State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 4398

03/17/2022 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to state government; appropriating money for the Department of Health and the Board of Dietetics and Nutrition Practice; amending certain health provisions for health care spending, health plan companies, balanced billing, rural health care, health care providers, suicide prevention, AIDS prevention, community health workers, health disparities, and long-term care facilities; establishing certain fees and surcharges, health professional education and loan forgiveness, and prescription drugs; requiring compliance with federal No Surprises Act; establishing Advisory Council on Water Supply Systems and Wastewater Treatment Facilities, Sentinel Event Review Committee, Law-Enforcement-Involved Deadly Force Encounter Community Advisory Committee, Long COVID Surveillance System, Mercury Surveillance System, and Healthy Beginnings, Healthy Families Act; establishing grants for health professions training sites, primary rural residency training, clinical health care training, drug overdose and substance abuse prevention, climate resiliency, healthy child development, lead remediation, community healing, chronic disease prevention and health disparities, public health education, public health Americorps, Minnesota School Health Initiative, and skin-lightening products public awareness and education; requiring reports; amending Minnesota Statutes 2020, sections 62J.84, subdivisions 2, 7, 8, by adding subdivisions; 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56, subdivision 2; 62Q.73, subdivision 7; 144.122; 144.1501, as amended; 144.1505, subdivision 2; 144.383; 144.554; 145.56, by adding subdivisions; 145.924; 403.161, subdivisions 1, 3, 5, 6; Minnesota Statutes 2021 Supplement, sections 62J.84, subdivisions 6, 9; 403.11, subdivision 1; Laws 2021, First Special Session chapter 7, article 3, section 44; proposing coding for new law in Minnesota Statutes, chapters 62J; 115; 144; 145.

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

ARTICLE 1
HEALTH POLICY

Section 1. **[62J.0411] HEALTH CARE SPENDING GROWTH TARGET COMMISSION.**

Subdivision 1. **Definition.** For purposes of this section, "commission" means the Minnesota Health Care Spending Growth Target Commission. For purposes of this section, "commissioner" means the commissioner of health.

Subd. 2. **Commission membership.** (a) The commission shall consist of 13 members, appointed as follows:

(1) four members appointed by the governor, including one representing labor unions and one representing academia;

(2) one member appointed by the majority leader of the senate;

(3) one member appointed by the minority leader of the senate;

(4) one member appointed by the speaker of the house;

(5) one member appointed by the minority leader of the house of representatives;

(6) one member appointed by the attorney general, representing consumers;

(7) one member appointed by the state auditor, representing employer organizations;

(8) one member appointed by medical care systems;

(9) one member appointed by health care providers; and

(10) one member appointed by health plan companies.

(b) All members appointed must have knowledge and demonstrated expertise in health care finance, health economics, health care management or administration at a senior level, health care consumer advocacy, representing the health care workforce as a leader in a labor organization, as purchaser of health insurance representing business management or health benefits administration, delivering primary care, health plan administration, public or population health, or addressing health disparities and structural inequities.

(c) No member may participate in commission proceedings that involve an individual provider, purchaser, or patient, or specific activity or transaction if the member has direct

financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 3. **Terms.** (a) The initial appointments to the commission shall be made by September 1, 2022. The initial appointed commission members shall serve staggered terms of two, three, or four years determined by lot by the secretary of state. Following the initial appointments, the commission members shall serve four-year terms. Members may not serve more than two consecutive four-year terms.

(b) Removal and vacancies of commission members shall be governed by section 15.059.

Subd. 4. **Chair; officers.** (a) The governor shall designate an acting chair from the members appointed by the governor.

(b) The commission shall elect a chair to replace the acting chair at the first meeting of the commission; the chair shall be elected by a majority of the members. The chair shall serve for one year.

(c) The board shall elect a vice-chair and other officers from its membership as it deems necessary.

Subd. 5. **Compensation.** Commission members may be compensated according to section 15.059.

Subd. 6. **Meetings.** Meetings of the commission:

(1) including any public hearings, are subject to chapter 13D;

(2) shall be held publicly monthly on the creation of the health care spending growth targets program until the initial targets are established; and

(3) after the growth targets are established, shall be held no less than quarterly at which the commission must consider summary data presented by the commissioner and must draft main findings for their reporting, consider updates to the program and target levels, discuss findings with health care providers and payers, and identify additional needed analysis and strategies to limit health care spending growth.

Subd. 7. **Duties of the commission.** (a) The commission shall be responsible for the development of the health care spending growth targets program, maintenance, and reporting about progress toward targets to the legislature and the public. Duties include all activities necessary for the successful implementation of the program in Minnesota with the goal of limiting health care spending growth, including:

(1) establishing a statement of purpose;

(2) developing a methodology to establish the health care spending growth targets, the economic indicators to be used in establishing the initial target level, as well as levels over time. The target must:

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

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

(iii) define the health care markets and the entities to which the targets apply;

(iv) take into consideration the need for variability in targets across public and private payers;

(v) consider whether and how the health status of patients are accounted for;

(vi) explore the addition of quality of care or primary care spending goals as part of the program;

(vii) incorporate health equity considerations, including explicit benchmarks; and

(viii) consider the impact of targets on health care access and disparities;

(3) identifying data to be used for tracking performance under the target and methods of data collection necessary for efficient implementation by the commissioner as specified in subdivision 9. In identifying data and methods, the commission shall:

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

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

(iii) limit the reporting burden as much as possible.

(b) By June 15, 2023, the commissioner must:

(1) establish target levels consistent with the methodology in paragraph (a), clause (2), for a five-year period with the goal of limiting health care spending growth;

(2) conduct, at a minimum, an annual public hearing to present findings from spending growth target monitoring;

(3) periodically review all components of the program methodology, including economic indicators and other factors, and, as appropriate, revise established target levels;

(4) based on analysis of drivers of health care spending conducted by the commissioner and evidence from public testimony, explore strategies and new policies, including the establishment of accountability mechanisms that can contribute to achieving targets or limiting health care spending growth without increasing disparities in access to health care; and

(5) complete reports as outlined in subdivision 10.

(c) In developing the target program, the commission must:

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

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

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

Subd. 8. **Administration.** The commissioner of health shall provide office space, equipment and supplies, and analytic staff support to the commission and the Health Care Spending Technical Advisory Council established in section 62J.0412.

Subd. 9. **Duties of the commissioner.** (a) The commissioner, in consultation with the commissioners of commerce and human services, shall be responsible for providing administrative and staff support to the commission, including performing and procuring consulting and analytic services. Duties include:

(1) establishing the form and manner of data reporting, including reporting methods and dates, consistent with program design and timelines formalized by the commission in subdivision 7;

(2) under authority in this chapter, collecting data identified by the commission for use in the health care spending growth targets program in a form and manner that ensures the collection of high-quality, transparent data;

(3) providing analytical support, including:

(i) conducting background research or environmental scans;

(ii) evaluating the suitability of available data;

(iii) performing needed analysis and data modeling;

(iv) calculating performance of under the spending trends; and

(v) researching drivers of spending growth trends;

(4) synthesizing and reporting to the commission;

(5) assisting health care entities subject to the targets with reporting of data, internal analysis of spending growth trends, and any necessary methodological issues; and

(6) making appointments and staffing the Health Care Spending Technical Advisory Council in section 62J.0412.

(b) In fulfilling the duties in paragraph (a), the commissioner may contract with entities with expertise in health economics, health finance, or actuarial science.

Subd. 10. **Reports.** (a) The commission shall be responsible for the following reports to the chairs and ranking members of the legislative committees with primary jurisdiction over health care:

(1) written progress updates about the development and implementation of the health care growth spending targets program by February 15, 2023, and February 15, 2024. The updates must include reporting on commission membership and activities, program design decisions, planned timelines for implementation of the program, and progress of implementation. The reports must include comprehensive methodological details underlying program design decisions;

(2) by December 15, 2024, and every December 15 thereafter, the commission shall submit a report on health care spending trends subject to the health care growth spending targets that shall include:

(i) spending growth in aggregate and for entities subject to health care growth spending targets relative to established target levels;

(ii) findings from analyses of drivers of health care spending growth;

(iii) estimates of the impact of health care spending growth on Minnesota residents, including for communities most impacted by health disparities, related to their access to insurance and care, value of health care, and the ability to pursue other spending priorities;

(iv) potential and observed impact of the health care spending growth targets on the financial viability of the rural delivery system;

(v) changes under consideration for revising the methodology to monitor the levels of spending targets; and

(vi) recommended policy provisions that could affect health care spending growth trends, including broader and more transparent adoption of value-based payment arrangements.

(b) The commission may delegate drafting of reports to the commissioner and any contractors the commissioner deems necessary. The reports shall be free to the public.

Subd. 11. **Access to information.** (a) The commission may request that a state agency provide at no cost to the commission any publicly available information related to the establishment of targets in subdivision 2 or monitoring performance under those targets in a usable format as requested by the commission or the commissioner.

(b) The commission or commissioner may request from a state agency unique or custom data sets. The agency may charge the commission or the commissioner for providing the data at the same rate the agency would charge any other public or private entity.

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

(d) Any data submitted to the commission or the commissioner shall retain their original classification under chapter 13.

Subd. 12. **Expiration exemption.** Notwithstanding section 15.059, the commission does not expire.

Sec. 2. **[62J.0412] HEALTH CARE SPENDING TECHNICAL ADVISORY COUNCIL.**

Subdivision 1. **Definition.** For purposes of this section, "council" means the Health Care Spending Technical Advisory Council. For purposes of this section, "commission" means the Minnesota Health Care Spending Growth Target Commission.

Subd. 2. **Establishment.** The commissioner of health shall appoint a ten-member Technical Advisory Council, referred to as the "council," to provide technical advice to the commission. Members shall be appointed based on their knowledge and demonstrated expertise in one or more of the following areas: health care spending trends and drivers, equitable access to health care services, health insurance operation and finance, actuarial science, the practice of medicine, patient experience, clinical and health services research, and the health care marketplace.

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

(1) two members representing patients and health care consumers, at least one of whom must have experience working with communities experiencing health disparities;

(2) the commissioner of health or a designee;

(3) the commissioner of commerce or a designee;

(4) the commissioner of human services or a designee;

(5) the commissioner of management and budget or a designee;

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

(7) two members who represent nonprofit group purchasers;

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

(9) two members who represent medical care systems;

(10) one member who represents independent health care providers; and

(11) two members who represent employee benefit plans.

Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September 30, 2022. The initial appointed council members shall serve terms until September 30, 2026.

(b) Removal and vacancies of council members shall be governed by section 15.059.

Subd. 5. **Meetings.** The council shall be convened by the request of the commission for up to six meetings per calendar year.

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

(1) provide technical advice to the commission relating to identifying metrics for health care spending growth targets;

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

(3) advise the commission on how to measure the impact on communities most impacted by health disparities, the providers who primarily serve communities most impacted by health disparities, individuals with disabilities, individuals with health coverage through medical assistance or MinnesotaCare, and individuals who reside in rural areas.

Sec. 3. **[62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. **[62J.821] STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

(b) "Health care provider directory" means an electronic catalog and index that supports management of health care provider information, both individual and organizational, in a directory structure for public use to look up available providers and networks and support state agency responsibilities.

(c) "Health care provider" means a practicing provider that accepts reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6.

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

Subd. 2. **Health care provider directory.** (a) The commissioners of health and human services shall develop and implement a statewide electronic directory of health care providers. The directory will take into consideration consumer information needs, state agency applications, stakeholder needs, technical requirements, alignment with national standards, governance, operations, legal and policy considerations, and existing directories.

Subd. 3. **Consultation.** The commissioners shall develop the directory in consultation with stakeholders including but not limited to consumers, group purchasers, health care providers, community health boards, and state agencies.

Subd. 4. **Access.** (a) The provider directory shall have a public-facing search portal that complies with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted under that act. The public portal shall provide functionality for consumers to look up available providers and their associated networks and must be published in a user-friendly format.

(b) Group purchasers shall provide timely provider network association updates such that consumers can determine which providers are in-network for their health plan coverage.

(c) The directory may be used by state agencies to carry out activities authorized by statute, including but not limited to conducting state health care purchasing functions for public programs and state employees, and for use in determination of compliance with health plan network adequacy requirements in sections 62D.124, 62K.10, and 256B.6927.

(d) The commissioners shall not post to the directory's website or portal any information described in this section if the information is not public data under section 13.02, subdivision 8a.

Subd. 5. **Recommendations.** By January 2025, the commissioners shall submit any additional legislative language needed for implementing the directory to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 5. Minnesota Statutes 2020, section 62J.84, subdivision 2, is amended to read:

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

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

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

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

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

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

(e) "Drug product family" means a group of one or more prescription drugs that share a unique generic drug description or nontrade name and dosage form.

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

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

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

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

~~(f)~~ (g) "Manufacturer" means a drug manufacturer licensed under section 151.252.

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

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

(j) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded, or dispensed under the supervision of a pharmacist.

(k) "Pharmacy benefits manager (PBM)" means an entity licensed to act as a pharmacy benefits manager under section 62W.03.

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

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

(n) "Pricing Unit" means the smallest dispensable amount of a prescription drug product that could be dispensed.

(o) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager, wholesale drug distributor, or any other entity required to submit data under section 62J.84.

(p) "Wholesale drug distributor" or "wholesaler" means an entity that:

(1) is licensed to act as a wholesale drug distributor under section 151.47; and

(2) distributes prescription drugs, of which it is not the manufacturer, to persons or entities other than a consumer or patient in the state.

Sec. 6. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 6, is amended to read:

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

(1) a list of the prescription drugs reported under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14.

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

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

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

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

Sec. 7. Minnesota Statutes 2020, section 62J.84, subdivision 7, is amended to read:

Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format

of the information reported under this section; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section.

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

Sec. 8. Minnesota Statutes 2020, section 62J.84, subdivision 8, is amended to read:

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

(1) failing to register under subdivision 15;

~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

~~(2)~~ (3) failing to provide information required under this section; or

~~(3)~~ (4) providing inaccurate or incomplete information under this section.

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

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

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

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

Sec. 9. Minnesota Statutes 2021 Supplement, section 62J.84, subdivision 9, is amended to read:

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

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

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

(3) assisting the state and other payers in the management of pharmaceutical costs.

(b) The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, ~~and~~ 5, 11, 12, 13, and 14.

Sec. 10. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than January 31, 2023, and quarterly thereafter, the commissioner shall produce and post on the department's website a list of prescription drugs that the department determines to represent a substantial public interest and for which the department intends to request data under subdivisions 11, 12, 13, and 14, subject to paragraph (c). The department shall base its inclusion of prescription drugs on any information the department determines is relevant to providing greater consumer awareness of the factors contributing to the cost of prescription drugs in the state, and the department shall consider drug product families that include prescription drugs:

(1) that triggered reporting under subdivisions 3, 4, or 5 during the previous calendar quarter;

(2) for which average claims paid amounts exceeded 125 percent of the price as of the claim incurred date during the most recent calendar quarter for which claims paid amounts are available; or

(3) that are identified by members of the public during a public comment period process.

(b) No sooner than 30 days after publicly posting the list of prescription drugs under paragraph (a), the department shall notify, via e-mail, reporting entities registered with the department of the requirement to report under subdivisions 11, 12, 13, and 14.

(c) No more than 500 prescription drugs may be designated as having a substantial public interest in any one notice.

Sec. 11. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 11. **Manufacturer prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a manufacturer must submit to the commissioner the information described in paragraph (b) for any prescription drug:

(1) included in a notification to report issued to the manufacturer by the department under subdivision 10;

(2) which the manufacturer manufactures or repackages;

(3) for which the manufacturer sets the wholesale acquisition cost; and

(4) for which the manufacturer has not submitted data under subdivisions 3 or 5 during the 120-day period prior to the date of the notification to report.

(b) For each of the drugs described in paragraph (a), the manufacturer shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the price of the drug product on the later of:

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

(11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(12) the patent expiration date of the prescription drug if it is under patent;

(13) the name and location of the company that manufactured the drug;

(14) if a brand name prescription drug, the ten countries other than the United States that paid the highest prices for the prescription drug during the previous calendar year and their prices; and

(15) if the prescription drug was acquired by the manufacturer within the 12-month period prior to the date of the notification to report, all of the following information:

(i) price at acquisition;

(ii) price in the calendar year prior to acquisition;

(iii) name of the company from which the drug was acquired;

(iv) date of acquisition; and

(v) acquisition price.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

Sec. 12. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a pharmacy must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the pharmacy by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the commissioner no later than 60 days after the date of the notification to report in the form and manner prescribed by the commissioner the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of units of the drug acquired during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report;

(5) the number of pricing units of the drug dispensed by the pharmacy during the 12-month period prior to the date of the notification to report;

(6) the total payment receivable by the pharmacy for dispensing the drug, including ingredient cost, dispensing fee, and administrative fees, during the 12-month period prior to the date of the notification to report;

(7) the total rebate payable amount accrued by the pharmacy for the drug during the 12-month period prior to the date of the notification to report; and

(8) the average cash price paid by consumers per pricing unit for prescriptions dispensed where no claim was submitted to a health care service plan or health insurer during the 12-month period prior to the date of the notification to report.

(c) The pharmacy may submit any documentation necessary to support the information reported under this subdivision.

Sec. 13. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 13. **Pharmacy benefit manager (PBM) prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a PBM as defined in section 62W.02, subdivision 14, must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the PBM by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the PBM shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(3) the total reimbursement amount accrued and payable to pharmacies for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(4) the total reimbursement or administrative fee amount or both accrued and receivable from payers for pricing units of the drug product filled for which the PBM administered claims during the 12-month period prior to the date of the notification to report;

(5) the total rebate receivable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report; and

(6) the total rebate payable amount accrued by the PBM for the drug product during the 12-month period prior to the date of the notification to report.

(c) The PBM may submit any documentation necessary to support the information reported under this subdivision.

Sec. 14. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a) Beginning January 1, 2023, a wholesaler must submit to the commissioner the information described in paragraph (b) for any prescription drug included in a notification to report issued to the wholesaler by the department under subdivision 10.

(b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the commissioner no later than 60 days after the date of the notification to report, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) a description of the drug with the following listed separately:

(i) National Drug Code;

(ii) product name;

(iii) dosage form;

(iv) strength; and

(v) package size;

(2) the number of units of the drug product acquired by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(3) the total spent before rebates by the wholesale drug distributor to acquire the drug product during the 12-month period prior to the date of the notification to report;

(4) the total rebate receivable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report;

(5) the number of units of the drug product sold by the wholesale drug distributor during the 12-month period prior to the date of the notification to report;

(6) gross revenue from sales in the United States generated by the wholesale drug distributor for this drug product during the 12-month period prior to the date of the notification to report; and

(7) total rebate payable amount accrued by the wholesale drug distributor for the drug product during the 12-month period prior to the date of the notification to report.

(c) The wholesaler may submit any documentation necessary to support the information reported under this subdivision.

Sec. 15. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 15. **Registration requirement.** Beginning January 1, 2023, a reporting entity subject to this chapter shall register with the department in a form and manner prescribed by the commissioner.

Sec. 16. Minnesota Statutes 2020, section 62J.84, is amended by adding a subdivision to read:

Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the expedited rulemaking process under section 14.389.

Sec. 17. Minnesota Statutes 2020, section 62Q.021, is amended by adding a subdivision to read:

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

Sec. 18. Minnesota Statutes 2020, section 62Q.55, subdivision 5, is amended to read:

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

Sec. 19. Minnesota Statutes 2020, section 62Q.556, is amended to read:

62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 20. Minnesota Statutes 2020, section 62Q.56, subdivision 2, is amended to read:

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

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

(i) an acute condition;

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2020, section 62Q.73, subdivision 7, is amended to read:

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

(b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the

external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

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

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

Sec. 22. **[115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND WASTEWATER TREATMENT FACILITIES.**

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

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

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

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

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

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

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

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

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

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

Sec. 23. **[144.0551] SENTINEL EVENT REVIEW COMMITTEE.**

Subdivision 1. **Purpose.** The commissioner of health shall establish a formal, protected, and nondisciplinary Sentinel Event Review Committee (SERC) to review all law-enforcement-involved deadly force encounters to make recommended changes to state and local policies and practices to prevent future events.

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

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

(c) "Use of force" refers to the effort required by police to compel compliance by an unwilling subject; it is the means of compelling compliance or overcoming resistance to an officer's commands to protect life or property or to take a person into custody. Types of force may include but are not limited to verbal, physical, chemical, impact, electronic, use of restraints, firearm or other weapon, and deaths from use of vehicles or from a police chase.

(d) A "law-enforcement-involved deadly force encounter" refers to any death where all of the following criteria are met:

(1) the death was sustained during an encounter between one or more law enforcement officials, including peace officers, state troopers, sheriffs, active military, national guard, correctional officers, federal agents, DNR officers, private security guards, enforcement personnel brought in from other jurisdictions, and one or more civilians;

(2) the death occurs during the officer's use of force while the officer is on duty or off duty but performing activities that are within the scope of the officer's law enforcement duties;

(3) the law enforcement official, whether on- or off-duty, was acting with the intention of arresting individuals that break the law, suppressing disturbances, maintaining order, or performing another legal action; and

(4) the injury leading to death took place outside of a jail or prison setting within the state.

Subd. 3. **Duties of the commissioner.** (a) The commissioner shall routinely collect and analyze data on the prevalence and incidence of law-enforcement-involved deadly force encounter in Minnesota. The commissioner shall routinely report findings to the legislature and to the public.

(b) Notwithstanding any law to the contrary, data on an individual collected by the commissioner in conducting an investigation to reduce law-enforcement-involved deadly force encounter morbidity or mortality is not subject to discovery in a legal action.

(c) The commissioner shall convene the SERC with representation from the following:

(1) Bureau of Criminal Apprehension;

(2) Board of Peace Officer Standards and Training;

(3) Department of Health;

(4) Department of Human Rights;

(5) Department of Corrections;

(6) Department of Human Services;

(7) a Minnesota medical examiner or coroner; and

(8) two appointed members at large.

(d) Members will be appointed to two-year terms, with up to two consecutive reappointments but not more than six years served consecutively. Local jurisdiction participation will be determined by the commissioner in consultation with local officials where the event occurred and organizations that provided services to the decedent, with up to five participants appointed per case. Participants will include but not be limited to law enforcement, public health officials, medical and social service providers, and community members. A member may not be a current or former employee of the agency that is the subject of the team's review.

(e) The commissioner shall convene the SERC no later than March 1, 2023, and provide meeting space and administrative assistance necessary for SERC to conduct its work, including documentation of convenings and findings in collaboration and coordination of SERC members and submission of required reports. The commissioner's staff shall facilitate the convenings and establish the sentinel event review process.

Subd. 4. **Sentinel Event Review.** (a) Initial review by the commissioner's staff will be completed within 90 days of the event to determine any immediate action, appropriate local representation, and timeline for review by the full SERC.

(b) The SERC is charged with identifying and analyzing the root causes of the incident. Following the analysis, the SERC must prepare a report that recommends policy and system changes to reduce and prevent future incidents across jurisdictions, agencies, and systems.

(c) The full review needs to be completed within six months of the event, or as soon as is practicable, and the report must be filed with the commissioner of health and agency that employed the peace officer involved in the event within 60 days of completion of the review. The commissioner of health must post the report on the Department of Health public website. The posted report must comply with chapter 13, and any data that is not public data must be redacted.

(d) By June 15 of each year, the SERC shall report to the chairs and ranking minority members of the house of representatives and senate committees and divisions with jurisdiction over public safety on the number of reviews performed under this subdivision, aggregate data on those reviews, the number of reviews that included a recommendation that the agency under review implement a corrective action plan, a description of any recommendations made to the commissioner of public safety statewide training of peace officers, and recommendations for legislative action.

Subd. 5. **Access to data.** (a) The SERC team shall collect, review, and analyze data related to the decedent and law enforcement official involved.

Data may include death certificates and death data, including investigative reports, medical and counseling records, victim service records, employment records, survivor interviews and surveys, witness accounts of incident, or other pertinent information concerning decedent's life and access to services as determined by the SERC.

Data may include law enforcement official's employment record, employment institution's standard operating procedures, and other pertinent information concerning law enforcement officer and law enforcement agency.

(b) The review team has access to the following not public data, as defined in section 13.02, subdivision 8a, relating to a case being reviewed by the SERC relating to the victim or a family or household member of the victim: (1) inactive law enforcement investigative data under section 13.82; (2) autopsy records and coroner or medical examiner investigative data under section 13.83; (3) hospital, public health, or other medical records of the victim under section 13.384; and (4) records under section 13.46, created by social service agencies that provided services to the victim, the alleged perpetrator, or another victim who experienced use of force or was threatened by the peace officer. Access to medical records under this paragraph also includes records governed by sections 144.291 to 144.298. The SERC has access to corrections and detention data as provided in section 13.85.

(c) As part of any review, the SERC may compel the production of other records by applying to the district court for a subpoena, which will be effective throughout the state according to the Rules of Civil Procedure.

Subd. 6. **Confidentiality and data privacy.** A person attending a SERC meeting may not disclose what transpired at the meeting, except to carry out the purposes of the review or as otherwise provided in this subdivision. The SERC may disclose the names of the victims in the cases it reviewed. The proceedings and records of the SERC are confidential data as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13, regardless of their classification in the hands of the person who provided the data, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency, arising out of the matters the team is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the SERC. This section does not limit a person who presented information before the SERC or who is a member of the panel from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding, a person may not be questioned about the person's good faith presentation of information to the SERC or opinions formed by the person as a result of the SERC meetings.

Subd. 7. **Violation a misdemeanor.** Any data disclosure other than as provided for in this section is a misdemeanor and punishable as such.

Subd. 8. **Immunity.** Members of the SERC are immune from claims and are not subject to any suits, liability, damages, or any other recourse, civil or criminal, arising from any act, proceeding, decision, or determination undertaken or performed or recommendation made by the SERC, provided they acted in good faith and without malice in carrying out their responsibilities. Good faith is presumed unless proven otherwise and the complainant has the burden of proving malice or a lack of good faith. No organization, institution, or person furnishing information, data, testimony, reports, or records to the domestic fatality review team as part of an investigation is civilly or criminally liable or subject to any other recourse for providing the information.

Subd. 9. **Community-based grant programs.** The commissioner shall establish a grant program to fund community grants of up to $5,000 each to implement actionable recommendations developed by the SERC.

Sec. 24. **[144.0552] LAW-ENFORCEMENT-INVOLVED DEADLY FORCE ENCOUNTER COMMUNITY ADVISORY COMMITTEE.**

Subdivision 1. **Establishment.** The commissioner shall establish an 18-member law-enforcement-involved deadly force encounter community advisory committee. The commissioner shall provide the advisory committee with staff support, office space, and access to office equipment and services. Members appointed by the commissioner are appointed for a three-year term and may be reappointed. Nonstate employee members of the advisory committee will be compensated at the rate of $55 per day spent on committee activities, plus expenses, when authorized by the committee as described in section 15.059, subdivision 3. Meetings must be held at least twice yearly, with additional meetings scheduled as necessary.

Subd. 2. **Membership.** (a) The commissioner shall appoint 18 members, none of whom may be lobbyists registered under chapter 10A, including:

(1) at least nine members from Minnesota-based nongovernmental organizations that advocate on behalf of one of the following groups:

(i) the American Indian and Alaska Native community, Black, African, or African American communities, Hispanic or Latino communities, and Asian or Asian American communities;

(ii) the LGBTQ+ community;

(iii) the disability community;

(iv) people affected by mental illness; and

(v) families and loved ones of persons who have died in law-enforcement-involved deadly force encounter incidents;

(2) at least one academic partner with experience studying racial equity in health;

(3) a representative from the Department of Human Rights

(4) a representative from the Department of Public Safety;

(5) a representative from the Department of Human Services; and

(6) a representative from the Department of Health's Center for Health Equity.

(b) The advisory committee may also invite other relevant persons to serve on an ad hoc basis and participate as full members of the review team for a particular review. These persons may include but are not limited to:

(1) individuals with expertise that would be helpful to the review panel; or

(2) representatives of organizations or agencies that had contact with or provided services to the decedent.

Subd. 3. **Duties.** The advisory committee shall:

(1) advise the commissioner and other state agencies on:

(i) health outcomes related to law-enforcement-involved deadly force encounter and priorities for data collection and public health research;

(ii) specific communities and geographic areas on which to focus prevention efforts; and

(iii) opportunities for community partnerships and sources of additional funding;

(2) develop goals and expectations for the Sentinel Event Review Committee (SERC) that can be used in future evaluations;

(3) review and approve of reports and recommendations drafted by SERC; and

(4) review applications for community-based grants as described in section 144.0551, subdivision 9, and make recommendations to the department about which should be funded.

Sec. 25. Minnesota Statutes 2020, section 144.122, is amended to read:

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

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

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

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals	$7,655 plus $16 per bed
Non-JCAHO and non-AOA hospitals	$5,280 plus $250 per bed
Nursing home	$183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018,

	and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

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

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

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

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

Prospective payment surveys for hospitals	$	900
Swing bed surveys for nursing homes	$	1,200
Psychiatric hospitals	$	1,400
Rural health facilities	$	1,100
Portable x-ray providers	$	500
Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	

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

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

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

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

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

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

Sec. 26. Minnesota Statutes 2020, section 144.1501, as amended by Laws 2021, First Special Session chapter 7, article 3, sections 22 to 24, is amended to read:

144.1501 HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS PROGRAM.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

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

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

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

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

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

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

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

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

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

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

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, except public health employees eligible under subdivision 2, paragraph (a), clause (7) may be eligible within three years of completing their training.

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. For distributions among public health employees, available funds are limited to the appropriations funded in fiscal year 2022. In considering applications, the commissioner shall give preference to applicants who document diverse cultural competencies. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic

area, facility type, teaching area, patient group, or specialty type specified in subdivision 2, except for funds for public health employees which will be distributed according to areas of high need as determined by the commissioner. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the

commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

Subd. 6. **Rules.** The commissioner may adopt rules to implement this section.

Sec. 27. Minnesota Statutes 2020, section 144.1505, subdivision 2, is amended to read:

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

(b) Funds may be used for:

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

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

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

(4) travel and lodging for students;

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

(6) development and implementation of cultural competency training;

(7) evaluations;

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

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

Sec. 28. **[144.1507] PRIMARY CARE RURAL RESIDENCY TRAINING GRANT PROGRAM.**

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

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

(1) is located in Minnesota;

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

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

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

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

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

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

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

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

(3) establishing new rural residency training programs;

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

(5) travel and lodging for new residents;

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

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

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

Subd. 3. **Applications for rural residency training program grants.** (a) Eligible programs seeking a grant shall apply to the commissioner. Applications must include: (1) the number of new primary care rural residency training program slots planned, under

development, or under contract; (2) a description of the training program, including the location of the established residency program and rural training sites; (3) a description of the project, including all costs associated with the project; (4) all sources of funds for the project; (5) detailed uses of all funds for the project; (6) the results expected; and (7) a plan to seek federal funding for graduate medical education for the site if eligible.

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

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

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

Sec. 29. **[144.1508] CLINICAL HEALTH CARE TRAINING.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2020, section 144.383, is amended to read:

144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2020, section 144.554, is amended to read:

144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.

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

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

Construction project total estimated cost	Fee
$0 - $10,000	~~$30~~ $45
$10,001 - $50,000	~~$150~~ $225
$50,001 - $100,000	~~$300~~ $450
$100,001 - $150,000	~~$450~~ $675
$150,001 - $200,000	~~$600~~ $900
$200,001 - $250,000	~~$750~~ $1,125
$250,001 - $300,000	~~$900~~ $1,350
$300,001 - $350,000	~~$1,050~~ $1,575
$350,001 - $400,000	~~$1,200~~ $1,800
$400,001 - $450,000	~~$1,350~~ $2,025
$450,001 - $500,000	~~$1,500~~ $2,250
$500,001 - $550,000	~~$1,650~~ $2,475
$550,001 - $600,000	~~$1,800~~ $2,700
$600,001 - $650,000	~~$1,950~~ $2,925
$650,001 - $700,000	~~$2,100~~ $3,150
$700,001 - $750,000	~~$2,250~~ $3,375
$750,001 - $800,000	~~$2,400~~ $3,600
$800,001 - $850,000	~~$2,550~~ $3,825
$850,001 - $900,000	~~$2,700~~ $4,050
$900,001 - $950,000	~~$2,850~~ $4,275
$950,001 - $1,000,000	~~$3,000~~ $4,500
$1,000,001 - $1,050,000	~~$3,150~~ $4,725
$1,050,001 - $1,100,000	~~$3,300~~ $4,950
$1,100,001 - $1,150,000	~~$3,450~~ $5,175
$1,150,001 - $1,200,000	~~$3,600~~ $5,400
$1,200,001 - $1,250,000	~~$3,750~~ $5,625
$1,250,001 - $1,300,000	~~$3,900~~ $5,850
$1,300,001 - $1,350,000	~~$4,050~~ $6,075
$1,350,001 - $1,400,000	~~$4,200~~ $6,300
$1,400,001 - $1,450,000	~~$4,350~~ $6,525
$1,450,001 - $1,500,000	~~$4,500~~ $6,750
$1,500,001 and over	~~$4,800~~ $7,200

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

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

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

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

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

Subd. 5. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) not-for-profit agencies or organizations with existing organizational structure, capacity, trainers, facilities, and infrastructure designed to deliver model workplace policies and practices; that have training and education for employees, supervisors, and executive

leadership of companies, businesses, and industry; and that have the ability to evaluate the three goals of the workplace initiative specified in subdivision 4; and

(2) at least one organization may be selected with statewide reach and influence. Up to five smaller organizations may be selected to reach specific geographic or population groups.

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

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

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

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

(1) increase awareness of climate change;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Grant recipient and contractor eligibility.** The commissioner of health shall award contracts and competitive grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within such groups.

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

Sec. 35. **[145.371] MERCURY SURVEILLANCE SYSTEM.**

Subdivision 1. **Surveillance.** The commissioner of health shall establish a statewide mercury surveillance system. The purpose of this system is to:

(1) monitor blood and urine mercury levels in children and adults to identify trends and populations at high risk for elevated mercury levels;

(2) ensure that screening services are provided to populations at high risk for elevated mercury levels;

(3) ensure that medical and environmental follow-up services for persons with elevated mercury levels are provided; and

(4) provide accurate and complete data for planning and implementing primary prevention programs that focus on the populations at high risk for elevated mercury levels.

Subd. 2. **Studies and surveys.** The commissioner of health shall collect blood and urine mercury level and exposure information, analyze the information, and conduct studies designed to determine the potential for high risk for elevated mercury levels among children and adults.

Subd. 3. **Reports of blood and urine mercury analysis required.** (a) Every hospital, medical clinic, medical laboratory, other facility, or individual performing blood or urine mercury analysis shall report the results after the analysis of each specimen analyzed and epidemiologic information required in this section to the commissioner of health, in a format prescribed by the commissioner, within two weeks of the analysis.

(b) If a blood or urine mercury analysis is performed outside of Minnesota and the facility performing the analysis does not report the mercury analysis results and epidemiological information required in this section to the commissioner, the provider who placed the test result order must satisfy the reporting requirements of this section. For purposes of this section, "provider" has the meaning given in section 62D.02, subdivision 9.

Subd. 4. **Blood and urine analyses and epidemiologic information.** The blood mercury analysis and urine mercury analysis reports required in this section must specify:

(1) specimen type, including whether urine samples were random or 24 hour collections;

(2) the urine creatinine level, if performed;

(3) the date the sample was collected;

(4) the results of the analysis;

(5) the date the sample was analyzed;

(6) the method of analysis used;

(7) the full name, address, and phone number of the laboratory performing the analysis;

(8) the full name, address, and phone number of the physician, advanced practice registered nurse, or facility requesting the analysis; and

(9) the full name, address, and phone number of the person with the blood or urine mercury level and the person's birthdate, gender, race, and ethnicity.

Subd. 5. **Follow-up epidemiologic information.** Reports that are required under this chapter shall contain as much of the following information as is known:

(1) date of first symptoms;

(2) primary signs and symptoms;

(3) place of work, school, or child care of the person with the blood or urine mercury level;

(4) pregnancy status and expected date of delivery; and

(5) other information pertinent to the case.

Subd. 6. **Reporting without liability.** The furnishing of the information required under this section shall not subject the person, laboratory, or other facility furnishing the information to any action for damages or relief.

Subd. 7. **Laboratory standards.** A laboratory performing blood or urine mercury analysis shall use methods that:

(1) meet or exceed the proficiency standards established in the federal Clinical Laboratory Improvement Regulations, Code of Federal Regulations, title 42, section XXX; or

(2) meet or exceed the Occupational Safety and Health Standards, Code of Federal Regulations, section XXX.

Subd. 8. **Classification of data.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected by the commissioner of health about persons with blood or urine mercury test results shall be private and may only be used by the commissioner of health, the commissioner of labor and industry, the commissioner of pollution control, the commissioner of commerce, authorized agents of Indian Tribes, and authorized employees of community health boards for the purposes set forth in this section.

Sec. 36. **[145.372] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of increasing public awareness and education on the health dangers associated with using skin-lightening creams and products that contain mercury that are manufactured in other countries and brought into this country and sold illegally online or in stores.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to community-based organizations serving ethnic communities, local public health entities, and nonprofit organizations that focus on providing health care and public health outreach to minorities. Priority shall be given to organizations that have historically served ethnic communities at significant risk from these products but have not traditionally had access to state grant funding.

Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness and education activities that are culturally specific and community-based and focus on:

(1) the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and contact with individuals who have used these skin-lightening products;

(2) the signs and symptoms of mercury poisoning;

(3) the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys;

(4) the dangers of using these products or being exposed to these products during pregnancy and breastfeeding to the mother and to the infant;

(5) knowing how to identify products that contain mercury; and

(6) proper disposal of the product if the product contains mercury.

(b) The grant application must include:

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

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

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

(c) The commissioner shall award 50 percent of the grant funds to community-based organizations and nonprofit organizations and 50 percent of the grant funds to local public health entities.

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

Subd. 6. **988; National Suicide Prevention Lifeline number.** The National Suicide Prevention Lifeline is expanded to improve the quality of care and access to behavioral health crisis services and to further health equity and save lives. A surcharge is imposed on certain communications services to support the 988 hotline for the purpose of complying with the National Suicide Hotline Designation Act of 2020 and the Federal Communication Commission's rules adopted July 16, 2020, that designated 988 as the new nationwide number for the National Suicide Prevention Lifeline.

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

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

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

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

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

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

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

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

Sec. 39. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 40. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 9. **988 special revenue account.** (a) A dedicated account in the special revenue fund is established for 988 special revenue.

(b) The account shall consist of:

(1) 988 telecommunications service surcharge imposed under subdivision 10;

(2) appropriations made by the state legislature;

(3) grants and gifts intended for deposit;

(4) interest, premiums, gains, or other earnings on the account; and

(5) money from any other source that is deposited in or transferred to the account.

(c) Money in the account:

(1) shall only be used to administer 988 services under subdivision 8;

(2) does not revert at the end of any state fiscal year and is carried forward to subsequent state fiscal years;

(3) is not subject to transfer to any other fund or to transfer, assignment, or reassignment for any other use or purpose outside of the purposes specified under subdivision 10; and

(4) is continuously appropriated to the commissioner of health for the purposes of the account.

Sec. 41. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 10. **988 telecommunications service surcharge.** (a) The Department of Public Safety shall impose a surcharge on each consumer access line of a wireless service an IP-enabled voice service, prepaid wireless, or wire-line service.

(b) The amount of the surcharge must not be more than 12 cents a month on or after July 1, 2022, for each consumer access line. The fee must be the same for all consumers.

(c) The 988 surcharge shall be collected by each telecommunications service provider and remitted to the Department of Health on a monthly basis and credited to the 988 account in the special revenue fund. Surcharges are payable to and must be submitted to the commissioner monthly before the 25th of each month following the month of collection, except that fees may be submitted quarterly if less than $250 a month is due, or annually if less than $25 a month is due. Receipts must be deposited in the state treasury and credited to the 988 account in the special revenue fund. The money in the account shall only be used for 988 services.

(d) The commissioner of health shall report on revenue and expenditures generated by the 988 surcharge as required by the United States Federal Communications Commission.

Sec. 42. Minnesota Statutes 2020, section 145.924, is amended to read:

145.924 AIDS PREVENTION GRANTS.

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

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including intravenous drug users and their partners, adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policy makers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific community.

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

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

Sec. 43. **[145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

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

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

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

(3) promote racial and geographic equity.

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

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

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

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

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the governor's early learning council on the request for proposal process;

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

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

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

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

Subd. 3. **Community solutions advisory council; establishment; duties; compensation.** (a) The commissioner of health shall establish a community solutions advisory council. By October 1, 2022, the commissioner shall convene a 12-member community solutions advisory council. Members of the advisory council are:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

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

(4) two members representing the American Indian community;

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

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

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

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

(c) The community solutions advisory council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 44. **[145.9272] LEAD REMEDIATION IN SCHOOLS AND CHILD CARE SETTINGS GRANT PROGRAM.**

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

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

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

Sec. 45. **[145.9281] COMMUNITY HEALING GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish the community healing grant program. The purposes of the program are to:

(1) improve outcomes as related to the well-being of Black, nonwhite Latino, American Indian, LGBTQ, and disability communities, including but not limited to health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce health inequities related to mental health and well-being; and

(3) promote racial and geographic equity.

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

(1) develop a request for proposals for a community healing grant program in consultation with community stakeholders, local public health organizations, and Tribal nations;

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

(3) review responses to requests for proposals in consultation with community stakeholders and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, Minnesota Council on Disability, and the governor's office on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with community stakeholders, focused on outcomes that grantees agree to achieve;

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

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

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities related to mental health and well-being.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with Black, nonwhite Latino, and American Indian communities;

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

(3) organizations or entities focused on supporting mental health and community healing.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, local public health organizations, and Tribal nations, shall develop a request for proposals for mental health, community healing, and well-being grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote well-being and support holistic health. Proposals must focus on increasing health equity and community healing and reducing health disparities experienced by Black, nonwhite Latino, American Indian, LGBTQ, and disability communities.

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

(1) organizations or entities led by Black and nonwhite populations of color and serving communities of color;

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

(3) organizations or entities with proposals focused on community healing, mental health, and well-being;

(4) organizations or entities located in or with proposals to serve communities most impacted by mental health inequities; and

(5) community-based organizations that have historically served and plan to serve Black, nonwhite Latino, American Indian, LGBTQ, and disability communities. The advisory council may recommend additional strategic considerations and priorities to the commissioner.

(c) The first round of grants must be awarded no later than May 15, 2023

Subd. 5. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino, American Indian, LGBTQ, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 46. **[145.9282] COMMUNITY HEALTH WORKERS; REDUCING HEALTH DISPARITIES WITH COMMUNITY-LED CARE.**

Subdivision 1. **Establishment.** The commissioner of health shall support collaboration and coordination between state and community partners to develop, refine, and expand the community health workers profession across the state equipping them to address health needs and to improve health outcomes by addressing the social conditions that impact health status. Community health professionals' work expands beyond health care to bring health and racial equity into public safety, social services, youth and family services, schools, neighborhood associations, and more.

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

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

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

Sec. 47. **[145.9283] REDUCING HEALTH DISPARITIES AMONG PEOPLE WITH DISABILITIES; GRANTS.**

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

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

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

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

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

Sec. 48. **[145.9291] PUBLIC HEALTH EDUCATION STIPEND PROGRAM.**

Subdivision 1. **Establishment and purpose.** The commissioner of health shall establish a grant program to provide educational stipends to students participating in a field placement or project in a local, Tribal, or state public health agency to gain experience in working in governmental public health.

Subd. 2. **Creation of account.** A public health education stipend program account is established in the special revenue fund in the state treasury. Appropriations made to the account do not cancel and are available until expended.

Subd. 3. **Eligibility.** To be eligible for a grant under this section, a student must:

(1) be enrolled in an institute of higher education in a public health related field or program; and

(2) identify a governmental public health agency able to support student participation in a significant public health program.

Subd. 4. **Administration.** The commissioner shall:

(1) establish an application process and other guidelines for implementing this program;

(2) make a determination each academic year for the stipend amount based on the amount of available funding and the number of eligible applicants;

(3) give equal consideration to all eligible applicants regardless of the order the application was received before the application deadline; and

(4) provide administrative support to the program by providing staff who will coordinate with institutions of higher education to make connections between students and governmental public health programs.

Sec. 49. **[145.9292] PUBLIC HEALTH AMERICORPS.**

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

Sec. 50. **[145.987] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

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

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

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

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

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

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

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

(b) Grantee activities shall:

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

(2) be based on community input;

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

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

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications under this subdivision, the commissioner shall establish criteria including but not limited to: (1) the eligibility of the project; (2) the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; (3) a description of the applicant's proposed project; (4) a description of the population demographics and service area of the proposed project; and (5) evidence of efficiencies and effectiveness gained through collaborative efforts.

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

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

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

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

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

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

(5) health equity.

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

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

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

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

(b) Help Me Connect shall provide community outreach that includes support for and participation in the help me connect system, including disseminating information and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health and human services and resources, and other appropriate early childhood information.

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

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

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

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

(b) The commissioner shall:

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

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

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

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

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

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

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

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

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

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

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

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

(1) parenting classes or groups;

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

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

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

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

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

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

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

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

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

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

Sec. 51. **[145.988] MINNESOTA SCHOOL HEALTH INITIATIVE.**

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

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

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, by licensed and qualified health professionals in accordance with federal, state, and local law. When not located on school property, the school-based health center must have an established relationship with one or more schools in the community and operate primarily to serve those student groups.

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

(1) health care providers;

(2) community clinics;

(3) hospitals;

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

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

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

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

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

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

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

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

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

(1) preventative health care;

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

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

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

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

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

(1) provide oral health-risk assessment, screening, education, and anticipatory guidance;

(2) provide oral health services including fluoride varnish and dental sealant;

(3) make referrals for restorative and other follow-up dental care as needed; and

(4) provide free access to fluoridated drinking water to give students a healthy alternative to sugar-sweetened beverages.

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

Subd. 7. **Whole school, whole community, whole child grants.** (a) The commissioner of health shall administer a program to provide competitive grants to schools, local public health organizations, and community organizations using the evidence-based Whole School, Whole Community, Whole Child (WSCC) model to increase alignment, integration and

collaboration between public health and education sectors to improve each child's cognitive, physical, oral, social, and emotional development.

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

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

(2) improve physical, nutritional, psychological, social, and emotional environment of schools;

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

(4) promote and establish lifelong healthy behaviors.

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

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

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

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

(1) needs assessment;

(2) community engagement and capacity building;

(3) community asset building and risk behavior reduction;

(4) dental provider training in calibration;

(5) dental services related equipment, instruments, supplies;

(6) communications;

(7) community, school, health care, work site, and other site-specific strategies;

(8) health equity;

(9) data collection and analysis; and

(10) evaluation.

Sec. 52. Minnesota Statutes 2021 Supplement, section 403.11, subdivision 1, is amended to read:

Subdivision 1. **Emergency telecommunications service fee; account.** (a) Each customer of a wireless or wire-line switched or packet-based telecommunications service provider connected to the public switched telephone network that furnishes service capable of originating a 911 emergency telephone call is assessed a fee based upon the number of wired or wireless telephone lines, or their equivalent, to cover the costs of ongoing maintenance and related improvements for trunking and central office switching equipment for 911 emergency telecommunications service, to offset administrative and staffing costs of the commissioner related to managing the 911 emergency telecommunications service program, to make distributions provided for in section 403.113, and to offset the costs, including administrative and staffing costs, incurred by the State Patrol Division of the Department of Public Safety in handling 911 emergency calls made from wireless phones.

(b) Money remaining in the 911 emergency telecommunications service account after all other obligations are paid must not cancel and is carried forward to subsequent years and may be appropriated from time to time to the commissioner to provide financial assistance to counties for the improvement of local emergency telecommunications services.

(c) The fee may not be more than 95 cents a month on or after July 1, 2010, for each customer access line or other basic access service, including trunk equivalents as designated by the Public Utilities Commission for access charge purposes and including wireless telecommunications services. With the approval of the commissioner of management and budget, the commissioner of public safety shall establish the amount of the fee within the limits specified and inform the companies and carriers of the amount to be collected. When the revenue bonds authorized under section 403.27, subdivision 1, have been fully paid or defeased, the commissioner shall reduce the fee to reflect that debt service on the bonds is no longer needed. The commissioner shall provide companies and carriers a minimum of 45 days' notice of each fee change. The fee must be the same for all customers, except that the fee imposed under this subdivision does not apply to prepaid wireless telecommunications service, which is instead subject to the fee imposed under section 403.161, subdivision 1, paragraph (a).

(d) The fee must be collected by each wireless or wire-line telecommunications service provider subject to the fee. Fees are payable to and must be submitted to the commissioner monthly before the 25th of each month following the month of collection, except that fees

may be submitted quarterly if less than $250 a month is due, or annually if less than $25 a month is due. Receipts must be deposited in the state treasury and credited to a 911 emergency telecommunications service account in the special revenue fund. The money in the account may only be used for 911 telecommunications services.

(e) Competitive local exchanges carriers holding certificates of authority from the Public Utilities Commission are eligible to receive payment for recurring 911 services.

(f) A 988 telecommunications service surcharge of 12 cents is imposed on each customer access line of a wireless service, an IP-enabled voice service, or wire-line service under section 144.56, subdivision 10.

Sec. 53. Minnesota Statutes 2020, section 403.161, subdivision 1, is amended to read:

Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail transaction is imposed on prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(c) A 988 telecommunications service surcharge of 12 cents is imposed on prepaid wireless telecommunication services under section 144.56, subdivision 10.

Sec. 54. Minnesota Statutes 2020, section 403.161, subdivision 3, is amended to read:

Subd. 3. **Fee collected.** The prepaid wireless E911, 988 telecommunications service surcharge, and telecommunications access Minnesota fees must be collected by the seller from the consumer for each retail transaction occurring in this state. The amount of each fee must be combined into one amount, which must be separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller.

Sec. 55. Minnesota Statutes 2020, section 403.161, subdivision 5, is amended to read:

Subd. 5. **Remittance.** The prepaid wireless E911, 988 telecommunications service surcharge, and telecommunications access Minnesota fees are the liability of the consumer and not of the seller or of any provider, except that the seller is liable to remit all fees as provided in section 403.162.

Sec. 56. Minnesota Statutes 2020, section 403.161, subdivision 6, is amended to read:

Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid wireless E911, 988 telecommunications service surcharge, and telecommunications access Minnesota fees collected by a seller from a consumer must not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

Sec. 57. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to read:

Sec. 44. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.**

(a) The commissioner of health shall develop a grant program, in consultation with the relevant mental health licensing boards, to:

(1) provide for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors to become supervisors for individuals pursuing licensure in mental health professions;

(2) cover the costs when supervision is required for professionals becoming supervisors; and

(3) cover the supervisory costs for mental health practitioners pursuing licensure at the professional level.

(b) Social workers, marriage and family therapists, psychologists, and professional clinical counselors obtaining continuing education and social workers, marriage and family therapists, and clinical counselors needing supervised hours to become licensed under this section must:

(1) be members of communities of color or underrepresented communities as defined in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health professional shortage area; and

(2) ~~work for community mental health providers and~~ agree to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

Sec. 58. **IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE; REPORT.**

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group purchasers and the amount of low-value care delivered to Minnesota residents. In support of the development of recommendations, the commissioner shall:

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

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

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

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

(b) By December 15, 2024, the commissioner shall report the recommendations to the chairs and ranking members of the legislative committees with jurisdiction over health and human services financing and policy.

Sec. 59. **PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

The commissioner shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value-based, global budgeting, or alternative payment systems and recommend steps needed to implement. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs. The commissioner shall develop recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial viability of rural health care systems in the context of spending growth targets. The commissioner shall share findings with the Minnesota Health Care Spending Growth Target Commission.

Sec. 60. **SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM CARE FACILITIES.**

Subdivision 1. **Temporary grant program for long-term care safety improvements.** The commissioner of health shall develop, implement, and manage a temporary, competitive grant process for state-licensed long-term care facilities to improve their ability to reduce the transmission of COVID-19 or other similar conditions.

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

(b) "Eligible facility" means:

(1) an assisted living facility licensed under chapter 144G;

(2) a supervised living facility licensed under chapter 144;

(3) a board and care facility that is not federally certified and is licensed under chapter 144; and

(4) a nursing home that is not federally certified and is licensed under chapter 144A.

(c) "Eligible project" means a modernization project to update, remodel or replace outdated equipment, systems, technology, or physical spaces.

Subd. 3. **Program.** (a) The commissioner of health shall award improvement grants to an eligible facility. An improvement grant shall not exceed $1,250,000.

(b) Funds may be used to improve the safety, quality of care, and livability of aging infrastructure in a Department of Health licensed eligible facility with an emphasis on reducing the transmission risk of COVID-19 and other infections. Projects include but are not limited to:

(1) heating, ventilation, and air-conditioning systems improvements to reduce airborne exposures;

(2) physical space changes for infection control; and

(3) technology improvements to reduce social isolation and improve resident or client well-being.

(c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not lapse until expended by the grantee.

Subd. 4. **Applications.** An eligible facility seeking a grant shall apply to the commissioner. The application must include a description of the resident population

demographics, the problem the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, including any in-kind resources, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals and organization. An applicant must submit to the commissioner evidence that competitive bidding was used to select contractors for the project.

Subd. 5. **Consideration of applications.** The commissioner shall review each application to determine if the application is complete and if the facility and the project are eligible for a grant. In evaluating applications, the commissioner shall develop a standardized scoring system that assesses: (1) the applicant's understanding of the problem, description of the project and the likelihood of a successful outcome of the project; (2) the extent to which the project will reduce the transmission of COVID-19; (3) the extent to which the applicant has demonstrated that it has made adequate provisions to ensure proper and efficient operation of the facility once the project is completed; (4) and other relevant factors as determined by the commissioner. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant.

Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible facility based on the relative score of each eligible facility's application, other relevant factors discussed during the review, and the funds available to the commissioner. During the grant period and within one year after completion of the grant period, the commissioner may collect from an eligible facility receiving a grant, any information necessary to evaluate the program.

Subd. 7. **Expiration.** This section expires June 30, 2025.

Sec. 61. **REVISOR INSTRUCTION.**

The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article 3, section 44, as Minnesota Statutes, section 144.1504. The revisor of statutes may make any necessary cross-reference changes.

ARTICLE 2

HEALTH APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2021, First Special Session chapter 7, article 16, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2021, First Special Session chapter 7, article 16. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2022, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2022	**2023**

Sec. 2. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **215,136,000**

Appropriations by Fund

	2022	2023
General	-0-	188,539,000
State Government Special Revenue	-0-	4,597,000
Health Care Access	-0-	22,000,000

Subd. 2. **Health Improvement**

Appropriations by Fund

General	-0-	173,550,000
State Government Special Revenue	-0-	430,000
Health Care Access	-0-	22,000,000

(a) **988 National Suicide Prevention Lifeline.**

The general fund base previously provided for 988 suicide prevention lifeline grants in Laws 2019, First Special Session chapter 9, article

14, section 3, subdivision 2, paragraph (c), clause (4), is reduced by $1,321,000 in fiscal year 2024 and is reduced by $1,321,000 in fiscal year 2025.

(b) **Address Growing Health Care Costs.** $0 in fiscal year 2022 and $3,375,000 in fiscal year 2023 are from the general fund for initiatives aimed at addressing growth in health care spending while ensuring stability in rural health care programs under Minnesota Statutes, section 62J.0411. The general fund base for this appropriation is $4,175,000 in fiscal year 2024, and $4,175,000 in fiscal year 2025.

(c) **Community Healing Program.** $0 in fiscal year 2022 and $2,019,000 in fiscal year 2023 are from the general fund for the community healing grant program under Minnesota Statutes, section 145.9281. Of the total appropriation in fiscal year 2023, $313,000 is for administration and $1,706,000 is for grants. The general fund base for this appropriation is $1,514,000 in fiscal year 2024 and $1,514,000 in fiscal year 2025, of which $310,000 is for administration and $1,204,000 in each fiscal year is for grants.

(d) **Community Health Workers.** $0 in fiscal year 2022 and $1,462,000 in fiscal year 2023 are from the general fund for a public health approach to developing community health workers across Minnesota, under Minnesota Statutes, section 145.9282. Of the fiscal year 2023 appropriation, $462,000 is for administration and $1,000,000 is for grants. The general fund base for this appropriation

is $1,097,000 in fiscal year 2024, of which $337,000 is for administration and $760,000 is for grants, and $1,098,000 in fiscal year 2025, of which $338,000 is for administration and $760,000 is for grants.

(e) **Community Solutions for Healthy Child Development.** $0 in fiscal year 2022 and $10,000,000 in fiscal year 2023 are from the general fund for the community solutions for healthy child development grant program under Minnesota Statutes, section 145.9271. Of the fiscal year 2023 appropriation, $1,250,000 is for administration and $8,750,000 is for grants. The general fund base appropriation is $10,000,000 in fiscal year 2024 and $10,000,000 in fiscal year 2025, of which $1,250,000 is for administration and $8,750,000 is for grants in each fiscal year.

(f) **Disability as a Health Equity Issue.** $0 is fiscal year 2022 and $1,575,000 in fiscal year 2023 are from the general fund to reduce disability-related health disparities through collaboration and coordination between state and community partners under Minnesota Statutes, section 145.9283. Of the fiscal year 2023 appropriation, $1,130,000 is for administration and $445,000 is for grants. The general fund base for this appropriation is $1,585,000 in fiscal year 2024 and $1,585,000 in fiscal year 2025, of which $1,140,000 is for administration and $445,000 is for grants.

(g) **Drug Overdose and Substance Abuse Prevention.** $0 in fiscal year 2022 and $5,042,000 in fiscal year 2023 are from the general fund for a public health prevention

approach to drug overdose and substance use disorder in Minnesota Statutes, section 144.8611. Of the total appropriation in fiscal year 2023, $921,000 is for administration and $4,121,000 is for grants.

(h) **Health Care Provider Directory.** $0 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are from the general fund for development of a statewide health care provider directory under Minnesota Statutes, section 62J.821. The general fund base for this appropriation is $2,000,000 in fiscal year 2024 and $7,000,000 in fiscal year 2025.

(i) **Healthy Beginnings, Healthy Families.** $0 in fiscal year 2022 and $11,700,000 in fiscal year 2023 are from the general fund for Healthy Beginnings, Healthy Families services under Minnesota Statutes, section 145.987. The general fund base for this appropriation is $11,818,000 in fiscal year 2024 and $11,763,000 in fiscal year 2025. Of this total appropriation:

(1) $0 in fiscal year 2022 and $7,510,000 in fiscal year 2023 are from the general fund for Minnesota Collaborative to Prevent Infant Mortality under Minnesota Statutes, section 145.987, subdivisions 2, 3, and 4. Of the fiscal year 2023 appropriation, $1,535,000 is for administration and $5,975,000 is for grants. The general fund base for this appropriation is $7,501,000 in fiscal year 2024, of which $1,526,000 is for administration and $5,975,000 is for grants, and $7,501,000 in fiscal year 2025, of which $1,526,000 is for administration and $5,975,000 is for grants.

(2) $0 in fiscal year 2022 and $340,000 in fiscal year 2023 are from the general fund for Help Me Connect under Minnesota Statutes, section 145.987, subdivisions 5 and 6. The general fund base for this appropriation is $663,000 in fiscal year 2024 and $663,000 in fiscal year 2025.

(3) $0 in fiscal year 2022 and $1,940,000 in fiscal year 2023 are from the general fund for voluntary developmental and social-emotional screening and follow-up under Minnesota Statutes, section 145.987, subdivisions 7 and 8. Of the fiscal year 2023 appropriation, $1,190,000 is for administration and $750,000 is for grants. The general fund base for this appropriation is $1,764,000 in fiscal year 2024, of which $1,014,000 is for administration and $750,000 is for grants, and $1,764,000 in fiscal year 2025 of which $1,014,000 is for administration and $750,000 is for grants.

(4) $0 in fiscal year 2022 and $1,910,000 in fiscal year 2023 are from the general fund for model jail practices for incarcerated parents under Minnesota Statutes, section 145.987, subdivisions 9, 10, and 11. Of the fiscal year 2023 appropriation, $485,000 is for administration and $1,425,000 is for grants. The general fund base for this appropriation is $1,890,000 in fiscal year 2024, of which $465,000 is for administration and $1,425,000 is for grants, and $1,835,000 in fiscal year 2025, of which $410,000 is for administration and $1,425,000 is for grants.

(j) **Home Visiting.** $0 in fiscal year 2022 and $126,700,000 in fiscal year 2023 are from the general fund for statewide home visiting services under Minnesota Statutes, section 145.87. The general fund base for this appropriation is $210,501,000 in fiscal year 2024 and $313,599,000 in fiscal year 2025. Of the total appropriation, ten percent is for administration and 90 percent is for implementation grants of home visiting services to families.

(k) **Long COVID.** $0 in fiscal year 2022 and $2,669,000 in fiscal year 2023 are from the general fund for a public health approach to supporting long COVID survivors under Minnesota Statutes, section 145.361. Of the fiscal year 2023 appropriation, $2,119,000 is for administration and $550,000 is for grants. The base for this appropriation is $3,706,000 in fiscal year 2024 and $3,706,000 in fiscal year 2025, of which $3,156,000 is for administration and $550,000 is for grants in each fiscal year.

(l) **Medical Education Research Cost (MERC).** Of the amount previously appropriated in the general fund by Laws 2015, chapter 71, article 3, section 2, for the MERC program, $150,000 in fiscal year 2023 and each year thereafter is for the administration of grants under Minnesota Statutes, section 62J.692.

(m) **No Surprises Act Enforcement.** $0 in fiscal year 2022 and $964,000 in fiscal year 2023 are from the general fund for implementation of the federal No Surprises

Act portion of the Consolidated Appropriations Act, 2021, under Minnesota Statutes, section 62Q.021, subdivision 3. The general fund base for this appropriation is $763,000 in fiscal year 2024 and $757,000 in fiscal year 2025.

(n) **Public Health Workforce.** $0 in fiscal year 2022 and $2,185,000 in fiscal year 2023 are from the general fund for a public health workforce retention and expansion. The general fund base for this appropriation is $1,436,000 in fiscal year 2024 and $1,437,000 in fiscal year 2025. Of this total appropriation:

(1) $0 in fiscal year 2022 and $800,000 in fiscal year 2023 are from the general fund for loan forgiveness for individuals working in local, Tribal, or state public health departments in Minnesota under Minnesota Statutes, section 144.1501, which may be added to the account annually under section 144.1501, subdivision 2. The base for this appropriation is $400,000 in fiscal year 2024 and $400,000 in fiscal year 2025.

(2) $0 in fiscal year 2022 and $1,000,000 in fiscal year 2023 are from the general fund for a public health AmeriCorps grant under Minnesota Statutes, section 145.9292. The base for this appropriation is $750,000 in fiscal year 2024 and $750,000 in fiscal year 2025.

(3) $0 in fiscal year 2022 and $70,000 in fiscal year 2023 are from the general fund for public health education stipend grants under Minnesota Statutes, section 145.9291. The base for this appropriation is $38,000 in fiscal year 2024 and $38,000 in fiscal year 2025.

(4) $0 in fiscal year 2022 and $315,000 in fiscal year 2023 are from the general fund for administration of the public health workforce retention and expansion program. The base for this appropriation is $248,000 in fiscal year 2024 and $249,000 in fiscal year 2025.

(o) **Revitalize Health Care Workforce.** $0 in fiscal year 2022 and $22,000,000 in fiscal year 2023 are from the health care access fund to address challenges of Minnesota's health care workforce. Of the total appropriation:

(1) $0 in fiscal year 2022 and $2,073,000 in fiscal year 2023 are from the health care access fund for the health professionals clinical training expansion and rural and underserved clinical rotations grant program under Minnesota Statutes, section 144.1505. Of the total appropriation in fiscal year 2023, $423,000 is for administration and $1,650,000 is for grants. Grant appropriations are available until expended under Minnesota Statutes, section 144.1505, subdivision 2.

(2) $0 in fiscal year 2022 and $4,507,000 in fiscal year 2023 are from the health care access fund for the primary care rural residency training grant program under Minnesota Statutes, section 144.1507. Of the total appropriation in fiscal year 2023, $207,000 is for administration and $4,300,000 is for grants. Grant appropriations are available until expended under Minnesota Statutes, section 144.1507, subdivision 2.

(3) $0 in fiscal year 2022 and $425,000 in fiscal year 2023 are from the health care access fund for workforce research that

provides needed information on status and causes of workforce shortages, maldistribution of health care providers in Minnesota, and determinants of practicing in rural areas, under Minnesota Statutes, section 144.051.

(4) $0 in fiscal year 2022 and $430,000 in fiscal year 2023 are from the health care access fund to the international medical graduates assistance program under Minnesota Statutes, section 144.1911, for international immigrant medical graduates to fill a gap in their preparedness for medical residencies or transition to a new career making use of their medical degrees. Of the total appropriation in fiscal year 2023, $55,000 is for administration and $375,000 is for grants.

(5) $0 in fiscal year 2022 and $12,565,000 in fiscal year 2023 are from the health care access fund for a grant program to health care systems, hospitals, clinics, and other providers to ensure the availability of clinical training for students, residents, and graduate students to meet health professions educational requirements, under Minnesota Statutes, section 144.1508. Of the total appropriation in fiscal year 2023, $565,000 is for administration and $12,000,000 is for grants.

(6) $0 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the health care access fund for the mental health cultural community continuing education grant program, under Minnesota Statutes, section 144.1504. Of the total appropriation in fiscal year 2023, $460,000 is for administration and $1,540,000 is for grants.

(p) **School Health.** $0 in fiscal year 2022 and $837,000 in fiscal year 2023 are from the general fund for the School Health Initiative under Minnesota Statutes, section 145.988. The general fund base for this appropriation is $3,462,000 in fiscal year 2024, of which $1,212,000 is for administration and $2,250,000 is for grants and $3,287,000 in fiscal year 2025, of which $1,037,000 is for administration and $2,250,000 is for grants.

(q) **Sentinel Event Reviews for Police-Involved Deadly Force Encounters.** $0 in fiscal year 2022 and $494,000 in fiscal year 2023 are from the general fund for a public health response to law enforcement-involved deadly force encounters under Minnesota Statutes, section 144.0551. Of the fiscal year 2023 appropriation, $444,000 is for administration of the sentinel event reviews and $50,000 is for a grant.

(r) **Trauma System.** $0 in fiscal year 2022 and $61,000 in fiscal year 2023 are from the general fund to administer the trauma care system throughout the state under Minnesota Statutes, sections 144.602, 144.603, 144.604, 144.606, and 144.608. $0 in fiscal year 2022 and $430,000 in fiscal year 2023 are from the state government special revenue fund for trauma designations per Minnesota Statutes, sections 144.122, paragraph (g), 144.605, and 144.6071.

(s) **Base Level Adjustments.** The general fund base is increased by $259,800,000 in fiscal year 2024 and $367,664,000 in fiscal year 2025. The health care access fund base

is increased by $22,000,000 in fiscal year 2024 and $22,000,000 in fiscal year 2025. The state government special revenue fund base is increased by $430,000 in fiscal year 2024 and $430,000 in fiscal year 2025.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	.....	14,989,000
State Government Special Revenue	.....	4,167,000

(a) **Climate Resiliency.** $0 in fiscal year 2022 and $1,977,000 in fiscal year 2023 are from the general fund for climate resiliency actions under Minnesota Statutes, section 144.9981. Of the fiscal year 2023 appropriation, $977,000 is for administration and $1,000,000 is for grants. The general fund base for this appropriation is $988,000 in fiscal year 2024, of which $888,000 is for administration and $100,000 is for grants, and $989,000 in fiscal year 2025, of which $889,000 is for administration and $100,000 is for grants.

(b) **Lead Remediation in Schools and Child Care Settings.** $0 in fiscal year 2022 and $2,054,000 in fiscal year 2023 are from the general fund for a lead in drinking water remediation in schools and child care settings grant program under Minnesota Statutes, section 145.9272. Of the total fiscal year 2023 appropriation, $454,000 is for administration and $1,600,000 is for grants. The general fund base for this appropriation is $1,540,000 in fiscal year 2024, of which $370,000 is for administration and $1,170,000 is for grants, and $1,541,000 in fiscal year 2025, of which

$371,000 is for administration and $1,170,000 is for grants.

(c) **Lead Service Line Inventory.** $0 in fiscal year 2022 and $4,029,000 in fiscal year 2023 are from the general fund for grants to public water suppliers to complete a lead service line inventory of their distribution systems under Minnesota Statutes, section 144.383, clause (6). Of the total fiscal year 2023 appropriation, $279,000 is for administration and $3,750,000 is for grants. The general fund base for this appropriation is $4,029,000 in fiscal year 2024, of which $279,000 is for administration and $3,750,000 is for grants, and $140,000 in fiscal year 2025, which is for administration.

(d) **Mercury in Skin-Lightening Products Grants.** $0 in fiscal year 2022 and $300,000 in fiscal year 2023 are from the general fund for a skin-lightening products public awareness and education grant program under Minnesota Statutes, section 145.372. Of the fiscal year 2023 appropriation, $150,000 is for administration and $150,000 is for grants.

(e) **HIV Prevention for People Experiencing Homelessness.** $0 in fiscal year 2022 and $1,129,000 in fiscal year 2023 from the general fund for expanding access to harm reduction services and improving linkages to care to prevent HIV/AIDS, hepatitis, and other infectious diseases for those experiencing homelessness or housing instability under Minnesota Statutes, section 145.924, paragraph (d). Of the total fiscal year 2023 appropriation, $169,000 is for administration and $960,000 is for grants.

(f) **Safety Improvements for State-Licensed Long-Term Care Facilities.** $0 in fiscal year 2022 and $5,500,000 in fiscal year 2023 are from the general fund for a temporary grant program. Of the total appropriation in fiscal year 2023, $500,000 is for administration and $5,000,000 is for grants. The general fund base for this appropriation is $8,200,000 in fiscal year 2024 and $0 in fiscal year 2025. Of the total appropriation in fiscal year 2024, $700,000 is for administration and $7,500,000 is for grants. Amounts appropriated in this paragraph are available until June 30, 2025.

(g) **Base Level Adjustments.** The general fund base is increased by $16,186,000 in fiscal year 2024 and $4,099,000 in fiscal year 2025. The state government special revenue fund base is increased by $4,167,000 in fiscal year 2024 and $4,167,000 in fiscal year 2025.

Sec. 3. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$**	**-0-**	**$**	**25,000**
Appropriations by Fund				
State Government Special Revenue	-0-	25,000		

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Dietetics and Nutrition Practice**	-0-	25,000