.22 to 152.37.

397.30 (b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and
 397.31 associated property is not subject to forfeiture under sections 609.531 to 609.5316.

398.1 (c) The commissioner, the commissioner's staff, the commissioner's agents or contractors,
398.2 and any health care practitioner are not subject to any civil or disciplinary penalties by the
398.3 Board of Medical Practice, the Board of Nursing, or by any business, occupational, or
398.4 professional licensing board or entity, solely for the participation in the registry program
398.5 under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to
398.6 any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance
398.7 with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional
398.8 licensing board from taking action in response to violations of any other section of law.

398.9 (d) Notwithstanding any law to the contrary, the commissioner, the governor of
398.10 Minnesota, or an employee of any state agency may not be held civilly or criminally liable
398.11 for any injury, loss of property, personal injury, or death caused by any act or omission
398.12 while acting within the scope of office or employment under sections 152.22 to 152.37.

398.13 (e) Federal, state, and local law enforcement authorities are prohibited from accessing
398.14 the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid
398.15 search warrant.

398.16 (f) Notwithstanding any law to the contrary, neither the commissioner nor a public
398.17 employee may release data or information about an individual contained in any report,
398.18 document, or registry created under sections 152.22 to 152.37 or any information obtained
398.19 about a patient participating in the program, except as provided in sections 152.22 to 152.37.

398.20 (g) No information contained in a report, document, or registry or obtained from a patient
398.21 under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding
398.22 unless independently obtained or in connection with a proceeding involving a violation of
398.23 sections 152.22 to 152.37.

398.24 (h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
398.25 of a gross misdemeanor.

398.26 (i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
398.27 Court or professional responsibility board for providing legal assistance to prospective or
398.28 registered manufacturers or others related to activity that is no longer subject to criminal
398.29 penalties under state law pursuant to sections 152.22 to 152.37.

398.30 (j) Possession of a registry verification or application for enrollment in the program by
398.31 a person entitled to possess or apply for enrollment in the registry program does not constitute
398.32 probable cause or reasonable suspicion, nor shall it be used to support a search of the person
398.33 or property of the person possessing or applying for the registry verification, or otherwise
398.34 subject the person or property of the person to inspection by any governmental agency.

399.1 (k) Subject to section 152.23, the listing of tetrahydrocannabinols as a Schedule I
399.2 controlled substance under this chapter does not apply to protected activities specified in
399.3 this subdivision.

399.4 Sec. 18. Minnesota Statutes 2021 Supplement, section 363A.50, is amended to read:

399.5 **363A.50 NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

399.6 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have
399.7 the meanings given unless the context clearly requires otherwise.

399.8 (b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

399.9 (c) "Auxiliary aids and services" include, but are not limited to:

399.10 (1) qualified interpreters or other effective methods of making aurally delivered materials
399.11 available to individuals with hearing impairments and to non-English-speaking individuals;

399.12 (2) qualified readers, taped texts, texts in accessible electronic format, or other effective
399.13 methods of making visually delivered materials available to individuals with visual
399.14 impairments;

399.15 (3) the provision of information in a format that is accessible for individuals with
399.16 cognitive, neurological, developmental, intellectual, or physical disabilities;

399.17 (4) the provision of supported decision-making services; and

399.18 (5) the acquisition or modification of equipment or devices.

399.19 (d) "Covered entity" means:

399.20 (1) any licensed provider of health care services, including licensed health care
399.21 practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric
399.22 residential treatment facilities, institutions for individuals with intellectual or developmental
399.23 disabilities, and prison health centers; or

399.24 (2) any entity responsible for matching anatomical gift donors to potential recipients.

399.25 (e) "Disability" has the meaning given in section 363A.03, subdivision 12.

399.26 (f) "Organ transplant" means the transplantation or infusion of a part of a human body
399.27 into the body of another for the purpose of treating or curing a medical condition.

399.28 (g) "Qualified individual" means an individual who, with or without available support
399.29 networks, the provision of auxiliary aids and services, or reasonable modifications to policies

400.1 or practices, meets the essential eligibility requirements for the receipt of an anatomical
400.2 gift.

400.3 (h) "Reasonable modifications" include, but are not limited to:

400.4 (1) communication with individuals responsible for supporting an individual with
400.5 postsurgical and post-transplantation care, including medication; and

400.6 (2) consideration of support networks available to the individual, including family,
400.7 friends, and home and community-based services, including home and community-based
400.8 services funded through Medicaid, Medicare, another health plan in which the individual
400.9 is enrolled, or any program or source of funding available to the individual, in determining
400.10 whether the individual is able to comply with post-transplant medical requirements.

400.11 (i) "Supported decision making" has the meaning given in section 524.5-102, subdivision
400.12 16a.

400.13 **Subd. 2. Prohibition of discrimination.** (a) A covered entity may not, on the basis of
400.14 a qualified individual's race, ethnicity, mental disability, or physical disability:

400.15 (1) deem an individual ineligible to receive an anatomical gift or organ transplant;

400.16 (2) deny medical or related organ transplantation services, including evaluation, surgery,
400.17 counseling, and postoperative treatment and care;

400.18 (3) refuse to refer the individual to a transplant center or other related specialist for the
400.19 purpose of evaluation or receipt of an anatomical gift or organ transplant;

400.20 (4) refuse to place an individual on an organ transplant waiting list or place the individual
400.21 at a lower-priority position on the list than the position at which the individual would have
400.22 been placed if not for the individual's race, ethnicity, or disability; or

400.23 (5) decline insurance coverage for any procedure associated with the receipt of the
400.24 anatomical gift or organ transplant, including post-transplantation and postinfusion care.

400.25 (b) Notwithstanding paragraph (a), a covered entity may take an individual's disability
400.26 into account when making treatment or coverage recommendations or decisions, solely to
400.27 the extent that the physical or mental disability has been found by a physician, following
400.28 an individualized evaluation of the potential recipient to be medically significant to the
400.29 provision of the anatomical gift or organ transplant. The provisions of this section may not
400.30 be deemed to require referrals or recommendations for, or the performance of, organ
400.31 transplants that are not medically appropriate given the individual's overall health condition.

401.1 (c) If an individual has the necessary support system to assist the individual in complying
401.2 with post-transplant medical requirements, an individual's inability to independently comply
401.3 with those requirements may not be deemed to be medically significant for the purposes of
401.4 paragraph (b).

401.5 (d) A covered entity must make reasonable modifications to policies, practices, or
401.6 procedures, when such modifications are necessary to make services such as
401.7 transplantation-related counseling, information, coverage, or treatment available to qualified
401.8 individuals with disabilities, unless the entity can demonstrate that making such modifications
401.9 would fundamentally alter the nature of such services.

401.10 (e) A covered entity must take such steps as may be necessary to ensure that no qualified
401.11 individual with a disability is denied services such as transplantation-related counseling,
401.12 information, coverage, or treatment because of the absence of auxiliary aids and services,
401.13 unless the entity can demonstrate that taking such steps would fundamentally alter the nature
401.14 of the services being offered or result in an undue burden. A covered entity is not required
401.15 to provide supported decision-making services.

401.16 (f) A covered entity must otherwise comply with the requirements of Titles II and III of
401.17 the Americans with Disabilities Act of 1990, the Americans with Disabilities Act
401.18 Amendments Act of 2008, and the Minnesota Human Rights Act.

401.19 (g) The provisions of this section apply to each part of the organ transplant process.

401.20 Subd. 3. **Remedies.** In addition to all other remedies available under this chapter, any
401.21 individual who has been subjected to discrimination in violation of this section may initiate
401.22 a civil action in a court of competent jurisdiction to enjoin violations of this section.

401.23 Sec. 19. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL**
401.24 **USE OF CANNABIS.**

401.25 By September 1, 2022, the commissioner of health shall apply to the Drug Enforcement
401.26 Administration's Office of Diversion Control for an exception under Code of Federal
401.27 Regulations, title 21, section 1307.03, and request formal written acknowledgment that the
401.28 listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances
401.29 in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section
401.30 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota
401.31 Statutes, sections 152.22 to 152.37. The application must include the list of presumptions
401.32 in Minnesota Statutes, section 152.32, subdivision 1.

402.1 **Sec. 20. REVISOR INSTRUCTION.**

402.2 The revisor of statutes shall renumber as Minnesota Statutes, section 256.4835, the
 402.3 Minnesota Rare Disease Advisory Council that is currently coded as Minnesota Statutes,
 402.4 section 137.68. The revisor shall also make necessary cross-reference changes consistent
 402.5 with the renumbering.

402.6 **ARTICLE 9**402.7 **FORECAST ADJUSTMENTS**402.8 **Section 1. HUMAN SERVICES APPROPRIATION.**

402.9 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
 402.10 shown in parentheses, are subtracted from the appropriations in Laws 2021, First Special
 402.11 Session chapter 7, article 16, from the general fund or any fund named to the Department
 402.12 of Human Services for the purposes specified in this article, to be available for the fiscal
 402.13 year indicated for each purpose. The figures "2022" and "2023" used in this article mean
 402.14 that the appropriations listed under them are available for the fiscal years ending June 30,
 402.15 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year"
 402.16 is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

402.17 **APPROPRIATIONS**402.18 **Available for the Year**402.19 **Ending June 30**402.20 **2022****2023**402.21 **Sec. 2. COMMISSIONER OF HUMAN**
402.22 **SERVICES**

402.23	<u>Subdivision 1. Total Appropriation</u>	\$	<u>(585,901,000)</u>	\$	<u>182,791,000</u>
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402.24 **Appropriations by Fund**

402.25	<u>General Fund</u>	<u>(406,629,000)</u>	<u>185,395,000</u>
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402.26	<u>Health Care Access</u>		
402.27	<u>Fund</u>	<u>(86,146,000)</u>	<u>(11,799,000)</u>

402.28	<u>Federal TANF</u>	<u>(93,126,000)</u>	<u>9,195,000</u>
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402.29 **Subd. 2. Forecasted Programs**402.30 **(a) MFIP/DWP**402.31 **Appropriations by Fund**

402.32	<u>General Fund</u>	<u>72,106,000</u>	<u>(14,397,000)</u>
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402.33	<u>Federal TANF</u>	<u>(93,126,000)</u>	<u>9,195,000</u>
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403.1	<u>(b) MFIP Child Care Assistance</u>		<u>(103,347,000)</u>	<u>(73,738,000)</u>
403.2	<u>(c) General Assistance</u>		<u>(4,175,000)</u>	<u>(1,488,000)</u>
403.3	<u>(d) Minnesota Supplemental Aid</u>		<u>318,000</u>	<u>1,613,000</u>
403.4	<u>(e) Housing Support</u>		<u>(1,994,000)</u>	<u>9,257,000</u>
403.5	<u>(f) Northstar Care for Children</u>		<u>(9,613,000)</u>	<u>(4,865,000)</u>
403.6	<u>(g) MinnesotaCare</u>		<u>(86,146,000)</u>	<u>(11,799,000)</u>
403.7	<u>These appropriations are from the health care</u>			
403.8	<u>access fund.</u>			
403.9	<u>(h) Medical Assistance</u>			
403.10	<u>Appropriations by Fund</u>			
403.11	<u>General Fund</u>	<u>(348,364,000)</u>	<u>292,880,000</u>	
403.12	<u>Health Care Access</u>			
403.13	<u>Fund</u>	<u>-0-</u>	<u>-0-</u>	
403.14	<u>(i) Alternative Care Program</u>		<u>-0-</u>	<u>-0-</u>
403.15	<u>(j) Behavioral Health Fund</u>		<u>(11,560,000)</u>	<u>(23,867,000)</u>
403.16	<u>Subd. 3. Technical Activities</u>		<u>-0-</u>	<u>-0-</u>
403.17	<u>These appropriations are from the federal</u>			
403.18	<u>TANF fund.</u>			
403.19	<u>EFFECTIVE DATE. This section is effective the day following final enactment.</u>			

ARTICLE 10

APPROPRIATIONS

403.22 Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.

403.23 The sums shown in the columns marked "Appropriations" are added to or, if shown in
403.24 parentheses, subtracted from the appropriations in Laws 2021, First Special Session chapter
403.25 7, article 16, to the agencies and for the purposes specified in this article. The appropriations
403.26 are from the general fund or other named fund and are available for the fiscal years indicated
403.27 for each purpose. The figures "2022" and "2023" used in this article mean that the addition
403.28 to or subtraction from the appropriation listed under them is available for the fiscal year
403.29 ending June 30, 2022, or June 30, 2023, respectively. Base adjustments mean the addition
403.30 to or subtraction from the base level adjustment set in Laws 2021, First Special Session
403.31 chapter 7, article 16. Supplemental appropriations and reductions to appropriations for the

404.1 fiscal year ending June 30, 2022, are effective the day following final enactment unless a
 404.2 different effective date is explicit.

404.3 **APPROPRIATIONS**

404.4 **Available for the Year**

404.5 **Ending June 30**

404.6 **2022 2023**

404.7 **Sec. 2. COMMISSIONER OF HUMAN**
 404.8 **SERVICES**

404.9 **Subdivision 1. Total Appropriation** **\$ **36,333,000** **\$ **308,379,000******

404.10 **Appropriations by Fund**

	<u>2022</u>	<u>2023</u>
404.11 <u>General</u>	<u>34,397,000</u>	<u>401,851,000</u>
404.12 <u>Health Care Access</u>	<u>1,936,000</u>	<u>(94,030,000)</u>
404.13 <u>Federal TANF</u>	<u>-0-</u>	<u>7,000</u>
404.14 <u>Opiate Epidemic</u>		
404.15 <u>Response</u>	<u>-0-</u>	<u>551,000</u>

404.16 **Subd. 2. Central Office; Operations**

404.17 **Appropriations by Fund**

404.18 <u>General</u>	<u>397,000</u>	<u>96,197,000</u>
404.19 <u>Health Care Access</u>	<u>-0-</u>	<u>10,029,000</u>

404.20 **(a) Background Studies. (1) \$1,779,000 in**
 404.21 **fiscal year 2023 is to provide a credit to**
 404.22 **providers who paid for emergency background**
 404.23 **studies in NETStudy 2.0. This is a onetime**
 404.24 **appropriation.**

404.25 **(2) \$1,851,000 in fiscal year 2023 is to fund**
 404.26 **the costs of reprocessing emergency studies**
 404.27 **conducted under interagency agreements. This**
 404.28 **is a onetime appropriation.**

404.29 **(b) Supporting Drug Pricing Litigation**
 404.30 **Costs. \$228,000 in fiscal year 2022 is for costs**
 404.31 **to comply with litigation requirements related**
 404.32 **to comply with litigation requirements related**

405.1 to pharmaceutical drug price litigation. This
 405.2 is a onetime appropriation.

405.3 (c) **Base Level Adjustment.** The general fund
 405.4 base is increased \$11,788,000 in fiscal year
 405.5 2024 and \$9,301,000 in fiscal year 2025. The
 405.6 health care access fund base is increased
 405.7 \$636,000 in fiscal year 2024 and \$2,015,000
 405.8 in fiscal year 2025.

405.9 Subd. 3. **Central Office; Children and Families** -0- 21,888,000

405.10 (a) **Foster Care Federal Cash Assistance**
 405.11 **Benefits Plan.** \$373,000 in fiscal year 2023
 405.12 is for the commissioner to develop the foster
 405.13 care federal cash assistance benefits plan. The
 405.14 base for this appropriation is \$342,000 in fiscal
 405.15 year 2024 and \$127,000 in fiscal year 2025.

405.16 (b) **Commissioner of Education.** \$53,000 in
 405.17 fiscal year 2023 is for transfer to the
 405.18 commissioner of education for staffing for the
 405.19 family and community resources hubs. The
 405.20 base for this appropriation is \$61,000 in fiscal
 405.21 year 2024 and \$61,000 in fiscal year 2025.

405.22 (c) **Commissioner of Health.** \$53,000 in
 405.23 fiscal year 2023 is for transfer to the
 405.24 commissioner of health for staffing for the
 405.25 family and community resources hubs. The
 405.26 base for this appropriation is \$61,000 in fiscal
 405.27 year 2024 and \$61,000 in fiscal year 2025.

405.28 (d) **Children's Cabinet.** The base shall
 405.29 include \$61,000 in fiscal year 2024 and
 405.30 \$61,000 in fiscal year 2025 for staffing at the
 405.31 Children's Cabinet at the Department of
 405.32 Management and Budget for the family and
 405.33 community resources hubs.

406.1 (e) Base Level Adjustment. The general fund
 406.2 base is increased \$7,782,000 in fiscal year
 406.3 2024 and \$7,537,000 in fiscal year 2025.

406.4 Subd. 4. Central Office; Health Care

406.5 Appropriations by Fund

406.6	<u>General</u>	<u>-0-</u>	<u>4,500,000</u>
406.7	<u>Health Care Access</u>	<u>-0-</u>	<u>811,000</u>

406.8 (a) Interactive Voice Response and
 406.9 Improving Access for Applications and
 406.10 Forms. \$1,350,000 in fiscal year 2023 is for
 406.11 the improvement of accessibility to Minnesota
 406.12 health care programs applications, forms, and
 406.13 other consumer support resources and services
 406.14 to enrollees with limited English proficiency.
 406.15 This is a onetime appropriation.

406.16 (b) Community-Driven Improvements.
 406.17 \$680,000 in fiscal year 2023 is for Minnesota
 406.18 health care program enrollee engagement
 406.19 activities.

406.20 (c) Responding to COVID-19 in Minnesota
 406.21 Health Care Programs. \$1,000,000 in fiscal
 406.22 year 2023 is for contract assistance relating to
 406.23 the resumption of eligibility and
 406.24 redetermination processes in Minnesota health
 406.25 care programs after the expiration of the
 406.26 federal public health emergency. Contracts
 406.27 entered into under this section are for
 406.28 emergency acquisition and are not subject to
 406.29 solicitation requirements under Minnesota
 406.30 Statutes, section 16C.10, subdivision 2. This
 406.31 is a onetime appropriation and is available
 406.32 until June 30, 2025.

406.33 (d) Initial PACE Implementation Funding.
 406.34 \$270,000 in fiscal year 2023 is from the

407.1 general fund to complete the initial actuarial
 407.2 and administrative work necessary to
 407.3 recommend a financing mechanism for the
 407.4 operation of PACE under Minnesota Statutes,
 407.5 section 256B.69, subdivision 23, paragraph
 407.6 (e).

407.7 (e) **Base Level Adjustment.** The general fund
 407.8 base is increased \$3,607,000 in fiscal year
 407.9 2024 and \$3,147,000 in fiscal year 2025. The
 407.10 health care access fund base is increased
 407.11 \$2,547,000 in fiscal year 2024 and \$5,715,000
 407.12 in fiscal year 2025.

407.13 Subd. 5. **Central Office; Continuing Care** -0- 177,000

407.14 (a) **Lifesharing Services.** \$57,000 in fiscal
 407.15 year 2023 is for engaging stakeholders and
 407.16 developing recommendations regarding
 407.17 establishing a lifesharing service under the
 407.18 state's medical assistance disability waivers
 407.19 and elderly waiver. The base for this
 407.20 appropriation is \$43,000 in fiscal year 2024.

407.21 (b) **Initial PACE Implementation Funding.**
 407.22 \$120,000 in fiscal year 2023 is to complete
 407.23 the initial actuarial and administrative work
 407.24 necessary to recommend a financing
 407.25 mechanism for the operation of PACE under
 407.26 Minnesota Statutes, section 256B.69,
 407.27 subdivision 23, paragraph (e).

407.28 (c) **Base Level Adjustment.** The general fund
 407.29 base is increased \$43,000 in fiscal year 2024.

407.30 Subd. 6. **Central Office; Community Supports**

407.31	<u>Appropriations by Fund</u>		
407.32	<u>General</u>	<u>-0-</u>	<u>8,531,000</u>
407.33	<u>Opioid Epidemic</u>		
407.34	<u>Response</u>	<u>-0-</u>	<u>551,000</u>

408.1 **(a) SEIU Health Care Arbitration Award.**
 408.2 \$5,444 in fiscal year 2023 is for arbitration
 408.3 awards resulting from a SEIU grievance. This
 408.4 is a onetime appropriation.

408.5 **(b) Lifesharing Services. \$57,000 in fiscal**
 408.6 year 2023 is from the general fund for
 408.7 engaging stakeholders and developing
 408.8 recommendations regarding establishing a
 408.9 lifesharing service under the state's medical
 408.10 assistance disability waivers and elderly
 408.11 waiver. The general fund base for this
 408.12 appropriation is \$43,000 in fiscal year 2024.

408.13 **(c) Intermediate Care Facilities for Persons**
 408.14 **with Developmental Disabilities; Rate**
 408.15 **Study.** \$250,000 in fiscal year 2023 is from
 408.16 the general fund for a study of medical
 408.17 assistance rates for intermediate care facilities
 408.18 for persons with developmental disabilities
 408.19 under Minnesota Statutes, sections 256B.5011
 408.20 to 256B.5015. This is a onetime appropriation.

408.21 **(d) Base Level Adjustment.** The general fund
 408.22 base is increased \$9,803,000 in fiscal year
 408.23 2024 and \$8,105,000 in fiscal year 2025.

408.24 **Subd. 7. Forecasted Programs; MFIP/DWP**

408.25	<u>Appropriations by Fund</u>		
408.26	<u>General</u>	<u>-0-</u>	<u>4,000</u>
408.27	<u>Federal TANF</u>	<u>-0-</u>	<u>7,000</u>

408.28	<u>Subd. 8. Forecasted Programs; MFIP Child Care</u>		
408.29	<u>Assistance</u>	<u>-0-</u>	<u>1,000</u>

408.30	<u>Subd. 9. Forecasted Programs; Minnesota</u>		
408.31	<u>Supplemental Aid</u>	<u>-0-</u>	<u>1,000</u>

408.32	<u>Subd. 10. Forecasted Programs; Housing</u>		
408.33	<u>Supports</u>	<u>-0-</u>	<u>2,181,000</u>

408.34 **Subd. 11. Forecasted Programs; MinnesotaCare**

409.1	<u>Appropriations by Fund</u>		
409.2	<u>General</u>	<u>-0-</u>	<u>(17,943,000)</u>
409.3	<u>Health Care Access</u>	<u>-0-</u>	<u>29,066,000</u>
409.4	<u>This appropriation is from the health care</u>		
409.5	<u>access fund.</u>		
409.6	<u>Subd. 12. Forecasted Programs; Medical</u>		
409.7	<u>Assistance</u>		
409.8	<u>Appropriations by Fund</u>		
409.9	<u>General</u>	<u>-0-</u>	<u>(56,603,000)</u>
409.10	<u>Health Care Access</u>	<u>-0-</u>	<u>(134,000,000)</u>
409.11	<u>Subd. 13. Forecasted Programs; Alternative</u>		
409.12	<u>Care</u>	<u>-0-</u>	<u>530,000</u>
409.13	<u>Subd. 14. Grant Programs; BSF Child Care</u>		
409.14	<u>Grants</u>	<u>-0-</u>	<u>6,000</u>
409.15	<u>Base Level Adjustment. The general fund</u>		
409.16	<u>base is increased \$29,000 in fiscal year 2024</u>		
409.17	<u>and \$248,000 in fiscal year 2025.</u>		
409.18	<u>Subd. 15. Grant Programs; Child Care</u>		
409.19	<u>Development Grants</u>	<u>-0-</u>	<u>-0-</u>
409.20	<u>Subd. 16. Grant Programs; Children's Services</u>		
409.21	<u>Grants</u>	<u>-0-</u>	<u>9,032,000</u>
409.22	<u>(a) American Indian Child Welfare</u>		
409.23	<u>Initiative; Mille Lacs Band of Ojibwe</u>		
409.24	<u>Planning. \$1,263,000 in fiscal year 2023 is</u>		
409.25	<u>to support activities necessary for the Mille</u>		
409.26	<u>Lacs Band of Ojibwe to join the American</u>		
409.27	<u>Indian child welfare initiative.</u>		
409.28	<u>(b) Expand Parent Support Outreach</u>		
409.29	<u>Program. The base shall include \$7,000,000</u>		
409.30	<u>in fiscal year 2024 and \$7,000,000 in fiscal</u>		
409.31	<u>year 2025 to expand the parent support</u>		
409.32	<u>outreach program to community-based</u>		
409.33	<u>agencies, public health agencies, and schools</u>		
409.34	<u>to prevent reporting of and entry into the child</u>		
409.35	<u>welfare system.</u>		

410.1 (c) **Thriving Families Safer Children.** The
410.2 base shall include \$30,000 in fiscal year 2024
410.3 to plan for an education attendance support
410.4 diversionary program to prevent entry into the
410.5 child welfare system. The commissioner shall
410.6 report back to the legislative committees that
410.7 oversee child welfare by January 1, 2025, on
410.8 the plan for this program. This is a onetime
410.9 appropriation.

410.10 (d) **Family Group Decision Making.** The
410.11 base shall include \$5,000,000 in fiscal year
410.12 2024 and \$5,000,000 in fiscal year 2025 to
410.13 expand the use of family group decision
410.14 making to provide opportunity for family
410.15 voices concerning critical decisions in child
410.16 safety and prevent entry into the child welfare
410.17 system.

410.18 (e) **Child Welfare Promising Practices.** The
410.19 base shall include \$5,000,000 in fiscal year
410.20 2024 and \$5,000,000 in fiscal year 2025 to
410.21 develop promising practices for prevention of
410.22 out-of-home placement of children and youth.

410.23 (f) **Family Assessment Response.** The base
410.24 shall include \$23,550,000 in fiscal year 2024
410.25 and \$23,550,000 in fiscal year 2025 to support
410.26 counties and Tribes that are members of the
410.27 American Indian child welfare initiative in
410.28 providing case management services and
410.29 support for families being served under family
410.30 assessment response, and prevent entry into
410.31 the child welfare system.

410.32 (g) **Extend Support for Youth Leaving**
410.33 **Foster Care.** \$600,000 in fiscal year 2023 is
410.34 to extend financial supports for young adults
410.35 aging out of foster care to age 22.

411.1 **(h) Grants to Counties for Child Protection**
411.2 **Staff.** \$1,000,000 in fiscal year 2023 is to
411.3 provide grants to counties and American
411.4 Indian child welfare initiative Tribes to be
411.5 used to reduce extended foster care caseload
411.6 sizes to ten cases per worker.

411.7 **(i) Statewide Pool of Qualified Individuals.**
411.8 \$1,177,400 in fiscal year 2023 is for grants to
411.9 one or more grantees to establish and manage
411.10 a pool of state-funded qualified individuals to
411.11 assess potential out-of-home placement of a
411.12 child in a qualified residential treatment
411.13 program. Up to \$200,000 of the grants each
411.14 fiscal year is available for grantee contracts to
411.15 manage the state-funded pool of qualified
411.16 individuals. This amount shall also pay for
411.17 qualified individual training, certification, and
411.18 background studies. Remaining grant money
411.19 shall be used until expended to provide
411.20 qualified individual services to counties and
411.21 Tribes that have joined the American Indian
411.22 child welfare initiative pursuant to Minnesota
411.23 Statutes, section 256.01, subdivision 14b, to
411.24 provide qualified residential treatment
411.25 program assessments at no cost to the county
411.26 or Tribal agency.

411.27 **(j) Quality Parenting Initiative Grant.**
411.28 \$100,000 in fiscal year 2023 is for a grant to
411.29 the Quality Parenting Initiative Minnesota, to
411.30 implement Quality Parenting Initiative
411.31 principles and practices and support children
411.32 and families experiencing foster care
411.33 placements. The grantee shall use grant funds
411.34 to provide training and technical assistance to
411.35 county and Tribal agencies, community-based

412.1 agencies, and other stakeholders, on
412.2 conducting initial foster care phone calls under
412.3 Minnesota Statutes, section 260C.219,
412.4 subdivision 6; supporting practices that create
412.5 birth family to foster family partnerships; and
412.6 informing child welfare practices by
412.7 supporting youth leadership and the
412.8 participation of individuals with experience
412.9 in the foster care system. Upon request, the
412.10 commissioner shall make information
412.11 regarding the use of this grant funding
412.12 available to the chairs and ranking minority
412.13 members of the legislative committees with
412.14 jurisdiction over human services. This is a
412.15 onetime appropriation.

412.16 **(k) Costs of Foster Care or Care,**
412.17 **Examination, or Treatment. \$5,000,000 in**
412.18 **fiscal year 2023 is for grants to counties and**
412.19 **Tribes, to reimburse counties and Tribes for**
412.20 **the costs of foster care or care, examination,**
412.21 **or treatment that would previously have been**
412.22 **paid by the parents or custodians of a child in**
412.23 **foster care using parental income and**
412.24 **resources, child support payments, or income**
412.25 **and resources attributable to a child under**
412.26 **Minnesota Statutes, sections 242.19, 256N.26,**
412.27 **260B.331, and 260C.331. Counties and Tribes**
412.28 **must apply for grant funds in a form**
412.29 **prescribed by the commissioner, and must**
412.30 **provide the information and data necessary to**
412.31 **calculate grant fund allocations accurately and**
412.32 **equitably, as required by the commissioner.**

412.33 **(l) Grants to Counties; Foster Care Federal**
412.34 **Cash Assistance Benefits Plan. \$50,000 in**
412.35 **fiscal year 2023 is for the commissioner to**

413.1 provide grants to counties, to assist counties
 413.2 with gathering and reporting the county data
 413.3 required for the commissioner to develop the
 413.4 foster care federal cash assistance benefits
 413.5 plan.

413.6 (m) **Base Level Adjustment.** The general fund
 413.7 base is increased \$52,440,000 in fiscal year
 413.8 2024 and \$49,769,000 in fiscal year 2025.

413.9 <u>Subd. 17. Grant Programs; Children and</u>		
413.10 <u>Community Service Grants</u>	-0-	-0-

413.11 **Base Level Adjustment.** The opiate epidemic
 413.12 response base is increased \$100,000 in fiscal
 413.13 year 2025.

413.14 <u>Subd. 18. Grant Programs; Children and</u>		
413.15 <u>Economic Support Grants</u>	14,000,000	144,386,000

413.16 (a) **Family and Community Resource Hubs.**
 413.17 \$2,550,000 in fiscal year 2023 is to implement
 413.18 a sustainable family and community resource
 413.19 hub model through the community action
 413.20 agencies under Minnesota Statutes, section
 413.21 256E.31, and federally recognized Tribes. The
 413.22 community resource hubs must offer
 413.23 navigation to several supports and services,
 413.24 including but not limited to basic needs and
 413.25 economic assistance, disability services,
 413.26 healthy development and screening,
 413.27 developmental and behavioral concerns,
 413.28 family well-being and mental health, early
 413.29 learning and child care, dental care, legal
 413.30 services, and culturally specific services for
 413.31 American Indian families.

413.32 (b) **Tribal Food Sovereignty Infrastructure**
 413.33 **Grants.** \$4,000,000 in fiscal year 2023 is for
 413.34 capital and infrastructure development to
 413.35 support food system changes and provide

414.1 equitable access to existing and new methods
414.2 of food support for American Indian
414.3 communities, including federally recognized
414.4 Tribes and American Indian nonprofit
414.5 organizations. This is a onetime appropriation
414.6 and is available until June 30, 2025.

414.7 **(c) Tribal Food Security.** \$2,836,000 in fiscal
414.8 year 2023 is to promote food security for
414.9 American Indian communities, including
414.10 federally recognized Tribes and American
414.11 Indian nonprofit organizations. This includes
414.12 hiring staff, providing culturally relevant
414.13 training for building food access, purchasing
414.14 technical assistance materials and supplies,
414.15 and planning for sustainable food systems.

414.16 **(d) Capital for Emergency Food**
414.17 **Distribution Facilities.** \$14,931,000 in fiscal
414.18 year 2023 is for improving and expanding the
414.19 infrastructure of food shelf facilities across
414.20 the state, including adding freezer or cooler
414.21 space and dry storage space, improving the
414.22 safety and sanitation of existing food shelves,
414.23 and addressing deferred maintenance or other
414.24 facility needs of existing food shelves. Grant
414.25 money shall be made available to nonprofit
414.26 organizations, federally recognized Tribes,
414.27 and local units of government. This is a
414.28 onetime appropriation and is available until
414.29 June 30, 2025.

414.30 **(e) Food Support Grants.** \$5,000,000 in
414.31 fiscal year 2023 is to provide additional
414.32 resources to a diverse food support network
414.33 that includes food shelves, food banks, and
414.34 meal and food outreach programs. Grant
414.35 money shall be made available to nonprofit

- 415.1 organizations, federally recognized Tribes,
415.2 and local units of government.
- 415.3 **(f) Transitional Housing.** \$2,500,000 in fiscal
415.4 year 2023 is for transitional housing programs
415.5 under Minnesota Statutes, section 256E.33.
- 415.6 **(g) Shelter-Linked Youth Mental Health**
415.7 **Grants.** \$1,650,000 in fiscal year 2023 is for
415.8 shelter-linked youth mental health grants under
415.9 Minnesota Statutes, section 256K.46.
- 415.10 **(h) Emergency Services Grants.** \$35,000,000
415.11 in fiscal year 2023 is for emergency services
415.12 under Minnesota Statutes, section 256E.36.
415.13 The base for this appropriation is \$25,000,000
415.14 in fiscal year 2024 and \$25,000,000 in fiscal
415.15 year 2025. Grant allocation balances in the
415.16 first year do not cancel but are available in the
415.17 second year.
- 415.18 **(i) Homeless Youth Act.** \$10,000,000 in fiscal
415.19 year 2023 is for homeless youth act grants
415.20 under Minnesota Statutes, section 256K.45,
415.21 subdivision 1. Grant allocation balances in the
415.22 first year do not cancel but are available in the
415.23 second year.
- 415.24 **(j) Pregnant and Parenting Homeless Youth**
415.25 **Study.** \$300,000 in fiscal year 2023 is to fund
415.26 a study of the prevalence of pregnancy and
415.27 parenting among homeless youths and youths
415.28 who are at risk of homelessness. This is a
415.29 onetime appropriation and is available until
415.30 June 30, 2024.
- 415.31 **(k) Safe Harbor Grants.** \$5,500,000 in fiscal
415.32 year 2023 is for safe harbor grants to fund
415.33 street outreach, emergency shelter, and
415.34 transitional and long-term housing beds for

416.1 sexually exploited youth and youth at risk of
416.2 exploitation.

416.3 **(l) Emergency Shelter Facilities. \$75,000,000**
416.4 in fiscal year 2023 is for grants to eligible
416.5 applicants for the acquisition of property, site
416.6 preparation, including demolition, predesign,
416.7 design, construction, renovation, furnishing,
416.8 and equipping of emergency shelter facilities
416.9 in accordance with emergency shelter facilities
416.10 project criteria in this act. This is a onetime
416.11 appropriation and is available until June 30,
416.12 2025.

416.13 **(m) Heading Home Ramsey Continuum of**
416.14 **Care. (1) \$8,000,000 in fiscal year 2022 is for**
416.15 **a grant to fund and support Heading Home**
416.16 **Ramsey Continuum of Care. This is a onetime**
416.17 **appropriation. The grant shall be used for:**

416.18 (i) maintaining funding for a 100-bed family
416.19 shelter that had been funded by CARES Act
416.20 money;

416.21 (ii) maintaining funding for an existing
416.22 100-bed single room occupancy shelter and
416.23 developing a replacement single-room
416.24 occupancy shelter for housing up to 100 single
416.25 adults; and

416.26 (iii) maintaining current day shelter
416.27 programming that had been funded with
416.28 CARES Act money and developing a
416.29 replacement for current day shelter facilities.

416.30 **(2) Ramsey County may use up to ten percent**
416.31 **of this appropriation for administrative**
416.32 **expenses. The commissioner shall make**
416.33 **available the grant funds under this section by**

417.1 May 1, 2022. This appropriation is available
417.2 until June 30, 2025.

417.3 (n) Hennepin County Funding for Serving
417.4 Homeless Persons. (1) \$6,000,000 in fiscal
417.5 year 2022 is for a grant to fund and support
417.6 Hennepin County shelters and services for
417.7 persons experiencing homelessness. This is a
417.8 onetime appropriation. Of this appropriation:

417.9 (i) up to \$4,000,000 in matching grant funding
417.10 is to design, construct, equip, and furnish
417.11 Simpson Housing Services shelter facility in
417.12 the city of Minneapolis; and

417.13 (ii) up to \$2,000,000 is to maintain current
417.14 shelter and homeless response programming
417.15 that had been funded with federal funding
417.16 from the CARES Act of the American Rescue
417.17 Plan Act, including:

417.18 (A) shelter operations and services to maintain
417.19 services at Avivo Village, including a shelter
417.20 comprised of 100 private dwellings and the
417.21 American Indian Community Development
417.22 Corporation Homeward Bound 50-bed shelter;

417.23 (B) shelter operations and services to maintain
417.24 shelter services 24 hours per day, seven days
417.25 per week;

417.26 (C) housing-focused case management; and

417.27 (D) shelter diversion services.

417.28 (2) Hennepin County may contract with
417.29 eligible nonprofit organizations and local and
417.30 Tribal governmental units to provide services
417.31 under the grant program. This appropriation
417.32 is available until June 30, 2025.

418.1 **(o) Chosen Family Hosting to Prevent**
418.2 **Youth Homelessness Pilot Program.**
418.3 \$1,000,000 in fiscal year 2023 is for the
418.4 chosen family hosting to prevent youth
418.5 homelessness pilot program to provide funds
418.6 to providers serving homeless youth. Of this
418.7 amount, \$218,000 is for a contract with a
418.8 technical assistance provider to: (1) provide
418.9 technical assistance to funding recipients; (2)
418.10 facilitate a monthly learning cohort for funding
418.11 recipients; (3) evaluate the efficacy and
418.12 cost-effectiveness of the pilot program; and
418.13 (4) submit annual updates and a final report
418.14 to the commissioner. This is a onetime
418.15 appropriation and is available until June 30,
418.16 2027.

418.17 **(p) Minnesota Association for Volunteer**
418.18 **Administration.** \$1,000,000 in fiscal year
418.19 2023 is for a grant to the Minnesota
418.20 Association for Volunteer Administration to
418.21 administer needs-based volunteerism subgrants
418.22 targeting underresourced nonprofit
418.23 organizations in greater Minnesota to support
418.24 selected organizations' ongoing efforts to
418.25 address and minimize disparities in access to
418.26 human services through increased
418.27 volunteerism. Successful subgrant applicants
418.28 must demonstrate that the populations to be
418.29 served by the subgrantee are considered
418.30 underserved or suffer from or are at risk of
418.31 homelessness, hunger, poverty, lack of access
418.32 to health care, or deficits in education. The
418.33 Minnesota Association for Volunteer
418.34 Administration must give priority to
418.35 organizations that are serving the needs of
418.36 vulnerable populations. By December 15,

419.1 2023, the Minnesota Association for Volunteer
 419.2 Administration must report data on outcomes
 419.3 from the subgrants and recommendations for
 419.4 improving and sustaining volunteer efforts
 419.5 statewide to the chairs and ranking minority
 419.6 members of the legislative committees and
 419.7 divisions with jurisdiction over human
 419.8 services. This is a onetime appropriation and
 419.9 is available until June 30, 2024.

419.10 (q) **Base Level Adjustment.** The general fund
 419.11 base is increased \$61,559,000 in fiscal year
 419.12 2024 and \$65,209,000 in fiscal year 2025.

419.13 **Subd. 19. Grant Programs; Health Care Grants**

	<u>Appropriations by Fund</u>	
	<u>2022</u>	<u>2023</u>
419.15		
419.16 <u>General Fund</u>	<u>-0-</u>	<u>2,500,000</u>
419.17 <u>Health Care Access</u>	<u>1,936,000</u>	<u>64,000</u>

419.18 (a) **Grant Funding to Support Urban**
 419.19 **American Indians in Minnesota Health**
 419.20 **Care Programs.** \$2,500,000 in fiscal year
 419.21 2023 is from the general fund for funding to
 419.22 the Indian Health Board of Minneapolis to
 419.23 support continued access to health care
 419.24 coverage through Minnesota health care
 419.25 programs, improve access to quality care, and
 419.26 increase vaccination rates among urban
 419.27 American Indians.

419.28 (b) **Grants for Navigator Organizations.** (1)
 419.29 \$1,936,000 in fiscal year 2022 is from the
 419.30 health care access fund for grants to
 419.31 organizations with a MNsure grant services
 419.32 navigator assister contract in good standing
 419.33 as of June 30, 2022. The grants to each
 419.34 organization must be in proportion to the
 419.35 number of medical assistance and

420.1 MinnesotaCare enrollees each organization
 420.2 assisted that resulted in a successful
 420.3 enrollment in the second quarter of fiscal year
 420.4 2020, as determined by MNsure's navigator
 420.5 payment process. This is a onetime
 420.6 appropriation and is available until June 30,
 420.7 2025. (2) \$64,000 in fiscal year 2023 is from
 420.8 the health care access fund for incentive
 420.9 payments as defined in Minnesota Statutes,
 420.10 section 256.962, subdivision 5. This
 420.11 appropriation is available until June 30, 2025.
 420.12 The general fund base for this appropriation
 420.13 is \$1,000,000 in fiscal year 2024 and \$0 in
 420.14 fiscal year 2025.

420.15 (c) **Base Level Adjustment.** The general fund
 420.16 base is increased \$3,750,000 in fiscal year
 420.17 2024 and \$1,250,000 in fiscal year 2025. The
 420.18 health care access fund base is increased
 420.19 \$1,000,000 in fiscal year 2024, and \$0 in fiscal
 420.20 year 2025.

420.21 Subd. 20. **Grant Programs; Other Long-Term**
 420.22 **Care Grants**

-0-

119,336,000

420.23 (a) **Workforce Incentive Fund Grant**
 420.24 **Program.** \$118,000,000 in fiscal year 2023
 420.25 is to assist disability, housing, substance use,
 420.26 and older adult service providers of public
 420.27 programs to pay for incentive benefits to
 420.28 current and new workers. This is a onetime
 420.29 appropriation and is available until June 30,
 420.30 2025. Three percent of the total amount of the
 420.31 appropriation may be used to administer the
 420.32 program, which could include contracting with
 420.33 a third-party administrator.

420.34 (b) **Supported Decision Making.** \$600,000
 420.35 in fiscal year 2023 is for a grant to Volunteers

421.1 for America for the Centers for Excellence in
421.2 Supported Decision Making to assist older
421.3 adults and people with disabilities in avoiding
421.4 unnecessary guardianships through using less
421.5 restrictive alternatives, such as supported
421.6 decision making. The base for this
421.7 appropriation is \$600,000 in fiscal year 2024,
421.8 \$600,000 in fiscal year 2025, and \$0 in fiscal
421.9 year 2026.

421.10 **(c) Support Coordination Training.**
421.11 \$736,000 in fiscal year 2023 is to develop and
421.12 implement a curriculum and training plan for
421.13 case managers to ensure all case managers
421.14 have the knowledge and skills necessary to
421.15 fulfill support planning and coordination
421.16 responsibilities for people who use home and
421.17 community-based disability services waivers
421.18 authorized under Minnesota Statutes, sections
421.19 256B.0913, 256B.092, and 256B.49, and
421.20 chapter 256S, and live in own-home settings.
421.21 Case manager support planning and
421.22 coordination responsibilities to be addressed
421.23 in the training include developing a plan with
421.24 the participant and their family to address
421.25 urgent staffing changes or unavailability and
421.26 other support coordination issues that may
421.27 arise for a participant. The commissioner shall
421.28 work with lead agencies, advocacy
421.29 organizations, and other stakeholders to
421.30 develop the training. An initial support
421.31 coordination training and competency
421.32 evaluation must be completed by all staff
421.33 responsible for case management, and the
421.34 support coordination training and competency
421.35 evaluation must be available to all staff
421.36 responsible for case management following

422.1 the initial training. The base for this
 422.2 appropriation is \$377,000 in fiscal year 2024,
 422.3 \$377,000 in fiscal year 2025, and \$0 in fiscal
 422.4 year 2026.

422.5 (d) **Base Level Adjustment.** The general fund
 422.6 base is increased \$977,000 in fiscal year 2024
 422.7 and \$977,000 in fiscal year 2025.

422.8 Subd. 21. **Grant Programs; Disabilities Grants** -0- 8,950,000

422.9 (a) **Electronic Visit Verification (EVV)**

422.10 **Stipends.** \$6,440,000 in fiscal year 2023 is
 422.11 for onetime stipends of \$200 to bargaining
 422.12 members to offset the potential costs related
 422.13 to people using individual devices to access
 422.14 EVV. \$5,600,000 of the appropriation is for
 422.15 stipends and the remaining 15 percent is for
 422.16 administration of these stipends. This is a
 422.17 onetime appropriation.

422.18 (b) **Self-Directed Collective Bargaining**

422.19 **Agreement; Temporary Rate Increase**

422.20 **Memorandum of Understanding.** \$1,610,000

422.21 in fiscal year 2023 is for onetime stipends for
 422.22 individual providers covered by the SEIU
 422.23 collective bargaining agreement based on the
 422.24 memorandum of understanding related to the
 422.25 temporary rate increase in effect between
 422.26 December 1, 2020, and February 7, 2021.

422.27 \$1,400,000 of the appropriation is for stipends
 422.28 and the remaining 15 percent is for
 422.29 administration of the stipends. This is a
 422.30 onetime appropriation.

422.31 (c) **Service Employees International Union**

422.32 **Memorandums.** The memorandums of

422.33 understanding submitted by the commissioner
 422.34 of management and budget to the Legislative

423.1 Coordinating Commission Subcommittee on
 423.2 Employee Relations on March 17, 2022, are
 423.3 ratified.

423.4 **(d) Direct Care Service Corps Pilot Project.**
 423.5 \$500,000 in fiscal year 2023 is for a grant to
 423.6 HealthForce Minnesota at Winona State
 423.7 University for purposes of the direct care
 423.8 service corps pilot project in this act. Up to
 423.9 \$25,000 may be used by HealthForce
 423.10 Minnesota for administrative costs. This is a
 423.11 onetime appropriation.

423.12 **(e) Task Force on Disability Services**
 423.13 **Accessibility.** \$250,000 in fiscal year 2023 is
 423.14 for the Task Force on Disability Services
 423.15 Accessibility. Of this amount, \$..... must be
 423.16 used to provide pilot project grants. This is a
 423.17 onetime appropriation and is available until
 423.18 March 31, 2026.

423.19 **(f) Base Level Adjustment.** The general fund
 423.20 base is increased \$805,000 in fiscal year 2024
 423.21 and \$2,420,000 in fiscal year 2025.

423.22 **Subd. 22. Grant Programs; Adult Mental Health**
 423.23 **Grants**

20,000,000

33,280,000

423.24 **(a) Inpatient Psychiatric and Psychiatric**
 423.25 **Residential Treatment Facilities.**
 423.26 \$10,000,000 in fiscal year 2023 is for
 423.27 competitive grants to hospitals or mental
 423.28 health providers to retain, build, or expand
 423.29 children's inpatient psychiatric beds for
 423.30 children in need of acute high-level psychiatric
 423.31 care or psychiatric residential treatment facility
 423.32 beds as described in Minnesota Statutes,
 423.33 section 256B.0941. In order to be eligible for
 423.34 a grant, a hospital or mental health provider
 423.35 must serve individuals covered by medical

- 424.1 assistance under Minnesota Statutes, section
424.2 256B.0625.
- 424.3 **(b) Expanding Support for Psychiatric**
424.4 **Residential Treatment Facilities. \$800,000**
424.5 in fiscal year 2023 is for start-up grants to
424.6 psychiatric residential treatment facilities as
424.7 described in Minnesota Statutes, section
424.8 256B.0941. Grantees can use grant money for
424.9 emergency workforce shortage uses.
- 424.10 Allowable grant uses related to emergency
424.11 workforce shortages may include but are not
424.12 limited to hiring and retention bonuses,
424.13 recruitment of a culturally responsive
424.14 workforce, and allowing providers to increase
424.15 the hourly rate in order to be competitive in
424.16 the market.
- 424.17 **(c) Workforce Incentive Fund Grant**
424.18 **Program. \$20,000,000 in fiscal year 2022 is**
424.19 **to provide mental health public program**
424.20 **providers the ability to pay for incentive**
424.21 **benefits to current and new workers. This is**
424.22 **a onetime appropriation and is available until**
424.23 **June 30, 2025. Three percent of the total**
424.24 **amount of the appropriation may be used to**
424.25 **administer the program, which may include**
424.26 **contracting with a third-party administrator.**
- 424.27 **(d) Cultural and Ethnic Infrastructure**
424.28 **Grant Funding. \$10,000,000 in fiscal year**
424.29 **2023 is for increasing cultural and ethnic**
424.30 **infrastructure grant funding under Minnesota**
424.31 **Statutes, section 245.4903. The base for this**
424.32 **appropriation is \$5,000,000 in fiscal year 2024**
424.33 **and \$5,000,000 in fiscal year 2025.**
- 424.34 **(e) Mental Health Provider Grants to Rural**
424.35 **and Underserved Communities. \$5,000,000**

425.1 in fiscal year 2023 is for a grant program to
425.2 recruit mental health providers in rural areas
425.3 and underserved communities. This money
425.4 may be used for reimbursement of supervision
425.5 costs of interns and clinical trainees,
425.6 reimbursing staff for master's degree tuition
425.7 costs in mental health fields, and licensing and
425.8 exam fees.

425.9 **(f) Culturally Specific Grants. \$2,000,000**
425.10 in fiscal year 2023 is for grants for small to
425.11 midsize nonprofit organizations who represent
425.12 and support American Indian, Indigenous, and
425.13 other communities disproportionately affected
425.14 by the opiate crisis. These grants utilize
425.15 traditional healing practices and other
425.16 culturally congruent and relevant supports to
425.17 prevent and curb opiate use disorders through
425.18 housing, treatment, education, aftercare, and
425.19 other activities as determined by the
425.20 commissioner. The base for this appropriation
425.21 is \$2,000,000 in fiscal year 2024 and \$0 in
425.22 fiscal year 2025.

425.23 **(g) African American Community Mental**
425.24 **Health Center Grant. \$1,000,000 in fiscal**
425.25 year 2023 is for a grant to an African
425.26 American mental health service provider that
425.27 is a licensed community mental health center
425.28 specializing in services for African American
425.29 children and families. The center must offer
425.30 culturally specific, comprehensive,
425.31 trauma-informed, practice- and
425.32 evidence-based, person- and family-centered
425.33 mental health and substance use disorder
425.34 services; supervision and training; and care
425.35 coordination to all ages, regardless of ability

426.1 to pay or place of residence. Upon request, the
 426.2 commissioner shall make information
 426.3 regarding the use of this grant funding
 426.4 available to the chairs and ranking minority
 426.5 members of the committees with jurisdiction
 426.6 over human services. This is a onetime
 426.7 appropriation.

426.8 **(h) Behavioral Health Peer Training.**
 426.9 \$1,000,000 in fiscal year 2023 is for training
 426.10 and development for mental health certified
 426.11 peer specialists, mental health certified family
 426.12 peer specialists, and recovery peer specialists.
 426.13 Training and development may include but is
 426.14 not limited to initial training and certification.

426.15 **(i) Intensive Residential Treatment Services**
 426.16 **Locked Facilities.** \$2,796,000 in fiscal year
 426.17 2023 is for start-up funds to intensive
 426.18 residential treatment service providers to
 426.19 provide treatment in locked facilities for
 426.20 patients who have been transferred from a jail
 426.21 or who have been deemed incompetent to
 426.22 stand trial and a judge has determined that the
 426.23 patient needs to be in a secure facility. This is
 426.24 a onetime appropriation.

426.25 **(j) Base Level Adjustment.** The general fund
 426.26 base is increased \$32,092,000 in fiscal year
 426.27 2024 and \$39,216,000 in fiscal year 2025. The
 426.28 opiate epidemic response base is increased
 426.29 \$2,000,000 in fiscal year 2025.

426.30 **Subd. 23. Grant Programs; Child Mental Health**
 426.31 **Grants**

-0-

16,396,000

426.32 **(a) First Episode of Psychosis Grants.**
 426.33 \$300,000 in fiscal year 2023 is for first
 426.34 episode of psychosis grants under Minnesota
 426.35 Statutes, section 245.4905.

427.1 **(b) Children's Residential Treatment**
 427.2 **Services Emergency Funding. \$2,500,000**
 427.3 in fiscal year 2023 is from the general fund to
 427.4 provide licensed children's residential
 427.5 treatment facilities with emergency funding
 427.6 for staff overtime, one-to-one staffing as
 427.7 needed, staff recruitment and retention, and
 427.8 training and related costs to maintain quality
 427.9 staff. Up to \$500,000 of this appropriation
 427.10 may be allocated to support group home
 427.11 organizations supporting children transitioning
 427.12 to lower levels of care. This is a onetime
 427.13 appropriation.

427.14 **(c) Children's Residential Facility Crisis**
 427.15 **Stabilization. \$3,000,000 in fiscal year 2023**
 427.16 is for implementing children's residential
 427.17 facility crisis stabilization services licensing
 427.18 requirements and reimbursing county costs
 427.19 for children's residential crisis stabilization
 427.20 services as required under Minnesota Statutes,
 427.21 section 245.4882, subdivision 6.

427.22 **(d) Base Level Adjustment.** The general fund
 427.23 base is increased \$16,100,000 in fiscal year
 427.24 2024 and \$1,100,000 in fiscal year 2025.

427.25 **Subd. 24. Grant Programs; Chemical**
 427.26 **Dependency Treatment Support Grants** -0- 2,000,000

427.27 **(a) Emerging Mood Disorder Grant**
 427.28 **Program. \$1,000,000 in fiscal year 2023 is**
 427.29 for emerging mood disorder grants under
 427.30 Minnesota Statutes, section 245.4904.
 427.31 Grantees must use grant money as required in
 427.32 Minnesota Statutes, section 245.4904,
 427.33 subdivision 2.

427.34 **(b) Substance Use Disorder Treatment and**
 427.35 **Prevention Grants.** The base shall include

428.1 \$4,000,000 in fiscal year 2024 and \$4,000,000
 428.2 in fiscal year 2025 for substance use disorder
 428.3 treatment and prevention grants recommended
 428.4 by the substance use disorder advisory council.

428.5 (c) **Traditional Healing Grants.** The base
 428.6 shall include \$2,000,000 in fiscal year 2025
 428.7 to extend the traditional healing grant funding
 428.8 appropriated in Laws 2019, chapter 63, article
 428.9 3, section 1, paragraph (h), from the opiate
 428.10 epidemic response account to the
 428.11 commissioner of human services. This funding
 428.12 is awarded to all Tribal nations and to five
 428.13 urban Indian communities for traditional
 428.14 healing practices to American Indians and to
 428.15 increase the capacity of culturally specific
 428.16 providers in the behavioral health workforce.

428.17 (d) **Base Level Adjustment.** The general fund
 428.18 base is increased \$2,000,000 in fiscal year
 428.19 2024 and \$2,000,000 in fiscal year 2025.

428.20 <u>Subd. 25. Direct Care and Treatment -</u>		
428.21 <u>Operations</u>	<u>-0-</u>	<u>6,501,000</u>

428.22 **Base Level Adjustment.** The general fund
 428.23 base is increased \$5,267,000 in fiscal year
 428.24 2024 and \$0 in fiscal year 2025.

428.25 <u>Subd. 26. Technical Activities</u>	<u>-0-</u>	<u>-0-</u>
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428.26 (a) **Transfers; Child Care and Development**
 428.27 **Fund.** For fiscal years 2024 and 2025, the base
 428.28 shall include a transfer of \$23,500,000 in fiscal
 428.29 year 2024 and \$23,500,000 in fiscal year 2025
 428.30 from the TANF fund to the child care and
 428.31 development fund. These are onetime
 428.32 transfers.

428.33 (b) **Base Level Adjustment.** The TANF base
 428.34 is increased \$23,500,000 in fiscal year 2024,

430.1 under Minnesota Statutes, section 145.9282.
430.2 Of this appropriation, \$462,000 is for
430.3 administration and \$1,000,000 is for grants.
430.4 The general fund base for this appropriation
430.5 is \$1,097,000 in fiscal year 2024, of which
430.6 \$337,000 is for administration and \$760,000
430.7 is for grants, and \$1,098,000 in fiscal year
430.8 2025, of which \$338,000 is for administration
430.9 and \$760,000 is for grants.

430.10 **(d) Community Solutions for Healthy Child**
430.11 **Development.** \$10,000,000 in fiscal year 2023
430.12 is from the general fund for the community
430.13 solutions for healthy child development grant
430.14 program under Minnesota Statutes, section
430.15 145.9271. Of this appropriation, \$1,250,000
430.16 is for administration and \$8,750,000 is for
430.17 grants. The general fund base appropriation
430.18 is \$10,000,000 in fiscal year 2024 and
430.19 \$10,000,000 in fiscal year 2025, of which
430.20 \$1,250,000 is for administration and
430.21 \$8,750,000 is for grants in each fiscal year.

430.22 **(e) Disability as a Health Equity Issue.**
430.23 \$1,575,000 in fiscal year 2023 is from the
430.24 general fund to reduce disability-related health
430.25 disparities through collaboration and
430.26 coordination between state and community
430.27 partners under Minnesota Statutes, section
430.28 145.9283. Of this appropriation, \$1,130,000
430.29 is for administration and \$445,000 is for
430.30 grants. The general fund base for this
430.31 appropriation is \$1,585,000 in fiscal year 2024
430.32 and \$1,585,000 in fiscal year 2025, of which
430.33 \$1,140,000 is for administration and \$445,000
430.34 is for grants.

431.1 **(f) Drug Overdose and Substance Abuse**
431.2 **Prevention.** \$5,042,000 in fiscal year 2023 is
431.3 from the general fund for a public health
431.4 prevention approach to drug overdose and
431.5 substance use disorder in Minnesota Statutes,
431.6 section 144.8611. Of this appropriation,
431.7 \$921,000 is for administration and \$4,121,000
431.8 is for grants.

431.9 **(g) Healthy Beginnings, Healthy Families.**
431.10 \$11,700,000 in fiscal year 2023 is from the
431.11 general fund for Healthy Beginnings, Healthy
431.12 Families services under Minnesota Statutes,
431.13 section 145.987. The general fund base for
431.14 this appropriation is \$11,818,000 in fiscal year
431.15 2024 and \$11,763,000 in fiscal year 2025. Of
431.16 this appropriation:

431.17 (1) \$7,510,000 in fiscal year 2023 is for the
431.18 Minnesota Collaborative to Prevent Infant
431.19 Mortality under Minnesota Statutes, section
431.20 145.987, subdivisions 2, 3, and 4, of which
431.21 \$1,535,000 is for administration and
431.22 \$5,975,000 is for grants. The general fund base
431.23 for this appropriation is \$7,501,000 in fiscal
431.24 year 2024, of which \$1,526,000 is for
431.25 administration and \$5,975,000 is for grants,
431.26 and \$7,501,000 in fiscal year 2025, of which
431.27 \$1,526,000 is for administration and
431.28 \$5,975,000 is for grants.

431.29 (2) \$340,000 in fiscal year 2023 is for Help
431.30 Me Connect under Minnesota Statutes, section
431.31 145.987, subdivisions 5 and 6. The general
431.32 fund base for this appropriation is \$663,000
431.33 in fiscal year 2024 and \$663,000 in fiscal year
431.34 2025.

432.1 (3) \$1,940,000 in fiscal year 2023 is for
432.2 voluntary developmental and social-emotional
432.3 screening and follow-up under Minnesota
432.4 Statutes, section 145.987, subdivisions 7 and
432.5 8, of which \$1,190,000 is for administration
432.6 and \$750,000 is for grants. The general fund
432.7 base for this appropriation is \$1,764,000 in
432.8 fiscal year 2024, of which \$1,014,000 is for
432.9 administration and \$750,000 is for grants, and
432.10 \$1,764,000 in fiscal year 2025, of which
432.11 \$1,014,000 is for administration and \$750,000
432.12 is for grants.

432.13 (4) \$1,910,000 in fiscal year 2023 is for model
432.14 jail practices for incarcerated parents under
432.15 Minnesota Statutes, section 145.987,
432.16 subdivisions 9, 10, and 11, of which \$485,000
432.17 is for administration and \$1,425,000 is for
432.18 grants. The general fund base for this
432.19 appropriation is \$1,890,000 in fiscal year
432.20 2024, of which \$465,000 is for administration
432.21 and \$1,425,000 is for grants, and \$1,835,000
432.22 in fiscal year 2025, of which \$410,000 is for
432.23 administration and \$1,425,000 is for grants.

432.24 (h) **Home Visiting.** \$62,386,000 in fiscal year
432.25 2023 is from the general fund for universal,
432.26 voluntary home visiting services under
432.27 Minnesota Statutes, section 145.871. Of this
432.28 appropriation, ten percent is for administration
432.29 and 90 percent is for implementation grants
432.30 of home visiting services to families. The
432.31 general fund base for this appropriation is
432.32 \$63,386,000 in fiscal year 2024 and
432.33 \$63,386,000 in fiscal year 2025.

432.34 (i) **Long COVID.** \$2,669,000 in fiscal year
432.35 2023 is from the general fund for a public

433.1 health approach to supporting long COVID
433.2 survivors under Minnesota Statutes, section
433.3 145.361. Of this appropriation, \$2,119,000 is
433.4 for administration and \$550,000 is for grants.
433.5 The base for this appropriation is \$3,706,000
433.6 in fiscal year 2024 and \$3,706,000 in fiscal
433.7 year 2025, of which \$3,156,000 is for
433.8 administration and \$550,000 is for grants in
433.9 each fiscal year.

433.10 **(j) Medical Education Research Cost**
433.11 **(MERC).** Of the amount previously
433.12 appropriated in the general fund by Laws
433.13 2015, chapter 71, article 3, section 2, for the
433.14 MERC program, \$150,000 in fiscal year 2023
433.15 and each year thereafter is for the
433.16 administration of grants under Minnesota
433.17 Statutes, section 62J.692.

433.18 **(k) No Surprises Act Enforcement. \$964,000**
433.19 in fiscal year 2023 is from the general fund
433.20 for implementation of the federal No Surprises
433.21 Act portion of the Consolidated
433.22 Appropriations Act, 2021, under Minnesota
433.23 Statutes, section 62Q.021, subdivision 3. The
433.24 general fund base for this appropriation is
433.25 \$763,000 in fiscal year 2024 and \$757,000 in
433.26 fiscal year 2025.

433.27 **(l) Public Health System Transformation.**
433.28 \$23,531,000 in fiscal year 2023 is from the
433.29 general fund for public health system
433.30 transformation. Of this appropriation:

433.31 (1) \$20,000,000 is for grants to community
433.32 health boards under Minnesota Statutes,
433.33 section 145A.131, subdivision 1, paragraph
433.34 (f).

- 434.1 (2) \$1,000,000 is for grants to Tribal
434.2 governments under Minnesota Statutes, section
434.3 145A.14, subdivision 2b.
- 434.4 (3) \$1,000,000 is for a public health
434.5 AmeriCorps program grant under Minnesota
434.6 Statutes, section 145.9292.
- 434.7 (4) \$1,531,000 is for the commissioner to
434.8 oversee and administer activities under this
434.9 paragraph.
- 434.10 **(m) Revitalize Health Care Workforce.**
434.11 \$21,575,000 in fiscal year 2023 is from the
434.12 health care access fund to address challenges
434.13 of Minnesota's health care workforce. Of this
434.14 appropriation:
- 434.15 (1) \$2,073,000 in fiscal year 2023 is for the
434.16 health professionals clinical training expansion
434.17 and rural and underserved clinical rotations
434.18 grant programs under Minnesota Statutes,
434.19 section 144.1505, of which \$423,000 is for
434.20 administration and \$1,650,000 is for grants.
434.21 Grant appropriations are available until
434.22 expended under Minnesota Statutes, section
434.23 144.1505, subdivision 2.
- 434.24 (2) \$4,507,000 in fiscal year 2023 is for the
434.25 primary care rural residency training grant
434.26 program under Minnesota Statutes, section
434.27 144.1507, of which \$207,000 is for
434.28 administration and \$4,300,000 is for grants.
434.29 Grant appropriations are available until
434.30 expended under Minnesota Statutes, section
434.31 144.1507, subdivision 2.
- 434.32 (3) \$430,000 in fiscal year 2023 is for the
434.33 international medical graduates assistance
434.34 program under Minnesota Statutes, section

435.1 144.1911, for international immigrant medical
435.2 graduates to fill a gap in their preparedness
435.3 for medical residencies or transition to a new
435.4 career making use of their medical degrees.
435.5 Of this appropriation, \$55,000 is for
435.6 administration and \$375,000 is for grants.

435.7 (4) \$12,565,000 in fiscal year 2023 is for a
435.8 grant program to health care systems,
435.9 hospitals, clinics, and other providers to ensure
435.10 the availability of clinical training for students,
435.11 residents, and graduate students to meet health
435.12 professions educational requirements, under
435.13 Minnesota Statutes, section 144.1511, of
435.14 which \$565,000 is for administration and
435.15 \$12,000,000 is for grants.

435.16 (5) \$2,000,000 in fiscal year 2023 is for the
435.17 mental health cultural community continuing
435.18 education grant program, of which \$460,000
435.19 is for administration and \$1,540,000 is for
435.20 grants.

435.21 (n) **School Health.** \$837,000 in fiscal year
435.22 2023 is from the general fund for the School
435.23 Health Initiative under Minnesota Statutes,
435.24 section 145.988. The general fund base for
435.25 this appropriation is \$3,462,000 in fiscal year
435.26 2024, of which \$1,212,000 is for
435.27 administration and \$2,250,000 is for grants
435.28 and \$3,287,000 in fiscal year 2025, of which
435.29 \$1,037,000 is for administration and
435.30 \$2,250,000 is for grants.

435.31 (o) **Trauma System.** \$61,000 in fiscal year
435.32 2023 is from the general fund to administer
435.33 the trauma care system throughout the state
435.34 under Minnesota Statutes, sections 144.602,
435.35 144.603, 144.604, 144.606, and 144.608.

436.1 \$430,000 in fiscal year 2023 is from the state
436.2 government special revenue fund for trauma
436.3 designations per Minnesota Statutes, sections
436.4 144.122, paragraph (g), 144.605, and
436.5 144.6071.

436.6 **(p) Mental Health Providers; Loan**
436.7 **Forgiveness, Grants, Information**
436.8 **Clearinghouse. \$3,275,000 in fiscal year 2023**
436.9 is from the general fund for activities to
436.10 increase the number of mental health
436.11 professionals in the state. Of this
436.12 appropriation:

436.13 (1) \$1,000,000 is for loan forgiveness under
436.14 the health professional education loan
436.15 forgiveness program under Minnesota Statutes,
436.16 section 144.1501, notwithstanding the
436.17 priorities and distribution requirements in that
436.18 section, for eligible mental health
436.19 professionals who provide clinical supervision
436.20 in their designated field;

436.21 (2) \$2,000,000 is for the mental health
436.22 provider supervision grant program under
436.23 Minnesota Statutes, section 144.1508;

436.24 (3) \$250,000 is for the mental health
436.25 professional scholarship grant program under
436.26 Minnesota Statutes, section 144.1509; and

436.27 (4) \$25,000 is for the commissioner to
436.28 establish and maintain a website to serve as
436.29 an information clearinghouse for mental health
436.30 professionals and individuals seeking to
436.31 qualify as a mental health professional. The
436.32 website must contain information on the
436.33 various master's level programs to become a
436.34 mental health professional, requirements for

- 437.1 supervision, where to find supervision, how
437.2 to access tools to study for the applicable
437.3 licensing examination, links to loan
437.4 forgiveness programs and tuition
437.5 reimbursement programs, and other topics of
437.6 use to individuals seeking to become a mental
437.7 health professional. This is a onetime
437.8 appropriation.
- 437.9 **(q) Palliative Care Advisory Council.**
437.10 \$44,000 in fiscal year 2023 is from the general
437.11 fund for the Palliative Care Advisory Council
437.12 under Minnesota Statutes, section 144.059.
- 437.13 **(r) Emmett Louis Till Victims Recovery**
437.14 **Program. \$500,000 in fiscal year 2023 is from**
437.15 **the general fund for the Emmett Louis Till**
437.16 **Victims Recovery Program. This is a onetime**
437.17 **appropriation and is available until June 30,**
437.18 **2024.**
- 437.19 **(s) Changes to Birth Certificates. \$75,000**
437.20 **in fiscal year 2023 is from the state**
437.21 **government special revenue fund for**
437.22 **implementation of Minnesota Statutes, section**
437.23 **144.2182. The state government special**
437.24 **revenue fund base for this appropriation is**
437.25 **\$7,000 in fiscal year 2024 and \$7,000 in fiscal**
437.26 **year 2025.**
- 437.27 **(t) Study; POLST Forms. \$292,000 in fiscal**
437.28 **year 2023 is from the general fund for the**
437.29 **commissioner to study the creation of a**
437.30 **statewide registry of provider orders for**
437.31 **life-sustaining treatment and issue a report and**
437.32 **recommendations.**
- 437.33 **(u) Benefit and Cost Analysis of Universal**
437.34 **Health Reform Proposal. \$461,000 in fiscal**

438.1 year 2023 is from the general fund for a
 438.2 contract for an analysis of the benefits and
 438.3 costs of a universal health care financing
 438.4 system and a similar analysis of the current
 438.5 health care financing system. The general fund
 438.6 base for this appropriation is \$288,000 in fiscal
 438.7 year 2024 and \$0 in 2025.

438.8 **(v) Technical Assistance; Health Care**
 438.9 **Trends and Costs.** \$5,000,000 in fiscal year
 438.10 2023 is from the general fund for technical
 438.11 assistance to the Health Care Affordability
 438.12 Board in analyzing health care trends and costs
 438.13 and setting health care spending growth
 438.14 targets.

438.15 **(w) Base Level Adjustments.** The general
 438.16 fund base is increased \$181,679,000 in fiscal
 438.17 year 2024 and \$181,156,000 in fiscal year
 438.18 2025. The health care access fund base is
 438.19 increased \$21,575,000 in fiscal year 2024 and
 438.20 \$21,575,000 in fiscal year 2025. The state
 438.21 government special revenue fund base is
 438.22 increased \$437,000 in fiscal year 2024 and
 438.23 \$437,000 in fiscal year 2025.

438.24 **Subd. 3. Health Protection**

438.25	<u>Appropriations by Fund</u>		
438.26	<u>General</u>	<u>-0-</u>	<u>77,150,000</u>
438.27	<u>State Government</u>		
438.28	<u>Special Revenue</u>	<u>-0-</u>	<u>4,386,000</u>

438.29 **(a) Climate Resiliency.** \$1,977,000 in fiscal
 438.30 year 2023 is from the general fund for climate
 438.31 resiliency actions under Minnesota Statutes,
 438.32 section 144.9981. Of this appropriation,
 438.33 \$977,000 is for administration and \$1,000,000
 438.34 is for grants. The general fund base for this
 438.35 appropriation is \$988,000 in fiscal year 2024,

439.1 of which \$888,000 is for administration and
439.2 \$100,000 is for grants, and \$989,000 in fiscal
439.3 year 2025, of which \$889,000 is for
439.4 administration and \$100,000 is for grants.

439.5 **(b) Lead Remediation in Schools and Child**
439.6 **Care Settings.** \$2,054,000 in fiscal year 2023
439.7 is from the general fund for a lead in drinking
439.8 water remediation in schools and child care
439.9 settings grant program under Minnesota
439.10 Statutes, section 145.9272. Of this
439.11 appropriation, \$454,000 is for administration
439.12 and \$1,600,000 is for grants. The general fund
439.13 base for this appropriation is \$1,540,000 in
439.14 fiscal year 2024, of which \$370,000 is for
439.15 administration and \$1,170,000 is for grants,
439.16 and \$1,541,000 in fiscal year 2025, of which
439.17 \$371,000 is for administration and \$1,170,000
439.18 is for grants.

439.19 **(c) Lead Service Line Inventory.** \$4,029,000
439.20 in fiscal year 2023 is from the general fund
439.21 for grants to public water suppliers to complete
439.22 a lead service line inventory of their
439.23 distribution systems under Minnesota Statutes,
439.24 section 144.383, clause (6). Of this
439.25 appropriation, \$279,000 is for administration
439.26 and \$3,750,000 is for grants. The general fund
439.27 base for this appropriation is \$4,029,000 in
439.28 fiscal year 2024, of which \$279,000 is for
439.29 administration and \$3,750,000 is for grants,
439.30 and \$140,000 in fiscal year 2025, which is for
439.31 administration.

439.32 **(d) Lead Service Line Replacement.**
439.33 \$5,000,000 in fiscal year 2023 is from the
439.34 general fund for administrative costs related

440.1 to the replacement of lead service lines in the
440.2 state.

440.3 **(e) Mercury in Skin-Lightening Products**
440.4 **Grants.** \$100,000 in fiscal year 2023 is from
440.5 the general fund for a skin-lightening products
440.6 public awareness and education grant program
440.7 under Minnesota Statutes, section 145.9275.

440.8 **(f) HIV Prevention for People Experiencing**
440.9 **Homelessness.** \$1,129,000 in fiscal year 2023
440.10 is from the general fund for expanding access
440.11 to harm reduction services and improving
440.12 linkages to care to prevent HIV/AIDS,
440.13 hepatitis, and other infectious diseases for
440.14 those experiencing homelessness or housing
440.15 instability under Minnesota Statutes, section
440.16 145.924, paragraph (d). Of this appropriation,
440.17 \$169,000 is for administration and \$960,000
440.18 is for grants.

440.19 **(g) Safety Improvements for State-Licensed**
440.20 **Long-Term Care Facilities.** \$5,500,000 in
440.21 fiscal year 2023 is from the general fund for
440.22 a temporary grant program for safety
440.23 improvements for state-licensed long-term
440.24 care facilities. Of this appropriation, \$500,000
440.25 is for administration and \$5,000,000 is for
440.26 grants. The general fund base for this
440.27 appropriation is \$8,200,000 in fiscal year 2024
440.28 and \$0 in fiscal year 2025. Of this
440.29 appropriation in fiscal year 2024, \$700,000 is
440.30 for administration and \$7,500,000 is for
440.31 grants. This appropriation is available until
440.32 June 30, 2025.

440.33 **(h) Sexual Exploitation and Trafficking**
440.34 **Study.** \$300,000 in fiscal year 2023 is to fund
440.35 a prevalence study on youth and adult victim

441.1 survivors of sexual exploitation and
441.2 trafficking. This is a onetime appropriation
441.3 and is available until June 30, 2024.

441.4 (i) **Mortuary Science.** \$219,000 in fiscal year
441.5 2023 is from the state government special
441.6 revenue fund for regulation of transfer care
441.7 specialists under Minnesota Statutes, chapter
441.8 149A, and for additional reporting
441.9 requirements under Minnesota Statutes,
441.10 section 149A.94. The state government special
441.11 revenue fund base for this appropriation is
441.12 \$132,000 in fiscal year 2024 and \$61,000 in
441.13 fiscal year 2025.

441.14 (j) **Drinking Water Lead Testing and**
441.15 **Remediation; Day Care Facilities.**
441.16 \$1,000,000 in fiscal year 2023 is from the
441.17 general fund for statewide testing of day care
441.18 facilities for the presence of lead in drinking
441.19 water and for remediation of contamination
441.20 where found.

441.21 (k) **Local and Tribal Public Health**
441.22 **Emergency Preparedness and Response.**
441.23 \$9,000,000 in fiscal year 2023 is from the
441.24 general fund for distribution to local and Tribal
441.25 public health organizations for emergency
441.26 preparedness and response capabilities. At
441.27 least 90 percent of this appropriation must be
441.28 distributed to local and Tribal public health
441.29 organizations, and up to ten percent of this
441.30 appropriation may be used by the
441.31 commissioner for administrative costs. Use of
441.32 this appropriation must align with the Centers
441.33 for Disease Control and Prevention's issued
441.34 report, Public Health Emergency Preparedness
441.35 and Response Capabilities: National Standards

442.1 for State, Local, Tribal, and Territorial Public
442.2 Health.

442.3 **(l) Grants to Local Public Health**

442.4 **Departments.** \$16,172,000 in fiscal year 2023
442.5 is from the general fund for grants to local
442.6 public health departments for public health
442.7 response related to defining elevated blood
442.8 lead level as 3.5 micrograms of lead or greater
442.9 per deciliter of whole blood. Of this amount,
442.10 \$172,000 is available to the commissioner for
442.11 administrative costs. This appropriation is
442.12 available until June 30, 2025. The general fund
442.13 base for this appropriation is \$5,000,000 in
442.14 fiscal year 2024 and \$5,000,000 in fiscal year
442.15 2025.

442.16 **(m) Loan Forgiveness for Nursing**

442.17 **Instructors.** Notwithstanding the priorities
442.18 and distribution requirements in Minnesota
442.19 Statutes, section 144.1501, \$50,000 in fiscal
442.20 year 2023 is from the general fund for loan
442.21 forgiveness under the health professional
442.22 education loan forgiveness program under
442.23 Minnesota Statutes, section 144.1501, for
442.24 eligible nurses who agree to teach.

442.25 **(n) Mental Health of Health Care Workers.**

442.26 \$1,000,000 in fiscal year 2023 is from the
442.27 general fund for competitive grants to
442.28 hospitals, community health centers, rural
442.29 health clinics, and medical professional
442.30 associations to establish or enhance
442.31 evidence-based or evidence-informed
442.32 programs dedicated to improving the mental
442.33 health of health care professionals.

442.34 **(o) Prevention of Violence in Health Care.**

442.35 \$50,000 in fiscal year 2023 is from the general

443.1 fund to continue the prevention of violence in
443.2 health care programs and to create violence
443.3 prevention resources for hospitals and other
443.4 health care providers to use to train their staff
443.5 on violence prevention.

443.6 **(p) Hospital Nursing Loan Forgiveness.**
443.7 \$5,000,000 in fiscal year 2023 is from the
443.8 general fund for the hospital nursing loan
443.9 forgiveness program under Minnesota Statutes,
443.10 section 144.1504.

443.11 **(q) Program to Distribute COVID-19 Tests,**
443.12 **Masks, and Respirators.** \$15,000,000 in
443.13 fiscal year 2023 is from the general fund for
443.14 a program to distribute COVID-19 tests,
443.15 masks, and respirators to individuals in the
443.16 state. This is a onetime appropriation.

443.17 **(r) Safe Harbor Grants.** \$1,000,000 in fiscal
443.18 year 2023 is for grants to fund supportive
443.19 services including but not limited to legal
443.20 services, mental health therapy, substance use
443.21 disorder counseling, and case management for
443.22 sexually exploited youth or youth at risk of
443.23 sexual exploitation under Minnesota Statutes,
443.24 section 145.4716.

443.25 **(s) Safe Harbor Regional Navigators.**
443.26 \$700,000 in fiscal year 2023 is for safe harbor
443.27 regional navigators under Minnesota Statutes,
443.28 section 145.4717.

443.29 **(t) Public Health Response Contingency**
443.30 **Account.** \$20,000,000 in fiscal year 2023 is
443.31 from the general fund for transfer to the public
443.32 health response contingency account under
443.33 Minnesota Statutes, section 144.4199.

444.1 (u) Base Level Adjustments. The general
 444.2 fund base is increased \$32,206,000 in fiscal
 444.3 year 2024 and \$20,021,000 in fiscal year 2025.

444.4 The state government special revenue fund
 444.5 base is increased \$4,299,000 in fiscal year
 444.6 2024 and \$4,288,000 in fiscal year 2025.

444.7 **Sec. 4. HEALTH-RELATED BOARDS**

444.8	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>203,000</u>
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444.9 Appropriations by Fund

444.10	<u>General Fund</u>	<u>-0-</u>		<u>175,000</u>
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444.11 State Government

444.12	<u>Special Revenue</u>	<u>-0-</u>		<u>28,000</u>
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444.13 This appropriation is from the state
 444.14 government special revenue fund unless
 444.15 specified otherwise. The amounts that may be
 444.16 spent for each purpose are specified in the
 444.17 following subdivisions.

444.18	<u>Subd. 2. Board of Dentistry</u>	<u>-0-</u>		<u>3,000</u>
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444.19 **Subd. 3. Board of Dietetics and Nutrition**
 444.20 **Practice**

<u>-0-</u>	<u>25,000</u>
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444.21 **Subd. 4. Board of Pharmacy**

<u>-0-</u>	<u>175,000</u>
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444.22 This appropriation is from the general fund.

444.23 **Medication repository program. \$175,000**

444.24 in fiscal year 2023 is from the general fund

444.25 for transfer by the Board of Pharmacy to the

444.26 central repository to be used to administer the

444.27 medication repository program according to

444.28 the contract between the central repository and

444.29 the Board of Pharmacy.

444.30	<u>Sec. 5. COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>375,000</u>
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444.31 **Sec. 6. EMERGENCY MEDICAL SERVICES**
 444.32 **REGULATORY BOARD**

<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>200,000</u>
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444.33 This is a onetime appropriation.

445.1	Sec. 7. <u>BOARD OF DIRECTORS OF MNSURE</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>7,775,000</u>
445.2	<u>This appropriation may be transferred to the</u>				
445.3	<u>MNsure account established in Minnesota</u>				
445.4	<u>Statutes, section 62V.07.</u>				
445.5	<u>Base Adjustment.</u> The general fund base for				
445.6	<u>this appropriation is \$10,982,000 in fiscal year</u>				
445.7	<u>2024, \$6,450,000 in fiscal year 2025, and \$0</u>				
445.8	<u>in fiscal year 2026.</u>				
445.9	Sec. 8. <u>HEALTH CARE AFFORDABILITY</u>				
445.10	<u>BOARD.</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>1,000,000</u>
445.11	<u>(a) Health Care Affordability Board.</u>				
445.12	<u>\$1,000,000 in fiscal year 2023 is from the</u>				
445.13	<u>general fund for the Health Care Affordability</u>				
445.14	<u>Board to implement Minnesota Statutes,</u>				
445.15	<u>sections 62J.86 to 62J.72.</u>				
445.16	<u>(b) Base Level Adjustment.</u> The general fund				
445.17	<u>base is increased \$500,000 in fiscal year 2024</u>				
445.18	<u>and \$1,000,000 in fiscal year 2025.</u>				
445.19	Sec. 9. <u>COMMISSIONER OF COMMERCE</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>251,000</u>
445.20	<u>(a) Prescription Drug Affordability Board.</u>				
445.21	<u>\$197,000 in fiscal year 2023 is from the</u>				
445.22	<u>general fund for the commissioner of</u>				
445.23	<u>commerce to establish the Prescription Drug</u>				
445.24	<u>Affordability Board under Minnesota Statutes,</u>				
445.25	<u>section 62J.87, and for the Prescription Drug</u>				
445.26	<u>Affordability Board to implement the</u>				
445.27	<u>Prescription Drug Affordability Act.</u>				
445.28	<u>Following the first meeting of the board and</u>				
445.29	<u>prior to June 30, 2023, the commissioner of</u>				
445.30	<u>commerce shall transfer any funds remaining</u>				
445.31	<u>from this appropriation to the board. The</u>				
445.32	<u>general fund base for this appropriation is</u>				
445.33	<u>\$357,000 in fiscal year 2024 and \$357,000 in</u>				
445.34	<u>fiscal year 2025.</u>				

446.1 (b) Ectodermal Dysplasias. \$54,000 in fiscal
 446.2 year 2023 is from the general fund for costs
 446.3 related to insurance coverage of ectodermal
 446.4 dysplasias. The general fund base for this
 446.5 appropriation is \$58,000 in fiscal year 2024
 446.6 and \$62,000 in fiscal year 2025.

446.7 **Sec. 10. COMMISSIONER OF LABOR AND**
 446.8 **INDUSTRY** **\$** **-0-** **\$** **641,000**

446.9 **Nursing Home Workforce Standards**
 446.10 **Board. \$641,000 in fiscal year 2023 is for**
 446.11 **establishment and operation of the Nursing**
 446.12 **Home Workforce Standards Board in**
 446.13 **Minnesota Statutes, sections 181.211 to**
 446.14 **181.217. The general fund base for this**
 446.15 **appropriation is \$322,000 in fiscal year 2024**
 446.16 **and \$368,000 in fiscal year 2025.**

446.17 **Sec. 11. ATTORNEY GENERAL** **\$** **-0-** **\$** **456,000**

446.18 **(a) Expert Witnesses. \$200,000 in fiscal year**
 446.19 **2023 is for expert witnesses and investigations**
 446.20 **under Minnesota Statutes, section 62J.844.**
 446.21 **This is a onetime appropriation.**

446.22 **(b) Prescription Drug Enforcement.**
 446.23 **\$256,000 in fiscal year 2023 is for prescription**
 446.24 **drug enforcement. This is a onetime**
 446.25 **appropriation.**

446.26 Sec. 12. Laws 2021, First Special Session chapter 2, article 1, section 4, subdivision 2, is
 446.27 amended to read:

446.28 **Subd. 2. Operations and Maintenance** **621,968,000** **621,968,000**

446.29 (a) \$15,000,000 in fiscal year 2022 and
 446.30 \$15,000,000 in fiscal year 2023 are to: (1)
 446.31 increase the medical school's research
 446.32 capacity; (2) improve the medical school's
 446.33 ranking in National Institutes of Health

447.1 funding; (3) ensure the medical school's
447.2 national prominence by attracting and
447.3 retaining world-class faculty, staff, and
447.4 students; (4) invest in physician training
447.5 programs in rural and underserved
447.6 communities; and (5) translate the medical
447.7 school's research discoveries into new
447.8 treatments and cures to improve the health of
447.9 Minnesotans.

447.10 (b) \$7,800,000 in fiscal year 2022 and
447.11 \$7,800,000 in fiscal year 2023 are for health
447.12 training restoration. This appropriation must
447.13 be used to support all of the following: (1)
447.14 faculty physicians who teach at eight residency
447.15 program sites, including medical resident and
447.16 student training programs in the Department
447.17 of Family Medicine; (2) the Mobile Dental
447.18 Clinic; and (3) expansion of geriatric
447.19 education and family programs.

447.20 (c) \$4,000,000 in fiscal year 2022 and
447.21 \$4,000,000 in fiscal year 2023 are for the
447.22 Minnesota Discovery, Research, and
447.23 InnoVation Economy funding program for
447.24 cancer care research.

447.25 (d) \$500,000 in fiscal year 2022 and \$500,000
447.26 in fiscal year 2023 are for the University of
447.27 Minnesota, Morris branch, to cover the costs
447.28 of tuition waivers under Minnesota Statutes,
447.29 section 137.16.

447.30 (e) \$150,000 in fiscal year 2022 and \$150,000
447.31 in fiscal year 2023 are for the Chloe Barnes
447.32 Advisory Council on Rare Diseases under
447.33 Minnesota Statutes, section 137.68. The fiscal
447.34 year 2023 appropriation shall be transferred
447.35 to the Council on Disability. The base for this

448.1 appropriation is \$0 in fiscal year 2024 and
448.2 later.

448.3 (f) The total operations and maintenance base
448.4 for fiscal year 2024 and later is \$620,818,000.

448.5 Sec. 13. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 29,
448.6 is amended to read:

448.7 **Subd. 29. Grant Programs; Disabilities Grants** 31,398,000 31,010,000

448.8 **(a) Training Stipends for Direct Support**
448.9 **Services Providers.** \$1,000,000 in fiscal year
448.10 2022 is from the general fund for stipends for
448.11 individual providers of direct support services
448.12 as defined in Minnesota Statutes, section
448.13 256B.0711, subdivision 1. These stipends are
448.14 available to individual providers who have
448.15 completed designated voluntary trainings
448.16 made available through the State-Provider
448.17 Cooperation Committee formed by the State
448.18 of Minnesota and the Service Employees
448.19 International Union Healthcare Minnesota.
448.20 Any unspent appropriation in fiscal year 2022
448.21 is available in fiscal year 2023. This is a
448.22 onetime appropriation. This appropriation is
448.23 available only if the labor agreement between
448.24 the state of Minnesota and the Service
448.25 Employees International Union Healthcare
448.26 Minnesota under Minnesota Statutes, section
448.27 179A.54, is approved under Minnesota
448.28 Statutes, section 3.855.

448.29 **(b) Parent-to-Parent Peer Support.** \$125,000
448.30 in fiscal year 2022 and \$125,000 in fiscal year
448.31 2023 are from the general fund for a grant to
448.32 an alliance member of Parent to Parent USA
448.33 to support the alliance member's
448.34 parent-to-parent peer support program for

449.1 families of children with a disability or special
449.2 health care need.

449.3 **(c) Self-Advocacy Grants.** (1) \$143,000 in
449.4 fiscal year 2022 and \$143,000 in fiscal year
449.5 2023 are from the general fund for a grant
449.6 under Minnesota Statutes, section 256.477,
449.7 subdivision 1.

449.8 (2) \$105,000 in fiscal year 2022 and \$105,000
449.9 in fiscal year 2023 are from the general fund
449.10 for subgrants under Minnesota Statutes,
449.11 section 256.477, subdivision 2.

449.12 **(d) Minnesota Inclusion Initiative Grants.**
449.13 \$150,000 in fiscal year 2022 and \$150,000 in
449.14 fiscal year 2023 are from the general fund for
449.15 grants under Minnesota Statutes, section
449.16 256.4772.

449.17 **(e) Grants to Expand Access to Child Care**
449.18 **for Children with Disabilities.** \$250,000 in
449.19 fiscal year 2022 and \$250,000 in fiscal year
449.20 2023 are from the general fund for grants to
449.21 expand access to child care for children with
449.22 disabilities. Any unspent amount in fiscal year
449.23 2022 is available through June 30, 2023. This
449.24 is a onetime appropriation.

449.25 **(f) Parenting with a Disability Pilot Project.**
449.26 The general fund base includes \$1,000,000 in
449.27 fiscal year 2024 and \$0 in fiscal year 2025 to
449.28 implement the parenting with a disability pilot
449.29 project.

449.30 **(g) Base Level Adjustment.** The general fund
449.31 base is \$29,260,000 in fiscal year 2024 and
449.32 \$22,260,000 in fiscal year 2025.

450.1 Sec. 14. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 31,
450.2 is amended to read:

450.3 Subd. 31. **Grant Programs; Adult Mental Health**
450.4 **Grants**

450.5	Appropriations by Fund		
450.6	General	98,772,000	98,703,000
450.7	Opiate Epidemic		
450.8	Response	2,000,000	2,000,000

450.9 (a) **Culturally and Linguistically**

450.10 **Appropriate Services Implementation**

450.11 **Grants.** \$2,275,000 in fiscal year 2022 and
 450.12 \$2,206,000 in fiscal year 2023 are from the
 450.13 general fund for grants to disability services,
 450.14 mental health, and substance use disorder
 450.15 treatment providers to implement culturally
 450.16 and linguistically appropriate services
 450.17 standards, according to the implementation
 450.18 and transition plan developed by the
 450.19 commissioner. Any unspent amount in fiscal
 450.20 year 2022 is available through June 30, 2023.
 450.21 The general fund base for this appropriation
 450.22 is \$1,655,000 in fiscal year 2024 and \$0 in
 450.23 fiscal year 2025.

450.24 (b) **Base Level Adjustment.** The general fund
 450.25 base is \$93,295,000 in fiscal year 2024 and
 450.26 \$83,324,000 in fiscal year 2025. The opiate
 450.27 epidemic response fund base is \$2,000,000 in
 450.28 fiscal year 2024 and \$0 in fiscal year 2025.

450.29 Sec. 15. Laws 2021, First Special Session chapter 7, article 16, section 2, subdivision 33,
450.30 is amended to read:

450.31 Subd. 33. **Grant Programs; Chemical**
450.32 **Dependency Treatment Support Grants**

450.33	Appropriations by Fund		
450.34	General	4,273,000	4,274,000

451.1	Lottery Prize	1,733,000	1,733,000
451.2	Opiate Epidemic		
451.3	Response	500,000	500,000

451.4 **(a) Problem Gambling.** \$225,000 in fiscal
 451.5 year 2022 and \$225,000 in fiscal year 2023
 451.6 are from the lottery prize fund for a grant to
 451.7 the state affiliate recognized by the National
 451.8 Council on Problem Gambling. The affiliate
 451.9 must provide services to increase public
 451.10 awareness of problem gambling, education,
 451.11 training for individuals and organizations
 451.12 providing effective treatment services to
 451.13 problem gamblers and their families, and
 451.14 research related to problem gambling.

451.15 **(b) Recovery Community Organization**
 451.16 **Grants.** \$2,000,000 in fiscal year 2022 and
 451.17 \$2,000,000 in fiscal year 2023 are from the
 451.18 general fund for grants to recovery community
 451.19 organizations, as defined in Minnesota
 451.20 Statutes, section 254B.01, subdivision 8, to
 451.21 provide for costs and community-based peer
 451.22 recovery support services that are not
 451.23 otherwise eligible for reimbursement under
 451.24 Minnesota Statutes, section 254B.05, as part
 451.25 of the continuum of care for substance use
 451.26 disorders. Any unspent amount in fiscal year
 451.27 2022 is available through June 30, 2023. The
 451.28 general fund base for this appropriation is
 451.29 \$2,000,000 in fiscal year 2024 and \$0 in fiscal
 451.30 year 2025

451.31 **(c) Base Level Adjustment.** The general fund
 451.32 base is \$4,636,000 in fiscal year 2024 and
 451.33 \$2,636,000 in fiscal year 2025. The opiate
 451.34 epidemic response fund base is \$500,000 in
 451.35 fiscal year 2024 and \$0 in fiscal year 2025.

452.1 Sec. 16. Laws 2021, First Special Session chapter 7, article 17, section 3, is amended to
452.2 read:

452.3 **Sec. 3. GRANTS FOR TECHNOLOGY FOR HCBS RECIPIENTS.**

452.4 (a) This act includes \$500,000 in fiscal year 2022 and \$2,000,000 in fiscal year 2023
452.5 for the commissioner of human services to issue competitive grants to home and
452.6 community-based service providers. Grants must be used to provide technology assistance,
452.7 including but not limited to Internet services, to older adults and people with disabilities
452.8 who do not have access to technology resources necessary to use remote service delivery
452.9 and telehealth. Any unspent amount in fiscal year 2022 is available through June 30, 2023.
452.10 The general fund base included in this act for this purpose is \$1,500,000 in fiscal year 2024
452.11 and \$0 in fiscal year 2025.

452.12 (b) All grant activities must be completed by March 31, 2024.

452.13 (c) This section expires June 30, 2024.

452.14 Sec. 17. Laws 2021, First Special Session chapter 7, article 17, section 6, is amended to
452.15 read:

452.16 **Sec. 6. TRANSITION TO COMMUNITY INITIATIVE.**

452.17 (a) This act includes \$5,500,000 in fiscal year 2022 and \$5,500,000 in fiscal year 2023
452.18 for additional funding for grants awarded under the transition to community initiative
452.19 described in Minnesota Statutes, section 256.478. Any unspent amount in fiscal year 2022
452.20 is available through June 30, 2023. The general fund base in this act for this purpose is
452.21 \$4,125,000 in fiscal year 2024 and \$0 in fiscal year 2025.

452.22 (b) All grant activities must be completed by March 31, 2024.

452.23 (c) This section expires June 30, 2024.

452.24 Sec. 18. Laws 2021, First Special Session chapter 7, article 17, section 10, is amended to
452.25 read:

452.26 **Sec. 10. PROVIDER CAPACITY GRANTS FOR RURAL AND UNDERSERVED**
452.27 **COMMUNITIES.**

452.28 (a) This act includes \$6,000,000 in fiscal year 2022 and \$8,000,000 in fiscal year 2023
452.29 for the commissioner to establish a grant program for small provider organizations that
452.30 provide services to rural or underserved communities with limited home and

453.1 community-based services provider capacity. The grants are available to build organizational
453.2 capacity to provide home and community-based services in Minnesota and to build new or
453.3 expanded infrastructure to access medical assistance reimbursement. Any unspent amount
453.4 in fiscal year 2022 is available through June 30, 2023. The general fund base in this act for
453.5 this purpose is \$8,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

453.6 (b) The commissioner shall conduct community engagement, provide technical assistance,
453.7 and establish a collaborative learning community related to the grants available under this
453.8 section and work with the commissioner of management and budget and the commissioner
453.9 of the Department of Administration to mitigate barriers in accessing grant funds. Funding
453.10 awarded for the community engagement activities described in this paragraph is exempt
453.11 from state solicitation requirements under Minnesota Statutes, section 16B.97, for activities
453.12 that occur in fiscal year 2022.

453.13 (c) All grant activities must be completed by March 31, 2024.

453.14 (d) This section expires June 30, 2024.

453.15 Sec. 19. Laws 2021, First Special Session chapter 7, article 17, section 11, is amended to
453.16 read:

453.17 Sec. 11. **EXPAND MOBILE CRISIS.**

453.18 (a) This act includes \$8,000,000 in fiscal year 2022 and \$8,000,000 in fiscal year 2023
453.19 for additional funding for grants for adult mobile crisis services under Minnesota Statutes,
453.20 section 245.4661, subdivision 9, paragraph (b), clause (15). Any unspent amount in fiscal
453.21 year 2022 is available through June 30, 2023. The general fund base in this act for this
453.22 purpose is \$4,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

453.23 (b) Beginning April 1, 2024, counties may fund and continue conducting activities
453.24 funded under this section.

453.25 (c) All grant activities must be completed by March 31, 2024.

453.26 (d) This section expires June 30, 2024.

454.1 Sec. 20. Laws 2021, First Special Session chapter 7, article 17, section 12, is amended to
454.2 read:

454.3 **Sec. 12. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND CHILD**
454.4 **AND ADOLESCENT MOBILE TRANSITION UNIT.**

454.5 (a) This act includes \$2,500,000 in fiscal year 2022 and \$2,500,000 in fiscal year 2023
454.6 for the commissioner of human services to create children's mental health transition and
454.7 support teams to facilitate transition back to the community of children from psychiatric
454.8 residential treatment facilities, and child and adolescent behavioral health hospitals. Any
454.9 unspent amount in fiscal year 2022 is available through June 30, 2023. The general fund
454.10 base included in this act for this purpose is \$1,875,000 in fiscal year 2024 and \$0 in fiscal
454.11 year 2025.

454.12 (b) Beginning April 1, 2024, counties may fund and continue conducting activities
454.13 funded under this section.

454.14 (c) This section expires March 31, 2024.

454.15 Sec. 21. Laws 2021, First Special Session chapter 7, article 17, section 17, subdivision 3,
454.16 is amended to read:

454.17 **Subd. 3. Respite services for older adults grants.** (a) This act includes \$2,000,000 in
454.18 fiscal year 2022 and \$2,000,000 in fiscal year 2023 for the commissioner of human services
454.19 to establish a grant program for respite services for older adults. The commissioner must
454.20 award grants on a competitive basis to respite service providers. Any unspent amount in
454.21 fiscal year 2022 is available through June 30, 2023. The general fund base included in this
454.22 act for this purpose is \$2,000,000 in fiscal year 2024 and \$0 in fiscal year 2025.

454.23 (b) All grant activities must be completed by March 31, 2024.

454.24 (c) This subdivision expires June 30, 2024.

454.25 **Sec. 22. APPROPRIATIONS FOR ADVISORY COUNCIL ON RARE DISEASES.**

454.26 In accordance with Minnesota Statutes, section 15.039, subdivision 6, the unexpended
454.27 balance of money appropriated from the general fund to the Board of Regents of the
454.28 University of Minnesota for purposes of the advisory council on rare diseases under
454.29 Minnesota Statutes, section 137.68, shall be under control of the Minnesota Rare Disease
454.30 Advisory Council and the Council on Disability.

455.1 Sec. 23. APPROPRIATION ENACTED MORE THAN ONCE.

455.2 If an appropriation is enacted more than once in the 2022 legislative session, the
 455.3 appropriation must be given effect only once.

455.4 Sec. 24. SUNSET OF UNCODIFIED LANGUAGE.

455.5 All uncodified language contained in this article expires on June 30, 2023, unless a
 455.6 different effective date is explicit.

455.7 Sec. 25. EFFECTIVE DATE.

455.8 This article is effective the day following final enactment."

455.9 Delete the title and insert:

455.10 "A bill for an act

455.11 relating to health; changing provisions for health care and nursing facilities, hospital
 455.12 construction moratorium, radioactive material, ST elevation myocardial infarction
 455.13 response, health care coverage, cancer reporting system, lead hazard, safe drinking
 455.14 water, nursing home and health profession licensure, certain advisory councils,
 455.15 assisted living and home care providers, body art, medical cannabis, health care
 455.16 financing, certain health care and provider fees, certain health profession loan
 455.17 forgiveness programs, hospital core staffing plans, medical cannabis, certain grant
 455.18 programs; modifying certain definitions, hemp and edible cannabinoid product
 455.19 requirements, prohibition of discrimination in access to transplants, medical
 455.20 assistance eligibility and coverage, co-payments, report requirements, treatment
 455.21 of trusts, telehealth requirements, health-related licensing board requirements,
 455.22 practice of pharmacy, temporary ambulance service, prescription drug price
 455.23 reporting and public posting, drug administration, medication repository program,
 455.24 health insurance coverage; establishing certain advisory councils and boards,
 455.25 managed care opt-out, public MinnesotaCare option, climate resiliency program,
 455.26 long COVID program, national suicide prevention lifeline number, drug overdose
 455.27 and substance abuse prevention, ombudsperson for managed care, certain grants,
 455.28 school health initiative, Emmett Louis Till Victims Recovery, Keeping Nurses at
 455.29 the Bedside Act, registry for life-sustaining treatment orders; allowing change of
 455.30 sex designation; addressing health disparities; requiring balance billing and analysis
 455.31 of Universal Health Reform proposal; making forecast adjustments; providing for
 455.32 fees; providing civil penalties, requiring reports; amending Minnesota Statutes
 455.33 2020, sections 34A.01, subdivision 4; 62A.02, subdivision 1; 62A.25, subdivision
 455.34 2; 62A.28, subdivision 2; 62A.30, by adding a subdivision; 62J.2930, subdivision
 455.35 3; 62J.84, as amended; 62Q.021, by adding a subdivision; 62Q.55, subdivision 5;
 455.36 62Q.556; 62Q.56, subdivision 2; 62Q.73, subdivision 7; 62U.04, subdivision 11,
 455.37 by adding a subdivision; 62U.10, subdivision 7; 137.68; 144.1201, subdivisions
 455.38 2, 4; 144.122; 144.1501, subdivision 4; 144.1503; 144.1505; 144.383; 144.497;
 455.39 144.554; 144.565, subdivision 4; 144.586, by adding a subdivision; 144.6502,
 455.40 subdivision 1; 144.651, by adding a subdivision; 144.69; 144.7055; 144.9501,
 455.41 subdivisions 9, 26a, 26b; 144.9505, subdivisions 1, 1h; 144A.01; 144A.03,
 455.42 subdivision 1; 144A.04, subdivisions 4, 6; 144A.06; 144A.4799, subdivisions 1,
 455.43 3; 144A.75, subdivision 12; 144G.08, by adding a subdivision; 144G.15; 144G.17;
 455.44 144G.19, by adding a subdivision; 144G.20, subdivisions 1, 4, 5, 8, 9, 12, 15;
 455.45 144G.30, subdivision 5; 144G.31, subdivisions 4, 8; 144G.41, subdivisions 7, 8;
 455.46 144G.42, subdivision 10; 144G.50, subdivision 2; 144G.52, subdivisions 2, 8, 9;
 455.47 144G.53; 144G.55, subdivisions 1, 3; 144G.56, subdivisions 3, 5; 144G.57,

456.1 subdivisions 1, 3, 5; 144G.70, subdivisions 2, 4; 144G.80, subdivision 2; 144G.90,
 456.2 subdivision 1; 144G.91, subdivisions 13, 21, by adding a subdivision; 144G.92,
 456.3 subdivision 1; 144G.93; 144G.95; 145.56, by adding subdivisions; 145.924;
 456.4 145A.131, subdivisions 1, 5; 145A.14, by adding a subdivision; 146B.04,
 456.5 subdivision 1; 148B.33, by adding a subdivision; 148E.100, subdivision 3;
 456.6 148E.105, subdivision 3; 148E.106, subdivision 3; 148E.110, subdivision 7;
 456.7 149A.01, subdivisions 2, 3; 149A.02, subdivision 13a, by adding subdivisions;
 456.8 149A.03; 149A.09; 149A.11; 149A.60; 149A.61, subdivisions 4, 5; 149A.62;
 456.9 149A.63; 149A.65, subdivision 2; 149A.70, subdivisions 3, 4, 5, 7; 149A.90,
 456.10 subdivisions 2, 4, 5; 149A.94, subdivision 1; 150A.06, subdivisions 1c, 2c, 6, by
 456.11 adding a subdivision; 150A.09; 150A.091, subdivisions 2, 5, 8, 9, by adding
 456.12 subdivisions; 151.01, subdivisions 23, 27, by adding subdivisions; 151.071,
 456.13 subdivisions 1, 2; 151.37, by adding a subdivision; 151.555, as amended; 151.72,
 456.14 subdivisions 1, 2, 3, 4, 6, by adding a subdivision; 152.01, subdivision 23; 152.02,
 456.15 subdivisions 2, 3; 152.11, by adding a subdivision; 152.12, by adding a subdivision;
 456.16 152.125; 152.22, subdivision 8, by adding subdivisions; 152.25, subdivision 1, by
 456.17 adding a subdivision; 152.29, subdivisions 3a, 4, by adding a subdivision; 152.30;
 456.18 152.32; 152.33, subdivision 1; 152.35; 152.36; 153.16, subdivision 1; 256B.021,
 456.19 subdivision 4; 256B.055, subdivisions 2, 17; 256B.056, subdivisions 3, 3b, 3c, 4,
 456.20 7, 11; 256B.0595, subdivision 1; 256B.0625, subdivisions 13f, 17a, 22, 28b, 64,
 456.21 by adding subdivisions; 256B.0631, as amended; 256B.69, subdivisions 4, 5c, 28,
 456.22 36; 256B.692, subdivision 1; 256B.6925, subdivisions 1, 2; 256B.6928, subdivision
 456.23 3; 256B.76, subdivision 1; 256B.77, subdivision 13; 256L.03, subdivisions 1a, 5;
 456.24 256L.04, subdivisions 1c, 7a, 10, by adding a subdivision; Minnesota Statutes
 456.25 2021 Supplement, sections 62J.497, subdivisions 1, 3; 62J.84, subdivisions 6, 9;
 456.26 144.0724, subdivision 4; 144.1481, subdivision 1; 144.1501, subdivisions 1, 2, 3;
 456.27 144.551, subdivision 1; 144.9501, subdivision 17; 148B.5301, subdivision 2;
 456.28 151.335; 151.72, subdivision 5; 152.27, subdivision 2; 152.29, subdivisions 1, 3;
 456.29 256B.0371, subdivision 4; 256B.04, subdivision 14; 256B.0625, subdivisions 3b,
 456.30 9, as amended, 13, 17, 30, 31; 256B.0631, subdivision 1, as amended; 256L.07,
 456.31 subdivision 1; 256L.15, subdivision 2; 363A.50; Laws 2015, chapter 71, article
 456.32 14, section 2, subdivision 5, as amended; Laws 2020, First Special Session chapter
 456.33 7, section 1, subdivision 1, as amended; Laws 2021, First Special Session chapter
 456.34 2, article 1, section 4, subdivision 2; Laws 2021, First Special Session chapter 7,
 456.35 article 1, section 36; article 3, section 44; article 16, section 2, subdivisions 29,
 456.36 31, 33; article 17, sections 3; 6; 10; 11; 12; 17, subdivision 3; proposing coding
 456.37 for new law in Minnesota Statutes, chapters 62A; 62J; 62Q; 62W; 115; 144; 144A;
 456.38 145; 149A; 152; 256B; repealing Minnesota Statutes 2020, sections 150A.091,
 456.39 subdivisions 3, 15, 17; 256B.057, subdivision 7; 256B.063; 256B.69, subdivision
 456.40 20; 501C.0408, subdivision 4; 501C.1206."