

**SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION**

S.F. No. 2360

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DATE	D-PG	OFFICIAL STATUS
04/06/2021	1215	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/07/2021	1313	Authors added Abeler; Draheim
04/12/2021	2147a	Comm report: To pass as amended and re-refer to Finance
04/26/2021		Comm report: To pass as amended Second reading

1.1 A bill for an act

1.2 relating to health; modifying provisions governing health care, human services,

1.3 and licensing and background studies; establishing a budget for health and human

1.4 services; making technical and conforming changes; transferring money;

1.5 appropriating money; amending Minnesota Statutes 2020, sections 16A.151,

1.6 subdivision 2; 62J.495, subdivisions 1, 2, 3, 4; 62J.498; 62J.4981; 62J.4982;

1.7 62J.701; 62J.72, subdivision 3; 62J.84, subdivision 6; 62W.11; 62W.13; 144.05,

1.8 by adding a subdivision; 144.057, subdivision 1; 144.1205, subdivisions 2, 4, 8,

1.9 9, by adding a subdivision; 144.125, subdivisions 1, 2; 144.1481, subdivision 1;

1.10 144.216, by adding subdivisions; 144.218, by adding a subdivision; 144.225,

1.11 subdivision 7; 144.226, subdivision 1; 144.551, subdivision 1; 144E.001, by adding

1.12 a subdivision; 144E.27; 144E.28, subdivisions 1, 3, 7, 8; 144E.283; 144E.285,

1.13 subdivisions 1, 2, 4, by adding subdivisions; 145.902; 148.995, subdivision 2;

1.14 148.996, subdivisions 2, 4, by adding a subdivision; 151.01, subdivision 29, by

1.15 adding subdivisions; 151.065, subdivisions 1, 3, 7; 151.066, subdivision 3; 151.555,

1.16 subdivisions 1, 7, 11, by adding a subdivision; 245C.02, subdivision 4a; 245C.05,

1.17 subdivisions 2c, 5; 245C.08, subdivision 1; 245C.32, subdivision 1a; 245F.03;

1.18 245G.02, subdivision 2; 245G.06, subdivision 3; 245G.11, subdivision 7; 254B.05,

1.19 subdivisions 1, 5, by adding a subdivision; 256.01, subdivision 28, by adding a

1.20 subdivision; 256.042, subdivision 4; 256.043, subdivision 4; 256.969, by adding

1.21 a subdivision; 256.9695, subdivision 1; 256.983; 256B.055, subdivision 6;

1.22 256B.056, subdivision 10; 256B.057, subdivision 3; 256B.06, subdivision 4;

1.23 256B.0625, subdivisions 3c, 3d, 3e, 9, 13, 13c, 13e, 13g, by adding subdivisions;

1.24 256B.0631, subdivision 1, by adding a subdivision; 256B.0638, subdivisions 3,

1.25 5, 6; 256B.0659, subdivision 13; 256B.196, subdivision 2; 256B.69, subdivision

1.26 6d, by adding a subdivision; 256B.6928, subdivision 5; 256B.75; 256L.01,

1.27 subdivision 5; 256L.04, subdivision 7b; 256L.05, subdivision 3a; 256L.15, by

1.28 adding a subdivision; 260E.31, subdivision 1; 295.53, subdivision 1; 326.71,

1.29 subdivision 4; 326.75, subdivisions 1, 2, 3; proposing coding for new law in

1.30 Minnesota Statutes, chapters 62A; 62J; 62Q; 144; 145; 148; 151; 256B; 363A;

1.31 repealing Minnesota Statutes 2020, sections 16A.724, subdivision 2; 144E.27,

1.32 subdivisions 1, 1a; 151.19, subdivision 3.

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

2.2 **ARTICLE 1**

2.3 **HEALTH CARE; DEPARTMENT OF HUMAN SERVICES**

2.4 Section 1. Minnesota Statutes 2020, section 245F.03, is amended to read:

2.5 **245F.03 APPLICATION.**

2.6 (a) This chapter establishes minimum standards for withdrawal management programs
2.7 licensed by the commissioner that serve one or more unrelated persons.

2.8 (b) This chapter does not apply to a withdrawal management program licensed as a
2.9 hospital under sections 144.50 to 144.581. A withdrawal management program located in
2.10 a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this
2.11 chapter is deemed to be in compliance with section 245F.13. This chapter does not apply
2.12 when a license holder is providing pre-treatment coordination services under section 254B.05,
2.13 subdivision 4a.

2.14 (c) Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to withdrawal
2.15 management programs licensed under this chapter.

2.16 **EFFECTIVE DATE.** This section is effective July 1, 2021.

2.17 Sec. 2. Minnesota Statutes 2020, section 245G.02, subdivision 2, is amended to read:

2.18 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
2.19 or recovery community organization that is providing a service for which the county or
2.20 recovery community organization is an eligible vendor under section 254B.05. This chapter
2.21 does not apply to an organization whose primary functions are information, referral,
2.22 diagnosis, case management, and assessment for the purposes of client placement, education,
2.23 support group services, or self-help programs. This chapter does not apply to the activities
2.24 of a licensed professional in private practice. A license holder providing the initial set of
2.25 substance use disorder services allowable under section 254A.03, subdivision 3, paragraph
2.26 (c), to an individual referred to a licensed nonresidential substance use disorder treatment
2.27 program after a positive screen for alcohol or substance misuse is exempt from sections
2.28 245G.05; 245G.06, subdivisions 1, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses
2.29 (2) to (4), and 2, clauses (1) to (7); and 245G.17. This chapter does not apply when a license
2.30 holder is providing pretreatment coordination services under section 254B.05, subdivision
2.31 4a.

2.32 **EFFECTIVE DATE.** This section is effective July 1, 2021.

3.1 Sec. 3. Minnesota Statutes 2020, section 245G.06, subdivision 3, is amended to read:

3.2 Subd. 3. **Documentation of treatment services and pretreatment services; treatment**
3.3 **plan review.** (a) A review of all treatment services must be documented weekly and include
3.4 a review of:

3.5 (1) ~~care~~ treatment coordination activities, including any pretreatment coordination
3.6 services;

3.7 (2) medical and other appointments the client attended;

3.8 (3) issues related to medications that are not documented in the medication administration
3.9 record; and

3.10 (4) issues related to attendance for treatment services, including the reason for any client
3.11 absence from a treatment service.

3.12 (b) A note must be entered immediately following any significant event. A significant
3.13 event is an event that impacts the client's relationship with other clients, staff, the client's
3.14 family, or the client's treatment plan.

3.15 (c) A treatment plan review must be entered in a client's file weekly or after each treatment
3.16 service, whichever is less frequent, by the staff member providing the service. The review
3.17 must indicate the span of time covered by the review and each of the six dimensions listed
3.18 in section 245G.05, subdivision 2, paragraph (c). The review must:

3.19 (1) indicate the date, type, and amount of each treatment service provided and the client's
3.20 response to each service;

3.21 (2) address each goal in the treatment plan and whether the methods to address the goals
3.22 are effective;

3.23 (3) include monitoring of any physical and mental health problems;

3.24 (4) document the participation of others;

3.25 (5) document staff recommendations for changes in the methods identified in the treatment
3.26 plan and whether the client agrees with the change; and

3.27 (6) include a review and evaluation of the individual abuse prevention plan according
3.28 to section 245A.65.

3.29 (d) Each entry in a client's record must be accurate, legible, signed, and dated. A late
3.30 entry must be clearly labeled "late entry." A correction to an entry must be made in a way
3.31 in which the original entry can still be read.

4.1 **EFFECTIVE DATE.** This section is effective July 1, 2021.

4.2 Sec. 4. Minnesota Statutes 2020, section 245G.11, subdivision 7, is amended to read:

4.3 Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination
4.4 must be provided by qualified staff. An individual is qualified to provide treatment
4.5 coordination if the individual meets the qualifications of an alcohol and drug counselor
4.6 under subdivision 5 or if the individual:

4.7 (1) is skilled in the process of identifying and assessing a wide range of client needs;

4.8 (2) is knowledgeable about local community resources and how to use those resources
4.9 for the benefit of the client;

4.10 (3) has successfully completed 30 hours of classroom instruction on treatment
4.11 coordination for an individual with substance use disorder;

4.12 (4) has either:

4.13 (i) a bachelor's degree in one of the behavioral sciences or related fields; or

4.14 (ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest
4.15 Indian Council on Addictive Disorders; and

4.16 (5) has at least 2,000 hours of supervised experience working with individuals with
4.17 substance use disorder.

4.18 (b) A treatment coordinator must receive at least one hour of supervision regarding
4.19 individual service delivery from an alcohol and drug counselor, or a mental health
4.20 professional who has substance use treatment and assessments within the scope of their
4.21 practice, on a monthly basis.

4.22 (c) County staff who conduct chemical use assessments under Minnesota Rules, part
4.23 9530.6615, and are employed as of July 1, 2022, are qualified to provide treatment
4.24 coordination under section 245G.07, subdivision 1, paragraph (a), clause (5). County staff
4.25 who conduct chemical use assessments under Minnesota Rules, part 9530.6615, and are
4.26 employed after July 1, 2021, are qualified to provide treatment coordination under section
4.27 245G.07, subdivision 1, paragraph (a), clause (5), if the county staff person completes the
4.28 classroom instruction in paragraph (a), clause (3).

4.29 **EFFECTIVE DATE.** This section is effective July 1, 2022.

5.1 Sec. 5. Minnesota Statutes 2020, section 254B.05, subdivision 1, is amended to read:

5.2 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are
5.3 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
5.4 notwithstanding the provisions of section 245A.03. American Indian programs that provide
5.5 substance use disorder treatment, extended care, transitional residence, ~~or~~ outpatient treatment
5.6 services, and are licensed by tribal government are eligible vendors. American Indian
5.7 programs are eligible vendors of peer support services according to section 245G.07,
5.8 subdivision 2, clause (8). An alcohol and drug counselor as defined in section 245G.11,
5.9 subdivision 5, must be available to recovery peers for ongoing consultation, as needed.

5.10 (b) A licensed professional in private practice as defined in section 245G.01, subdivision
5.11 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible
5.12 vendor of a comprehensive assessment and assessment summary provided according to
5.13 section 245G.05, and treatment services provided according to sections 245G.06 and
5.14 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses
5.15 (1) to (6).

5.16 (c) A county is an eligible vendor for a comprehensive assessment and assessment
5.17 summary when provided by an individual who meets the staffing credentials of section
5.18 245G.11, subdivisions 1 and 5, and completed according to the requirements of section
5.19 245G.05. A county is an eligible vendor of ~~care~~ treatment coordination services when
5.20 provided by an individual who meets the staffing credentials of section 245G.11, subdivisions
5.21 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1,
5.22 paragraph (a), clause (5). A county is an eligible vendor of peer recovery support services
5.23 according to section 245G.07, subdivision 2, clause (8). An alcohol and drug counselor as
5.24 defined in section 245G.11, subdivision 5, must be available to recovery peers for ongoing
5.25 consultation, as needed.

5.26 (d) Nonresidential programs licensed under chapter 245G, withdrawal management
5.27 programs licensed under chapter 245F, American Indian programs described in paragraph
5.28 (a), and counties are eligible vendors of pretreatment coordination services as defined under
5.29 section 254B.05, subdivision 4a, when the individual providing the services meets the
5.30 staffing credentials in section 245G.11, subdivisions 1 and 7.

5.31 (e) A recovery community organization that meets certification requirements identified
5.32 by the commissioner is an eligible vendor of peer support services.

5.33 ~~(e)~~ (f) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
5.34 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or

6.1 nonresidential substance use disorder treatment or withdrawal management program by the
6.2 commissioner or by tribal government or do not meet the requirements of subdivisions 1a
6.3 and 1b are not eligible vendors.

6.4 **EFFECTIVE DATE.** This section is effective July 1, 2021.

6.5 Sec. 6. Minnesota Statutes 2020, section 254B.05, is amended by adding a subdivision to
6.6 read:

6.7 Subd. 4a. **Pretreatment coordination services.** (a) An enrolled provider may provide
6.8 pretreatment coordination services to an individual prior to the individual's comprehensive
6.9 assessment under section 245G.05, to facilitate an individual's access to a comprehensive
6.10 assessment. The total pretreatment coordination services must not exceed 36 units per
6.11 eligibility determination.

6.12 (b) An individual providing pretreatment coordination services must meet the staff
6.13 qualifications in section 245G.11, subdivision 7. Section 245G.05 and Minnesota Rules,
6.14 parts 9530.6600 to 9530.6655, do not apply to pretreatment coordination services.

6.15 (c) To be eligible for pretreatment coordination services, an individual must screen
6.16 positive for alcohol or substance misuse using a screening tool approved by the commissioner.
6.17 The provider may bill the screening as a pretreatment coordination service.

6.18 (d) Pretreatment coordination services include:

6.19 (1) assisting with connecting an individual with a qualified comprehensive assessment
6.20 provider;

6.21 (2) identifying barriers that might inhibit an individual's ability to participate in a
6.22 comprehensive assessment; and

6.23 (3) assisting with connecting an individual with resources to mitigate an individual's
6.24 immediate safety risks.

6.25 (e) A license holder is authorized to provide up to 36 units of pretreatment coordination
6.26 services, excluding travel time, and must document the following information in the client's
6.27 case file:

6.28 (1) the dates, number of units, and description of pretreatment coordination services
6.29 provided;

6.30 (2) identifying an individual's safety concerns and developing a plan to address those
6.31 concerns;

- 7.1 (3) assisting an individual with scheduling an appointment for a comprehensive
7.2 assessment and confirming that the individual and provider keep the appointment; and
7.3 (4) assisting an individual with accessing resources for obtaining a comprehensive
7.4 assessment authorizing substance use disorder treatment services.

7.5 **EFFECTIVE DATE.** This section is effective July 1, 2021.

7.6 Sec. 7. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

7.7 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance
7.8 use disorder services and service enhancements funded under this chapter.

7.9 (b) Eligible substance use disorder treatment services include:

7.10 (1) outpatient treatment services that are licensed according to sections 245G.01 to
7.11 245G.17, or applicable tribal license;

7.12 (2) comprehensive assessments provided according to sections 245.4863, paragraph (a),
7.13 and 245G.05;

7.14 (3) ~~care~~ treatment coordination services provided according to section 245G.07,
7.15 subdivision 1, paragraph (a), clause (5);

7.16 (4) peer recovery support services provided according to section 245G.07, subdivision
7.17 2, clause (8);

7.18 (5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management
7.19 services provided according to chapter 245F;

7.20 (6) medication-assisted therapy services that are licensed according to sections 245G.01
7.21 to 245G.17 and 245G.22, or applicable tribal license;

7.22 (7) medication-assisted therapy plus enhanced treatment services that meet the
7.23 requirements of clause (6) and provide nine hours of clinical services each week;

7.24 (8) high, medium, and low intensity residential treatment services that are licensed
7.25 according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which
7.26 provide, respectively, 30, 15, and five hours of clinical services each week;

7.27 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
7.28 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
7.29 144.56;

7.30 (10) adolescent treatment programs that are licensed as outpatient treatment programs
7.31 according to sections 245G.01 to 245G.18 or as residential treatment programs according

8.1 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
8.2 applicable tribal license;

8.3 (11) high-intensity residential treatment services that are licensed according to sections
8.4 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
8.5 clinical services each week provided by a state-operated vendor or to clients who have been
8.6 civilly committed to the commissioner, present the most complex and difficult care needs,
8.7 and are a potential threat to the community; ~~and~~

8.8 (12) room and board facilities that meet the requirements of subdivision 1a; and

8.9 (13) pretreatment coordination services provided according to subdivision 4a.

8.10 (c) The commissioner shall establish higher rates for programs that meet the requirements
8.11 of paragraph (b) and one of the following additional requirements:

8.12 (1) programs that serve parents with their children if the program:

8.13 (i) provides on-site child care during the hours of treatment activity that:

8.14 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
8.15 9503; or

8.16 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
8.17 (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

8.18 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
8.19 licensed under chapter 245A as:

8.20 (A) a child care center under Minnesota Rules, chapter 9503; or

8.21 (B) a family child care home under Minnesota Rules, chapter 9502;

8.22 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
8.23 programs or subprograms serving special populations, if the program or subprogram meets
8.24 the following requirements:

8.25 (i) is designed to address the unique needs of individuals who share a common language,
8.26 racial, ethnic, or social background;

8.27 (ii) is governed with significant input from individuals of that specific background; and

8.28 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
8.29 whom are of that specific background, except when the common social background of the
8.30 individuals served is a traumatic brain injury or cognitive disability and the program employs
8.31 treatment staff who have the necessary professional training, as approved by the

9.1 commissioner, to serve clients with the specific disabilities that the program is designed to
9.2 serve;

9.3 (3) programs that offer medical services delivered by appropriately credentialed health
9.4 care staff in an amount equal to two hours per client per week if the medical needs of the
9.5 client and the nature and provision of any medical services provided are documented in the
9.6 client file; and

9.7 (4) programs that offer services to individuals with co-occurring mental health and
9.8 chemical dependency problems if:

9.9 (i) the program meets the co-occurring requirements in section 245G.20;

9.10 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
9.11 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
9.12 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
9.13 mental health professional, except that no more than 50 percent of the mental health staff
9.14 may be students or licensing candidates with time documented to be directly related to
9.15 provisions of co-occurring services;

9.16 (iii) clients scoring positive on a standardized mental health screen receive a mental
9.17 health diagnostic assessment within ten days of admission;

9.18 (iv) the program has standards for multidisciplinary case review that include a monthly
9.19 review for each client that, at a minimum, includes a licensed mental health professional
9.20 and licensed alcohol and drug counselor, and their involvement in the review is documented;

9.21 (v) family education is offered that addresses mental health and substance abuse disorders
9.22 and the interaction between the two; and

9.23 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
9.24 training annually.

9.25 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
9.26 that provides arrangements for off-site child care must maintain current documentation at
9.27 the chemical dependency facility of the child care provider's current licensure to provide
9.28 child care services. Programs that provide child care according to paragraph (c), clause (1),
9.29 must be deemed in compliance with the licensing requirements in section 245G.19.

9.30 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
9.31 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
9.32 in paragraph (c), clause (4), items (i) to (iv).

10.1 (f) Subject to federal approval, chemical dependency services that are otherwise covered
10.2 as direct face-to-face services may be provided via two-way interactive video. The use of
10.3 two-way interactive video must be medically appropriate to the condition and needs of the
10.4 person being served. Reimbursement shall be at the same rates and under the same conditions
10.5 that would otherwise apply to direct face-to-face services. The interactive video equipment
10.6 and connection must comply with Medicare standards in effect at the time the service is
10.7 provided.

10.8 (g) For the purpose of reimbursement under this section, substance use disorder treatment
10.9 services provided in a group setting without a group participant maximum or maximum
10.10 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.
10.11 At least one of the attending staff must meet the qualifications as established under this
10.12 chapter for the type of treatment service provided. A recovery peer may not be included as
10.13 part of the staff ratio.

10.14 **EFFECTIVE DATE.** This section is effective July 1, 2021.

10.15 Sec. 8. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

10.16 Subd. 28. **Statewide health information exchange.** (a) The commissioner has the
10.17 authority to join and participate as a member in a legal entity developing and operating a
10.18 statewide health information exchange or to develop and operate an encounter alerting
10.19 service that shall meet the following criteria:

10.20 (1) the legal entity must meet all constitutional and statutory requirements to allow the
10.21 commissioner to participate; and

10.22 (2) the commissioner or the commissioner's designated representative must have the
10.23 right to participate in the governance of the legal entity under the same terms and conditions
10.24 and subject to the same requirements as any other member in the legal entity and in that
10.25 role shall act to advance state interests and lessen the burdens of government.

10.26 (b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share
10.27 of development-related expenses of the legal entity retroactively from October 29, 2007,
10.28 regardless of the date the commissioner joins the legal entity as a member.

10.29 Sec. 9. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to
10.30 read:

10.31 **Subd. 42. Expiration of report mandates.** (a) If the submission of a report by the
10.32 commissioner of human services to the legislature is mandated by statute and the enabling

11.1 legislation does not include a date for the submission of a final report, the mandate to submit
 11.2 the report shall expire in accordance with this section.

11.3 (b) If the mandate requires the submission of an annual report and the mandate was
 11.4 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate
 11.5 requires the submission of a biennial or less frequent report and the mandate was enacted
 11.6 before January 1, 2021, the mandate shall expire on January 1, 2024.

11.7 (c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years
 11.8 after the date of enactment if the mandate requires the submission of an annual report and
 11.9 shall expire five years after the date of enactment if the mandate requires the submission
 11.10 of a biennial or less frequent report unless the enacting legislation provides for a different
 11.11 expiration date.

11.12 (d) The commissioner shall submit a list to the chairs and ranking minority members of
 11.13 the legislative committee with jurisdiction over human services by February 15 of each
 11.14 year, beginning February 15, 2022, of all reports set to expire during the following calendar
 11.15 year in accordance with this section.

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

11.17 Sec. 10. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

11.18 Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report of the
 11.19 ~~grants proposed by the advisory council to be awarded for the upcoming fiscal year to the~~
 11.20 chairs and ranking minority members of the legislative committees with jurisdiction over
 11.21 health and human services policy and finance, by March 1 of each year, beginning March
 11.22 1, 2020, describing the priorities and specific activities the advisory council intends to
 11.23 address for the upcoming fiscal year based on the projected funds available for grant
 11.24 distribution.

11.25 ~~(b) The commissioner of human services shall award grants from the opiate epidemic~~
 11.26 ~~response fund under section 256.043. The grants shall be awarded to proposals selected by~~
 11.27 the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1)
 11.28 to (4), unless otherwise appropriated by the legislature. The advisory council shall determine
 11.29 grant awards and funding amounts based on the funds appropriated to the commissioner
 11.30 under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the
 11.31 grants from the opiate epidemic response fund and administer the grants in compliance with
 11.32 section 16B.97. No more than three percent of the grant amount may be used by a grantee
 11.33 for administration.

12.1 Sec. 11. Minnesota Statutes 2020, section 256.043, subdivision 4, is amended to read:

12.2 Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of \$250,000,000 either
12.3 as a result of a settlement agreement or an assurance of discontinuance entered into by the
12.4 attorney general of the state, or resulting from a court order in litigation brought by the
12.5 attorney general of the state on behalf of the state or a state agency, against one or more
12.6 opioid manufacturers or opioid wholesale drug distributors or consulting firms working for
12.7 an opioid manufacturer or opioid wholesale drug distributor related to alleged violations of
12.8 consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other
12.9 alleged illegal actions that contributed to the excessive use of opioids, or from the fees
12.10 collected under sections 151.065, subdivisions 1 and 3, and 151.066, that are deposited into
12.11 the opiate epidemic response fund established in this section, or from a combination of both,
12.12 the fees specified in section 151.065, subdivisions 1, clause (16), and 3, clause (14), shall
12.13 be reduced to \$5,260, and the opiate registration fee in section 151.066, subdivision 3, shall
12.14 be repealed.

12.15 (b) The commissioner of management and budget shall inform the Board of Pharmacy,
12.16 the governor, and the legislature when the amount specified in paragraph (a) has been
12.17 reached. The board shall apply the reduced license fee for the next licensure period.

12.18 (c) Notwithstanding paragraph (a), the reduction of the license fee in section 151.065,
12.19 subdivisions 1 and 3, and the repeal of the registration fee in section 151.066 shall not occur
12.20 before July 1, 2024.

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

12.22 Sec. 12. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision
12.23 to read:

12.24 Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital
12.25 eligible to receive disproportionate share hospital payments under subdivision 9, paragraph
12.26 (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9,
12.27 paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate.
12.28 The alternate payment rate shall be structured to target a total aggregate reimbursement
12.29 amount equal to what the hospital would have received for providing fee-for-service inpatient
12.30 services under this section to patients enrolled in medical assistance had the hospital received
12.31 the entire amount calculated under subdivision 9, paragraph (d), clause (6).

12.32 **EFFECTIVE DATE.** This section is effective January 1, 2022.

13.1 Sec. 13. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

13.2 Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application
 13.3 of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would
 13.4 result in a change to the hospital's payment rate or payments. Both overpayments and
 13.5 underpayments that result from the submission of appeals shall be implemented. Regardless
 13.6 of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge
 13.7 ratios, and policy adjusters shall not be changed. The appeal shall be heard by an
 13.8 administrative law judge according to sections 14.57 to 14.62, or upon agreement by both
 13.9 parties, according to a modified appeals procedure established by the commissioner and the
 13.10 Office of Administrative Hearings. In any proceeding under this section, the appealing party
 13.11 must demonstrate by a preponderance of the evidence that the commissioner's determination
 13.12 is incorrect or not according to law.

13.13 To appeal a payment rate or payment determination or a determination made from base
 13.14 year information, the hospital shall file a written appeal request to the commissioner within
 13.15 60 days of the date the preliminary payment rate determination was mailed. The appeal
 13.16 request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or
 13.17 rule upon which the hospital relies for each disputed item; and (iii) the name and address
 13.18 of the person to contact regarding the appeal. Facts to be considered in any appeal of base
 13.19 year information are limited to those in existence ~~12~~ 18 months after the last day of the
 13.20 calendar year that is the base year for the payment rates in dispute.

13.21 Sec. 14. Minnesota Statutes 2020, section 256.983, is amended to read:

13.22 **256.983 FRAUD PREVENTION INVESTIGATIONS.**

13.23 Subdivision 1. **Programs established.** Within the limits of available appropriations, the
 13.24 commissioner of human services shall require the maintenance of budget neutral fraud
 13.25 prevention investigation programs in the counties or tribal agencies participating in the
 13.26 fraud prevention investigation project established under this section. If funds are sufficient,
 13.27 the commissioner may also extend fraud prevention investigation programs to other counties
 13.28 or tribal agencies provided the expansion is budget neutral to the state. Under any expansion,
 13.29 the commissioner has the final authority in decisions regarding the creation and realignment
 13.30 of individual county, tribal agency, or regional operations.

13.31 Subd. 2. **County and tribal agency proposals.** Each participating county and tribal
 13.32 agency shall develop and submit an annual staffing and funding proposal to the commissioner
 13.33 no later than April 30 of each year. Each proposal shall include, but not be limited to, the
 13.34 staffing and funding of the fraud prevention investigation program, a job description for

14.1 investigators involved in the fraud prevention investigation program, and the organizational
14.2 structure of the county or tribal agency unit, training programs for case workers, and the
14.3 operational requirements which may be directed by the commissioner. The proposal shall
14.4 be approved, to include any changes directed or negotiated by the commissioner, no later
14.5 than June 30 of each year.

14.6 Subd. 3. **Department responsibilities.** The commissioner shall establish training
14.7 programs which shall be attended by all investigative and supervisory staff of the involved
14.8 county and tribal agencies. The commissioner shall also develop the necessary operational
14.9 guidelines, forms, and reporting mechanisms, which shall be used by the involved county
14.10 or tribal agencies. An individual's application or redetermination form for public assistance
14.11 benefits, including child care assistance programs and medical care programs, must include
14.12 an authorization for release by the individual to obtain documentation for any information
14.13 on that form which is involved in a fraud prevention investigation. The authorization for
14.14 release is effective for six months after public assistance benefits have ceased.

14.15 Subd. 4. **Funding.** (a) County and tribal agency reimbursement shall be made through
14.16 the settlement provisions applicable to the Supplemental Nutrition Assistance Program
14.17 (SNAP), MFIP, child care assistance programs, the medical assistance program, and other
14.18 federal and state-funded programs.

14.19 (b) The commissioner will maintain program compliance if for any three consecutive
14.20 month period, a county or tribal agency fails to comply with fraud prevention investigation
14.21 program guidelines, or fails to meet the cost-effectiveness standards developed by the
14.22 commissioner. This result is contingent on the commissioner providing written notice,
14.23 including an offer of technical assistance, within 30 days of the end of the third or subsequent
14.24 month of noncompliance. The county or tribal agency shall be required to submit a corrective
14.25 action plan to the commissioner within 30 days of receipt of a notice of noncompliance.
14.26 Failure to submit a corrective action plan or, continued deviation from standards of more
14.27 than ten percent after submission of a corrective action plan, will result in denial of funding
14.28 for each subsequent month, or billing the county or tribal agency for fraud prevention
14.29 investigation (FPI) service provided by the commissioner, or reallocation of program grant
14.30 funds, or investigative resources, or both, to other counties or tribal agencies. The denial of
14.31 funding shall apply to the general settlement received by the county or tribal agency on a
14.32 quarterly basis and shall not reduce the grant amount applicable to the FPI project.

14.33 Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency
14.34 may conduct investigations of financial misconduct by child care providers as described in
14.35 chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the

15.1 commissioner to determine whether an investigation under this chapter may compromise
15.2 an ongoing investigation.

15.3 (b) If, upon investigation, a preponderance of evidence shows a provider committed an
15.4 intentional program violation, intentionally gave the county or tribe materially false
15.5 information on the provider's billing forms, provided false attendance records to a county,
15.6 tribe, or the commissioner, or committed financial misconduct as described in section
15.7 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment
15.8 pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section
15.9 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.
15.10 The county or tribe must send notice in accordance with the requirements of section
15.11 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment
15.12 suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law
15.13 enforcement authority determines that there is insufficient evidence warranting the action
15.14 and a county, tribe, or the commissioner does not pursue an additional administrative remedy
15.15 under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and
15.16 administrative proceedings related to the provider's alleged misconduct conclude and any
15.17 appeal rights are exhausted.

15.18 (c) For the purposes of this section, an intentional program violation includes intentionally
15.19 making false or misleading statements; intentionally misrepresenting, concealing, or
15.20 withholding facts; and repeatedly and intentionally violating program regulations under
15.21 chapters 119B and 245E.

15.22 (d) A provider has the right to administrative review under section 119B.161 if: (1)
15.23 payment is suspended under chapter 245E; or (2) the provider's authorization was denied
15.24 or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).

15.25 Sec. 15. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

15.26 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for
15.27 a pregnant woman who meets the other eligibility criteria of this section and whose unborn
15.28 child would be eligible as a needy child under subdivision 10 if born and living with the
15.29 woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the
15.30 commissioner must accept self-attestation of pregnancy unless the agency has information
15.31 that is not reasonably compatible with such attestation. For purposes of this subdivision, a
15.32 woman is considered pregnant for ~~60 days~~ six months postpartum.

16.1 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
16.2 whichever is later. The commissioner shall notify the revisor of statutes when federal
16.3 approval has been obtained.

16.4 Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

16.5 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are
16.6 applying for the continuation of medical assistance coverage following the end of the ~~60-day~~
16.7 six months postpartum period to update their income and asset information and to submit
16.8 any required income or asset verification.

16.9 (b) The commissioner shall determine the eligibility of private-sector health care coverage
16.10 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
16.11 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is
16.12 determined to be cost-effective.

16.13 (c) The commissioner shall verify assets and income for all applicants, and for all
16.14 recipients upon renewal.

16.15 (d) The commissioner shall utilize information obtained through the electronic service
16.16 established by the secretary of the United States Department of Health and Human Services
16.17 and other available electronic data sources in Code of Federal Regulations, title 42, sections
16.18 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
16.19 standards to define when information obtained electronically is reasonably compatible with
16.20 information provided by applicants and enrollees, including use of self-attestation, to
16.21 accomplish real-time eligibility determinations and maintain program integrity.

16.22 (e) Each person applying for or receiving medical assistance under section 256B.055,
16.23 subdivision 7, and any other person whose resources are required by law to be disclosed to
16.24 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
16.25 information from financial institutions to identify unreported accounts as required in section
16.26 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner
16.27 may determine that the applicant or recipient is ineligible for medical assistance. For purposes
16.28 of this paragraph, an authorization to identify unreported accounts meets the requirements
16.29 of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not
16.30 be furnished to the financial institution.

16.31 (f) County and tribal agencies shall comply with the standards established by the
16.32 commissioner for appropriate use of the asset verification system specified in section 256.01,
16.33 subdivision 18f.

17.1 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
 17.2 whichever is later. The commissioner shall notify the revisor of statutes when federal
 17.3 approval has been obtained.

17.4 Sec. 17. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

17.5 Subd. 3. **Qualified Medicare beneficiaries.** (a) A person who is entitled to Part A
 17.6 Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty
 17.7 guidelines, and whose assets are no more than \$10,000 for a single individual and \$18,000
 17.8 for a married couple or family of two or more, is eligible for medical assistance
 17.9 reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance
 17.10 and deductibles, and cost-effective premiums for enrollment with a health maintenance
 17.11 organization or a competitive medical plan under section 1876 of the Social Security Act,
 17.12 if:

17.13 (1) the person is entitled to Medicare Part A benefits;

17.14 (2) the person's income is equal to or less than 100 percent of the federal poverty
 17.15 guidelines; and

17.16 (3) the person's assets are no more than (i) \$10,000 for a single individual, or (ii) \$18,000
 17.17 for a married couple or family of two or more; or, when the resource limits for eligibility
 17.18 for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item
 17.19 (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code,
 17.20 title 42, section 1396d, subsection (p).

17.21 (b) Reimbursement of the Medicare coinsurance and deductibles, when added to the
 17.22 amount paid by Medicare, must not exceed the total rate the provider would have received
 17.23 for the same service or services if the person were a medical assistance recipient with
 17.24 Medicare coverage. Increases in benefits under Title II of the Social Security Act shall not
 17.25 be counted as income for purposes of this subdivision until July 1 of each year.

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

17.27 Sec. 18. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

17.28 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to
 17.29 citizens of the United States, qualified noncitizens as defined in this subdivision, and other
 17.30 persons residing lawfully in the United States. Citizens or nationals of the United States
 17.31 must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality

18.1 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
18.2 109-171.

18.3 (b) "Qualified noncitizen" means a person who meets one of the following immigration
18.4 criteria:

18.5 (1) admitted for lawful permanent residence according to United States Code, title 8;

18.6 (2) admitted to the United States as a refugee according to United States Code, title 8,
18.7 section 1157;

18.8 (3) granted asylum according to United States Code, title 8, section 1158;

18.9 (4) granted withholding of deportation according to United States Code, title 8, section
18.10 1253(h);

18.11 (5) paroled for a period of at least one year according to United States Code, title 8,
18.12 section 1182(d)(5);

18.13 (6) granted conditional entrant status according to United States Code, title 8, section
18.14 1153(a)(7);

18.15 (7) determined to be a battered noncitizen by the United States Attorney General
18.16 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
18.17 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

18.18 (8) is a child of a noncitizen determined to be a battered noncitizen by the United States
18.19 Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility
18.20 Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
18.21 or

18.22 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
18.23 Law 96-422, the Refugee Education Assistance Act of 1980.

18.24 (c) All qualified noncitizens who were residing in the United States before August 22,
18.25 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical
18.26 assistance with federal financial participation.

18.27 (d) Beginning December 1, 1996, qualified noncitizens who entered the United States
18.28 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
18.29 chapter are eligible for medical assistance with federal participation for five years if they
18.30 meet one of the following criteria:

18.31 (1) refugees admitted to the United States according to United States Code, title 8, section
18.32 1157;

19.1 (2) persons granted asylum according to United States Code, title 8, section 1158;

19.2 (3) persons granted withholding of deportation according to United States Code, title 8,
19.3 section 1253(h);

19.4 (4) veterans of the United States armed forces with an honorable discharge for a reason
19.5 other than noncitizen status, their spouses and unmarried minor dependent children; or

19.6 (5) persons on active duty in the United States armed forces, other than for training,
19.7 their spouses and unmarried minor dependent children.

19.8 Beginning July 1, 2010, children and pregnant women who are noncitizens described
19.9 in paragraph (b) or who are lawfully present in the United States as defined in Code of
19.10 Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements
19.11 of this chapter, are eligible for medical assistance with federal financial participation as
19.12 provided by the federal Children's Health Insurance Program Reauthorization Act of 2009,
19.13 Public Law 111-3.

19.14 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are
19.15 eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision,
19.16 a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8,
19.17 section 1101(a)(15).

19.18 (f) Payment shall also be made for care and services that are furnished to noncitizens,
19.19 regardless of immigration status, who otherwise meet the eligibility requirements of this
19.20 chapter, if such care and services are necessary for the treatment of an emergency medical
19.21 condition.

19.22 (g) For purposes of this subdivision, the term "emergency medical condition" means a
19.23 medical condition that meets the requirements of United States Code, title 42, section
19.24 1396b(v).

19.25 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of
19.26 an emergency medical condition are limited to the following:

19.27 (i) services delivered in an emergency room or by an ambulance service licensed under
19.28 chapter 144E that are directly related to the treatment of an emergency medical condition;

19.29 (ii) services delivered in an inpatient hospital setting following admission from an
19.30 emergency room or clinic for an acute emergency condition; and

20.1 (iii) follow-up services that are directly related to the original service provided to treat
20.2 the emergency medical condition and are covered by the global payment made to the
20.3 provider.

20.4 (2) Services for the treatment of emergency medical conditions do not include:

20.5 (i) services delivered in an emergency room or inpatient setting to treat a nonemergency
20.6 condition;

20.7 (ii) organ transplants, stem cell transplants, and related care;

20.8 (iii) services for routine prenatal care;

20.9 (iv) continuing care, including long-term care, nursing facility services, home health
20.10 care, adult day care, day training, or supportive living services;

20.11 (v) elective surgery;

20.12 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part
20.13 of an emergency room visit;

20.14 (vii) preventative health care and family planning services;

20.15 (viii) rehabilitation services;

20.16 (ix) physical, occupational, or speech therapy;

20.17 (x) transportation services;

20.18 (xi) case management;

20.19 (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

20.20 (xiii) dental services;

20.21 (xiv) hospice care;

20.22 (xv) audiology services and hearing aids;

20.23 (xvi) podiatry services;

20.24 (xvii) chiropractic services;

20.25 (xviii) immunizations;

20.26 (xix) vision services and eyeglasses;

20.27 (xx) waiver services;

20.28 (xxi) individualized education programs; or

21.1 (xxii) chemical dependency treatment.

21.2 (i) Pregnant noncitizens who are ineligible for federally funded medical assistance
21.3 because of immigration status, are not covered by a group health plan or health insurance
21.4 coverage according to Code of Federal Regulations, title 42, section 457.310, and who
21.5 otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance
21.6 through the period of pregnancy, including labor and delivery, and ~~60 days~~ six months
21.7 postpartum, ~~to the extent federal funds are available under title XXI of the Social Security~~
21.8 ~~Act, and the state children's health insurance program.~~

21.9 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services
21.10 from a nonprofit center established to serve victims of torture and are otherwise ineligible
21.11 for medical assistance under this chapter are eligible for medical assistance without federal
21.12 financial participation. These individuals are eligible only for the period during which they
21.13 are receiving services from the center. Individuals eligible under this paragraph shall not
21.14 be required to participate in prepaid medical assistance. The nonprofit center referenced
21.15 under this paragraph may establish itself as a provider of mental health targeted case
21.16 management services through a county contract under section 256.0112, subdivision 6. If
21.17 the nonprofit center is unable to secure a contract with a lead county in its service area, then,
21.18 notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner
21.19 may negotiate a contract with the nonprofit center for provision of mental health targeted
21.20 case management services. When serving clients who are not the financial responsibility
21.21 of their contracted lead county, the nonprofit center must gain the concurrence of the county
21.22 of financial responsibility prior to providing mental health targeted case management services
21.23 for those clients.

21.24 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
21.25 emergency medical conditions under paragraph (f) except where coverage is prohibited
21.26 under federal law for services under clauses (1) and (2):

21.27 (1) dialysis services provided in a hospital or freestanding dialysis facility;

21.28 (2) surgery and the administration of chemotherapy, radiation, and related services
21.29 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and
21.30 requires surgery, chemotherapy, or radiation treatment; and

21.31 (3) kidney transplant if the person has been diagnosed with end stage renal disease, is
21.32 currently receiving dialysis services, and is a potential candidate for a kidney transplant.

21.33 (l) Effective July 1, 2013, recipients of emergency medical assistance under this
21.34 subdivision are eligible for coverage of the elderly waiver services provided under chapter

22.1 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit
 22.2 for elderly waiver services does not apply. In order to qualify for coverage, a recipient of
 22.3 emergency medical assistance is subject to the assessment and reassessment requirements
 22.4 of section 256B.0911. Initial and continued enrollment under this paragraph is subject to
 22.5 the limits of available funding.

22.6 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
 22.7 whichever is later. The commissioner shall notify the revisor of statutes when federal
 22.8 approval has been obtained.

22.9 Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 3c, is amended to read:

22.10 Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner,
 22.11 after receiving recommendations from professional physician associations, professional
 22.12 associations representing licensed nonphysician health care professionals, and consumer
 22.13 groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory
 22.14 Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health
 22.15 Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1)
 22.16 health services pertaining to the administration of health care benefits covered under the
 22.17 medical assistance and Minnesota Care programs Minnesota health care programs (MHCP);
 22.18 and (2) evidence-based decision-making and health care benefit and coverage policies for
 22.19 MHCP. The Health Services Advisory Council shall consider available evidence regarding
 22.20 quality, safety, and cost-effectiveness when advising the commissioner. The Health Services
 22.21 ~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy~~
 22.22 ~~Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its
 22.23 members; who shall work directly with the commissioner's medical director; to establish
 22.24 the agenda for each meeting. The Health Services ~~Policy Committee~~ shall also Advisory
 22.25 Council may recommend criteria for verifying centers of excellence for specific aspects of
 22.26 medical care where a specific set of combined services, a volume of patients necessary to
 22.27 maintain a high level of competency, or a specific level of technical capacity is associated
 22.28 with improved health outcomes.

22.29 (b) The commissioner shall establish a dental ~~subcommittee~~ subcouncil to operate under
 22.30 the Health Services ~~Policy Committee~~ Advisory Council. The dental ~~subcommittee~~
 22.31 subcouncil consists of general dentists, dental specialists, safety net providers, dental
 22.32 hygienists, health plan company and county and public health representatives, health
 22.33 researchers, consumers, and a designee of the commissioner of health. The dental
 22.34 ~~subcommittee~~ subcouncil shall advise the commissioner regarding:

23.1 (1) the critical access dental program under section 256B.76, subdivision 4, including
 23.2 but not limited to criteria for designating and terminating critical access dental providers;

23.3 (2) any changes to the critical access dental provider program necessary to comply with
 23.4 program expenditure limits;

23.5 (3) dental coverage policy based on evidence, quality, continuity of care, and best
 23.6 practices;

23.7 (4) the development of dental delivery models; and

23.8 (5) dental services to be added or eliminated from subdivision 9, paragraph (b).

23.9 ~~(e) The Health Services Policy Committee shall study approaches to making provider~~
 23.10 ~~reimbursement under the medical assistance and MinnesotaCare programs contingent on~~
 23.11 ~~patient participation in a patient-centered decision-making process, and shall evaluate the~~
 23.12 ~~impact of these approaches on health care quality, patient satisfaction, and health care costs.~~
 23.13 ~~The committee shall present findings and recommendations to the commissioner and the~~
 23.14 ~~legislative committees with jurisdiction over health care by January 15, 2010.~~

23.15 ~~(d)~~ (c) The Health Services Policy Committee shall Advisory Council may monitor and
 23.16 track the practice patterns of ~~physicians providing services to medical assistance and~~
 23.17 ~~MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under
 23.18 fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring
 23.19 and tracking shall focus on services or specialties for which there is a high variation in
 23.20 utilization or quality across ~~physicians~~ providers, or which are associated with high medical
 23.21 costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory
 23.22 Council, shall ~~regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate
 23.23 below average quality or higher than average utilization or costs. Managed care and
 23.24 county-based purchasing plans shall provide the commissioner with utilization and cost
 23.25 data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these
 23.26 data available to the ~~committee~~ Health Services Advisory Council.

23.27 ~~(e) The Health Services Policy Committee shall review caesarean section rates for the~~
 23.28 ~~fee-for-service medical assistance population. The committee may develop best practices~~
 23.29 ~~policies related to the minimization of caesarean sections, including but not limited to~~
 23.30 ~~standards and guidelines for health care providers and health care facilities.~~

23.31 Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 3d, is amended to read:

23.32 Subd. 3d. **Health Services ~~Policy Committee~~ Advisory Council members.** (a) The
 23.33 Health Services ~~Policy Committee~~ Advisory Council consists of:

24.1 (1) ~~seven~~ six voting members who are licensed physicians actively engaged in the practice
 24.2 of medicine in Minnesota, ~~one of whom must be actively engaged in the treatment of persons~~
 24.3 ~~with mental illness, and~~ three of whom must represent health plans currently under contract
 24.4 to serve ~~medical assistance~~ MHCP recipients;

24.5 (2) two voting members who are licensed physician specialists actively practicing their
 24.6 specialty in Minnesota;

24.7 (3) two voting members who are nonphysician health care professionals licensed or
 24.8 registered in their profession and actively engaged in their practice of their profession in
 24.9 Minnesota;

24.10 (4) one voting member who is a health care or mental health professional licensed or
 24.11 registered in the member's profession, actively engaged in the practice of the member's
 24.12 profession in Minnesota, and actively engaged in the treatment of persons with mental
 24.13 illness;

24.14 ~~(4) one consumer~~ (5) two consumers who shall serve as a voting ~~member~~ members; and

24.15 ~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

24.16 (b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be
 24.17 employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical
 24.18 director. A quorum shall comprise a simple majority of the voting members. Vacant seats
 24.19 shall not count toward a quorum.

24.20 Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

24.21 Subd. 3e. **Health Services ~~Policy Committee~~ Advisory Council terms and**
 24.22 **compensation.** ~~Committee~~ Members shall serve staggered three-year terms, with one-third
 24.23 of the voting members' terms expiring annually. Members may be reappointed by the
 24.24 commissioner. The commissioner may require more frequent Health Services ~~Policy~~
 24.25 ~~Committee~~ Advisory Council meetings as needed. An honorarium of \$200 per meeting and
 24.26 reimbursement for mileage and parking shall be paid to each ~~committee~~ council member
 24.27 in attendance except the medical director. The Health Services ~~Policy Committee~~ Advisory
 24.28 Council does not expire as provided in section 15.059, subdivision 6.

24.29 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

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

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

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

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

25.5 (3) limited exams;

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

25.7 (5) periapical x-rays;

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

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

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

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

25.15 (10) anterior fillings;

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

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

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

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

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

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

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

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

25.27 (2) general anesthesia; and

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

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

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

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

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

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

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

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

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

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

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

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

26.22 Sec. 23. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
26.23 to read:

26.24 Subd. 9c. Uniform prior authorization for dental services. (a) For purposes of this
26.25 subdivision, "dental benefits administrator" means an organization licensed under chapter
26.26 62C or 62D that contracts with a managed care plan or county-based purchasing plan to
26.27 provide covered dental care services to enrollees of the plan.

26.28 (b) By January 1, 2022, the commissioner, in consultation with interested stakeholders,
26.29 shall develop uniform prior authorization criteria for all dental services requiring prior
26.30 authorization. The commissioner shall publish a list of the dental services requiring prior
26.31 authorization and the process for obtaining prior authorization on the department's website.

27.1 Dental services on the list and the process for obtaining prior authorization approval must
27.2 be consistent. The commissioner shall require that dental providers, managed care plans,
27.3 county-based purchasing plans, and dental benefit administrators use the dental services on
27.4 the list regardless of whether the services are provided through a fee-for-service system or
27.5 through a prepaid medical assistance program.

27.6 (c) Managed care plans and county-based purchasing plans may require prior
27.7 authorization for additional dental services not on the list described in paragraph (b) if a
27.8 uniform process for obtaining prior approvals is applied, including a process for
27.9 reconsideration when a prior approval request is denied that can be utilized by both the
27.10 patient and the patient's dental provider.

27.11 Sec. 24. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
27.12 to read:

27.13 Subd. 9d. **Uniform credentialing process.** (a) For purposes of this subdivision, "dental
27.14 benefits administrator" has the meaning given in subdivision 9c.

27.15 (b) By January 1, 2022, the commissioner, in consultation with interested stakeholders,
27.16 shall develop a uniform credentialing process for dental providers. Upon federal approval,
27.17 the credentialing process must be accepted by all managed care plans, county-based
27.18 purchasing plans, and dental benefits administrators that contract with the commissioner or
27.19 subcontract with plans to provide dental services to medical assistance or MinnesotaCare
27.20 enrollees.

27.21 (c) The process developed in this subdivision must include a uniform credentialing
27.22 application that must be available in electronic format and accessible on the department's
27.23 website. The process developed under this subdivision must include an option to submit a
27.24 completed application electronically. The uniform credentialing application must be available
27.25 to providers for free.

27.26 (d) If applicable, a managed care plan, county-based purchasing plan, dental benefits
27.27 administrator, contractor, or vendor that reviews and approves a credentialing application
27.28 must notify a provider regarding a deficiency on a submitted credentialing application form
27.29 no later than 30 business days after receiving the application form from the provider.

27.30 Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

27.31 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
27.32 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed

28.1 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
28.2 dispensing physician, or by a physician, a physician assistant, or an advanced practice
28.3 registered nurse employed by or under contract with a community health board as defined
28.4 in section 145A.02, subdivision 5, for the purposes of communicable disease control.

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

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

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

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

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

28.26 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
28.27 a licensed practitioner or by a licensed pharmacist who meets standards established by the
28.28 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
28.29 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
28.30 with documented vitamin deficiencies, vitamins for children under the age of seven and
28.31 pregnant or nursing women, and any other over-the-counter drug identified by the
28.32 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
28.33 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
28.34 disorders, and this determination shall not be subject to the requirements of chapter 14. A

29.1 pharmacist may prescribe over-the-counter medications as provided under this paragraph
29.2 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
29.3 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
29.4 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
29.5 and make referrals as needed to other health care professionals.

29.6 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
29.7 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
29.8 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
29.9 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
29.10 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
29.11 individuals, medical assistance may cover drugs from the drug classes listed in United States
29.12 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
29.13 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
29.14 not be covered.

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

29.19 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
29.20 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
29.21 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
29.22 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
29.23 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
29.24 pharmacist in accordance with section 151.37, subdivision 16.

29.25 Sec. 26. Minnesota Statutes 2020, section 256B.0625, subdivision 13c, is amended to
29.26 read:

29.27 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
29.28 from professional medical associations and professional pharmacy associations, and consumer
29.29 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
29.30 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively
29.31 engaged in the practice of medicine in Minnesota, one of whom must be actively engaged
29.32 in the treatment of persons with mental illness; at least three licensed pharmacists actively
29.33 engaged in the practice of pharmacy in Minnesota; and one consumer representative; the
29.34 remainder to be made up of health care professionals who are licensed in their field and

30.1 have recognized knowledge in the clinically appropriate prescribing, dispensing, and
 30.2 monitoring of covered outpatient drugs. Members of the Formulary Committee shall not
 30.3 be employed by the Department of Human Services, but the committee shall be staffed by
 30.4 an employee of the department who shall serve as an ex officio, nonvoting member of the
 30.5 committee. The department's medical director shall also serve as an ex officio, nonvoting
 30.6 member for the committee. Committee members shall serve three-year terms and may be
 30.7 reappointed by the commissioner. The Formulary Committee shall meet at least twice per
 30.8 year. The commissioner may require more frequent Formulary Committee meetings as
 30.9 needed. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid
 30.10 to each committee member in attendance. The Formulary Committee ~~expires June 30, 2022~~
 30.11 does not expire as provided in section 15.059, subdivision 6.

30.12 Sec. 27. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to
 30.13 read:

30.14 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
 30.15 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
 30.16 usual and customary price charged to the public. The usual and customary price means the
 30.17 lowest price charged by the provider to a patient who pays for the prescription by cash,
 30.18 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
 30.19 a prescription savings club or prescription discount club administered by the pharmacy or
 30.20 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
 30.21 amounts applied to the charge by any third-party provider/insurer agreement or contract for
 30.22 submitted charges to medical assistance programs. The net submitted charge may not be
 30.23 greater than the patient liability for the service. The professional dispensing fee shall be
 30.24 ~~\$10.48~~ \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered
 30.25 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
 30.26 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
 30.27 be ~~\$10.48~~ \$10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled
 30.28 with over-the-counter drugs meeting the definition of covered outpatient drugs shall be
 30.29 ~~\$10.48~~ \$10.77 for dispensed quantities equal to or greater than the number of units contained
 30.30 in the manufacturer's original package. The professional dispensing fee shall be prorated
 30.31 based on the percentage of the package dispensed when the pharmacy dispenses a quantity
 30.32 less than the number of units contained in the manufacturer's original package. The pharmacy
 30.33 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
 30.34 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
 30.35 contained in the manufacturer's original package and shall be prorated based on the

31.1 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
31.2 number of units contained in the manufacturer's original package. The National Average
31.3 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
31.4 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
31.5 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
31.6 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
31.7 Drug Pricing Program ceiling price established by the Health Resources and Services
31.8 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
31.9 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
31.10 the United States, not including prompt pay or other discounts, rebates, or reductions in
31.11 price, for the most recent month for which information is available, as reported in wholesale
31.12 price guides or other publications of drug or biological pricing data. The maximum allowable
31.13 cost of a multisource drug may be set by the commissioner and it shall be comparable to
31.14 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
31.15 product. Establishment of the amount of payment for drugs shall not be subject to the
31.16 requirements of the Administrative Procedure Act.

31.17 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
31.18 an automated drug distribution system meeting the requirements of section 151.58, or a
31.19 packaging system meeting the packaging standards set forth in Minnesota Rules, part
31.20 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
31.21 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
31.22 retrospectively billing pharmacy must submit a claim only for the quantity of medication
31.23 used by the enrolled recipient during the defined billing period. A retrospectively billing
31.24 pharmacy must use a billing period not less than one calendar month or 30 days.

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

31.30 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC
31.31 of the generic product or the maximum allowable cost established by the commissioner
31.32 unless prior authorization for the brand name product has been granted according to the
31.33 criteria established by the Drug Formulary Committee as required by subdivision 13f,
31.34 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in
31.35 a manner consistent with section 151.21, subdivision 2.

32.1 (e) The basis for determining the amount of payment for drugs administered in an
32.2 outpatient setting shall be the lower of the usual and customary cost submitted by the
32.3 provider, 106 percent of the average sales price as determined by the United States
32.4 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
32.5 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
32.6 set by the commissioner. If average sales price is unavailable, the amount of payment must
32.7 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
32.8 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
32.9 The commissioner shall discount the payment rate for drugs obtained through the federal
32.10 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
32.11 outpatient setting shall be made to the administering facility or practitioner. A retail or
32.12 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
32.13 eligible for direct reimbursement.

32.14 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
32.15 products that are lower than the ingredient cost formulas specified in paragraph (a). The
32.16 commissioner may require individuals enrolled in the health care programs administered
32.17 by the department to obtain specialty pharmacy products from providers with whom the
32.18 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
32.19 defined as those used by a small number of recipients or recipients with complex and chronic
32.20 diseases that require expensive and challenging drug regimens. Examples of these conditions
32.21 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
32.22 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
32.23 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
32.24 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
32.25 require complex care. The commissioner shall consult with the Formulary Committee to
32.26 develop a list of specialty pharmacy products subject to maximum allowable cost
32.27 reimbursement. In consulting with the Formulary Committee in developing this list, the
32.28 commissioner shall take into consideration the population served by specialty pharmacy
32.29 products, the current delivery system and standard of care in the state, and access to care
32.30 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
32.31 to prevent access to care issues.

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

32.34 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
32.35 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient

33.1 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
33.2 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
33.3 department to dispense outpatient prescription drugs to fee-for-service members must
33.4 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
33.5 section 256B.064 for failure to respond. The commissioner shall require the vendor to
33.6 measure a single statewide cost of dispensing for specialty prescription drugs and a single
33.7 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
33.8 to measure the mean, mean weighted by total prescription volume, mean weighted by
33.9 medical assistance prescription volume, median, median weighted by total prescription
33.10 volume, and median weighted by total medical assistance prescription volume. The
33.11 commissioner shall post a copy of the final cost of dispensing survey report on the
33.12 department's website. The initial survey must be completed no later than January 1, 2021,
33.13 and repeated every three years. The commissioner shall provide a summary of the results
33.14 of each cost of dispensing survey and provide recommendations for any changes to the
33.15 dispensing fee to the chairs and ranking members of the legislative committees with
33.16 jurisdiction over medical assistance pharmacy reimbursement.

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

33.20 Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 13g, is amended to
33.21 read:

33.22 Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a
33.23 preferred drug list by January 1, 2004. The commissioner may enter into a contract with a
33.24 vendor for the purpose of participating in a preferred drug list and supplemental rebate
33.25 program. The commissioner shall ensure that any contract meets all federal requirements
33.26 and maximizes federal financial participation. The commissioner shall publish the preferred
33.27 drug list annually in the State Register and shall maintain an accurate and up-to-date list on
33.28 the agency website.

33.29 (b) The commissioner may add to, delete from, and otherwise modify the preferred drug
33.30 list, after consulting with the Formulary Committee and appropriate medical specialists and
33.31 providing public notice and the opportunity for public comment.

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

34.1 (d) For purposes of this subdivision, "preferred drug list" means a list of prescription
34.2 drugs within designated therapeutic classes selected by the commissioner, for which prior
34.3 authorization based on the identity of the drug or class is not required.

34.4 (e) The commissioner shall seek any federal waivers or approvals necessary to implement
34.5 this subdivision.

34.6 (f) Notwithstanding paragraph (b), before the commissioner may delete a drug from the
34.7 preferred drug list or modify the inclusion of a drug on the preferred drug list, the
34.8 commissioner, in consultation with the commissioner of health, shall consider any
34.9 implications the deletion or modification may have on state public health policies or
34.10 initiatives and any impact the deletion or modification may have on increasing health
34.11 disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the
34.12 commissioner shall also conduct a public hearing. The commissioner shall provide adequate
34.13 notice to the public prior to the hearing that specifies the drug the commissioner is proposing
34.14 to delete or modify, any medical or clinical analysis that the commissioner has relied on in
34.15 proposing the deletion or modification, and evidence that the commissioner has consulted
34.16 with the commissioner of health and has evaluated the impact of the proposed deletion or
34.17 modification on public health and health disparities.

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

34.19 Sec. 29. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
34.20 to read:

34.21 Subd. 13k. **Eligible providers.** (a) To be eligible to dispense prescription drugs under
34.22 this section as an enrolled dispensing provider, the dispensing provider must be a:

34.23 (1) pharmacy located within the state that is licensed by the Board of Pharmacy under
34.24 chapter 151;

34.25 (2) physician located in a service area where there is no medical assistance enrolled
34.26 pharmacy; or

34.27 (3) physician or advanced practice registered nurse employed by or under contract with
34.28 a community health board for communicable disease control.

34.29 (b) A licensed out-of-state pharmacy may be enrolled as a dispensing provider under
34.30 paragraph (a) if the pharmacy is:

35.1 (1) a retail pharmacy located within 50 miles of the Minnesota border that serves walk-in
 35.2 medical assistance enrollees and whose walk-in customers represent at least 75 percent of
 35.3 the pharmacy's prescription volume;

35.4 (2) a retail pharmacy serving foster children enrolled in medical assistance and living
 35.5 outside of Minnesota;

35.6 (3) serving enrollees receiving preapproved organ transplants who require medication
 35.7 during after-care while residing outside of Minnesota; or

35.8 (4) providing products with limited or exclusive distribution channels for which there
 35.9 is no potential dispensing provider located within the state.

35.10 (c) A dispensing provider must attest that they meet the requirements in paragraphs (a)
 35.11 and (b) before enrolling as a dispensing provider in the medical assistance program. If a
 35.12 provider is found to be out of compliance with the requirements in paragraphs (a) and (b),
 35.13 any funds paid to that provider during the time they were out of compliance shall be recovered
 35.14 under section 256B.064.

35.15 Sec. 30. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
 35.16 to read:

35.17 Subd. 67. **Pretreatment coordination services.** Effective January 1, 2022, or upon
 35.18 federal approval, whichever is later, medical assistance covers pretreatment coordination
 35.19 services provided according to section 254B.05, subdivision 4a.

35.20 **EFFECTIVE DATE.** This section is effective July 1, 2021. The commissioner of human
 35.21 services shall notify the revisor of statutes when federal approval is obtained or denied.

35.22 Sec. 31. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

35.23 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
 35.24 assistance benefit plan shall include the following cost-sharing for all recipients, effective
 35.25 for services provided on or after September 1, 2011:

35.26 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
 35.27 subdivision, a visit means an episode of service ~~which~~ that is required because of a recipient's
 35.28 symptoms, diagnosis, or established illness, and ~~which~~ that is delivered in an ambulatory
 35.29 setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
 35.30 practice nurse, audiologist, optician, or optometrist. Co-payments must not apply to visits
 35.31 that involve tobacco cessation treatments or services;

36.1 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
36.2 co-payment shall be increased to \$20 upon federal approval;

36.3 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject
36.4 to a \$12 per month maximum for prescription drug co-payments. ~~No~~ Co-payments shall
36.5 must not apply to antipsychotic drugs when used for the treatment of mental illness or to
36.6 drugs used for tobacco cessation;

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

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

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

36.18 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
36.19 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
36.20 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
36.21 of the family deductible shall not be included in the capitation payment to managed care
36.22 plans and county-based purchasing plans. Managed care plans and county-based purchasing
36.23 plans shall certify annually to the commissioner the dollar value of the family deductible.

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

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

37.1 Sec. 32. Minnesota Statutes 2020, section 256B.0631, is amended by adding a subdivision
37.2 to read:

37.3 Subd. 5. **Tobacco abstinence cost-sharing exception.** In addition to the cost-sharing
37.4 exemptions listed under subdivision 2, the co-payments and deductibles described in
37.5 subdivision 1 must be waived for nontobacco users, and must only apply to tobacco users.
37.6 For purposes of this subdivision, "tobacco user" means an individual who uses, four or more
37.7 times per week within the past six months, any tobacco product. Tobacco products include
37.8 cigarettes, cigars, pipe tobacco, chewing tobacco, or snuff. Tobacco products do not include
37.9 the use of tobacco by an American Indian who meets the requirements in Code of Federal
37.10 Regulations, title 42, sections 447.51 and 447.56, as part of a traditional Native American
37.11 spiritual or cultural ceremony.

37.12 **EFFECTIVE DATE.** This section is effective July 1, 2022, or upon federal approval,
37.13 whichever is later. The commissioner of human services shall notify the revisor of statutes
37.14 when federal approval is obtained.

37.15 Sec. 33. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

37.16 Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in
37.17 consultation with the commissioner of health, shall appoint the following voting members
37.18 to an opioid prescribing work group:

37.19 (1) two consumer members who have been impacted by an opioid abuse disorder or
37.20 opioid dependence disorder, either personally or with family members;

37.21 (2) one member who is a licensed physician actively practicing in Minnesota and
37.22 registered as a practitioner with the DEA;

37.23 (3) one member who is a licensed pharmacist actively practicing in Minnesota and
37.24 registered as a practitioner with the DEA;

37.25 (4) one member who is a licensed nurse practitioner actively practicing in Minnesota
37.26 and registered as a practitioner with the DEA;

37.27 (5) one member who is a licensed dentist actively practicing in Minnesota and registered
37.28 as a practitioner with the DEA;

37.29 (6) two members who are nonphysician licensed health care professionals actively
37.30 engaged in the practice of their profession in Minnesota, and their practice includes treating
37.31 pain;

38.1 (7) one member who is a mental health professional who is licensed or registered in a
 38.2 mental health profession, who is actively engaged in the practice of that profession in
 38.3 Minnesota, and whose practice includes treating patients with chemical dependency or
 38.4 substance abuse;

38.5 (8) one member who is a medical examiner for a Minnesota county;

38.6 (9) one member of the Health Services Policy Committee established under section
 38.7 256B.0625, subdivisions 3c to 3e;

38.8 (10) one member who is a medical director of a health plan company doing business in
 38.9 Minnesota;

38.10 (11) one member who is a pharmacy director of a health plan company doing business
 38.11 in Minnesota; ~~and~~

38.12 (12) one member representing Minnesota law enforcement; and

38.13 (13) two consumer members who are Minnesota residents and who have used or are
 38.14 using opioids to manage chronic pain.

38.15 (b) In addition, the work group shall include the following nonvoting members:

38.16 (1) the medical director for the medical assistance program;

38.17 (2) a member representing the Department of Human Services pharmacy unit; ~~and~~

38.18 (3) the medical director for the Department of Labor and Industry; and

38.19 (4) a member representing the Department of Health.

38.20 (c) An honorarium of \$200 per meeting and reimbursement for mileage and parking
 38.21 shall be paid to each voting member in attendance.

38.22 Sec. 34. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

38.23 Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs
 38.24 within the Minnesota health care program to improve the health of and quality of care
 38.25 provided to Minnesota health care program enrollees. The commissioner shall annually
 38.26 collect and report to provider groups the sentinel measures of data showing individual opioid
 38.27 prescribers data showing the sentinel measures of their prescribers' opioid prescribing
 38.28 patterns compared to their anonymized peers. Provider groups shall distribute data to their
 38.29 affiliated, contracted, or employed opioid prescribers.

38.30 (b) The commissioner shall notify an opioid prescriber and all provider groups with
 38.31 which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing

39.1 pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber
 39.2 and any provider group that receives a notice under this paragraph shall submit to the
 39.3 commissioner a quality improvement plan for review and approval by the commissioner
 39.4 with the goal of bringing the opioid prescriber's prescribing practices into alignment with
 39.5 community standards. A quality improvement plan must include:

39.6 (1) components of the program described in subdivision 4, paragraph (a);

39.7 (2) internal practice-based measures to review the prescribing practice of the opioid
 39.8 prescriber and, where appropriate, any other opioid prescribers employed by or affiliated
 39.9 with any of the provider groups with which the opioid prescriber is employed or affiliated;
 39.10 and

39.11 (3) appropriate use of the prescription monitoring program under section 152.126.

39.12 (c) If, after a year from the commissioner's notice under paragraph (b), the opioid
 39.13 prescriber's prescribing practices do not improve so that they are consistent with community
 39.14 standards, the commissioner shall take one or more of the following steps:

39.15 (1) monitor prescribing practices more frequently than annually;

39.16 (2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel
 39.17 measures; or

39.18 (3) require the opioid prescriber to participate in additional quality improvement efforts,
 39.19 including but not limited to mandatory use of the prescription monitoring program established
 39.20 under section 152.126.

39.21 (d) The commissioner shall terminate from Minnesota health care programs all opioid
 39.22 prescribers and provider groups whose prescribing practices fall within the applicable opioid
 39.23 disenrollment standards.

39.24 Sec. 35. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

39.25 Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private
 39.26 data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber
 39.27 is subject to termination as a medical assistance provider under this section. Notwithstanding
 39.28 this data classification, the commissioner shall share with all of the provider groups with
 39.29 which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an~~
 39.30 ~~opioid prescriber who is subject to quality improvement activities~~ the data under subdivision
 39.31 5, paragraph (a), (b), or (c).

40.1 (b) Reports and data identifying a provider group are nonpublic data as defined under
 40.2 section 13.02, subdivision 9, until the provider group is subject to termination as a medical
 40.3 assistance provider under this section.

40.4 (c) Upon termination under this section, reports and data identifying an opioid prescriber
 40.5 or provider group are public, except that any identifying information of Minnesota health
 40.6 care program enrollees must be redacted by the commissioner.

40.7 Sec. 36. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

40.8 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must
 40.9 work for a personal care assistance provider agency, meet the definition of qualified
 40.10 professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as~~
 40.11 ~~a qualified professional after clearing~~ clear a background study, and meet provider training
 40.12 requirements. Before a qualified professional provides services, the personal care assistance
 40.13 provider agency must initiate a background study on the qualified professional under chapter
 40.14 245C, and the personal care assistance provider agency must have received a notice from
 40.15 the commissioner that the qualified professional:

40.16 (1) is not disqualified under section 245C.14; or

40.17 (2) is disqualified, but the qualified professional has received a set aside of the
 40.18 disqualification under section 245C.22.

40.19 (b) The qualified professional shall perform the duties of training, supervision, and
 40.20 evaluation of the personal care assistance staff and evaluation of the effectiveness of personal
 40.21 care assistance services. The qualified professional shall:

40.22 (1) develop and monitor with the recipient a personal care assistance care plan based on
 40.23 the service plan and individualized needs of the recipient;

40.24 (2) develop and monitor with the recipient a monthly plan for the use of personal care
 40.25 assistance services;

40.26 (3) review documentation of personal care assistance services provided;

40.27 (4) provide training and ensure competency for the personal care assistant in the individual
 40.28 needs of the recipient; and

40.29 (5) document all training, communication, evaluations, and needed actions to improve
 40.30 performance of the personal care assistants.

40.31 (c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training
 40.32 with basic information about the personal care assistance program approved by the

41.1 commissioner. Newly hired qualified professionals must complete the training within six
41.2 months of the date hired by a personal care assistance provider agency. Qualified
41.3 professionals who have completed the required training as a worker from a personal care
41.4 assistance provider agency do not need to repeat the required training if they are hired by
41.5 another agency, if they have completed the training within the last three years. The required
41.6 training must be available with meaningful access according to title VI of the Civil Rights
41.7 Act and federal regulations adopted under that law or any guidance from the United States
41.8 Health and Human Services Department. The required training must be available online or
41.9 by electronic remote connection. The required training must provide for competency testing
41.10 to demonstrate an understanding of the content without attending in-person training. A
41.11 qualified professional is allowed to be employed and is not subject to the training requirement
41.12 until the training is offered online or through remote electronic connection. A qualified
41.13 professional employed by a personal care assistance provider agency certified for
41.14 participation in Medicare as a home health agency is exempt from the training required in
41.15 this subdivision. When available, the qualified professional working for a Medicare-certified
41.16 home health agency must successfully complete the competency test. The commissioner
41.17 shall ensure there is a mechanism in place to verify the identity of persons completing the
41.18 competency testing electronically.

41.19 Sec. 37. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

41.20 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
41.21 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
41.22 payment limit for nonstate government hospitals. The commissioner shall then determine
41.23 the amount of a supplemental payment to Hennepin County Medical Center and Regions
41.24 Hospital for these services that would increase medical assistance spending in this category
41.25 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
41.26 In making this determination, the commissioner shall allot the available increases between
41.27 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
41.28 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
41.29 shall adjust this allotment as necessary based on federal approvals, the amount of
41.30 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
41.31 in order to maximize the additional total payments. The commissioner shall inform Hennepin
41.32 County and Ramsey County of the periodic intergovernmental transfers necessary to match
41.33 federal Medicaid payments available under this subdivision in order to make supplementary
41.34 medical assistance payments to Hennepin County Medical Center and Regions Hospital
41.35 equal to an amount that when combined with existing medical assistance payments to

42.1 nonstate governmental hospitals would increase total payments to hospitals in this category
42.2 for outpatient services to the aggregate upper payment limit for all hospitals in this category
42.3 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
42.4 supplementary payments to Hennepin County Medical Center and Regions Hospital.

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

42.21 (c) Beginning January 1, 2010, ~~Hennepin County and Ramsey County~~ may make monthly
42.22 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
42.23 ~~\$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.~~
42.24 The commissioner shall increase the medical assistance capitation payments to any licensed
42.25 health plan under contract with the medical assistance program that agrees to make enhanced
42.26 payments to ~~Hennepin County Medical Center or Regions Hospital~~. The increase shall be
42.27 in an amount equal to the annual value of the monthly transfers plus federal financial
42.28 participation, with each health plan receiving its pro rata share of the increase based on the
42.29 pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~
42.30 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"
42.31 means the total annual value of increased medical assistance capitation payments, including
42.32 the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For
42.33 managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce
42.34 the total annual value of increased medical assistance capitation payments under this
42.35 paragraph by an amount equal to ten percent of the base amount, and by an additional ten

43.1 percent of the base amount for each subsequent contract year until December 31, 2025.
43.2 Upon the request of the commissioner, health plans shall submit individual-level cost data
43.3 for verification purposes. The commissioner may ratably reduce these payments on a pro
43.4 rata basis in order to satisfy federal requirements for actuarial soundness. If payments are
43.5 reduced, transfers shall be reduced accordingly. Any licensed health plan that receives
43.6 increased medical assistance capitation payments under the intergovernmental transfer
43.7 described in this paragraph shall increase its medical assistance payments to ~~Hennepin~~
43.8 ~~County Medical Center~~ and Regions Hospital by the same amount as the increased payments
43.9 received in the capitation payment described in this paragraph. This paragraph expires
43.10 January 1, 2026.

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

43.27 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
43.28 determine an upper payment limit for physicians, dentists, and other billing professionals
43.29 affiliated with the University of Minnesota and University of Minnesota Physicians. The
43.30 upper payment limit shall be based on the average commercial rate or be determined using
43.31 another method acceptable to the Centers for Medicare and Medicaid Services. The
43.32 commissioner shall inform the University of Minnesota Medical School and University of
43.33 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
43.34 match the federal Medicaid payments available under this subdivision in order to make
43.35 supplementary payments to physicians, dentists, and other billing professionals affiliated

44.1 with the University of Minnesota and the University of Minnesota Physicians equal to the
44.2 difference between the established medical assistance payment for physician, dentist, and
44.3 other billing professional services and the upper payment limit. Upon receipt of these periodic
44.4 transfers, the commissioner shall make supplementary payments to physicians, dentists,
44.5 and other billing professionals affiliated with the University of Minnesota and the University
44.6 of Minnesota Physicians.

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

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

44.13 (h) All of the data and funding transactions related to the payments in paragraphs (a) to
44.14 (e) shall be between the commissioner and the governmental entities.

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

44.19 **EFFECTIVE DATE.** This section is effective December 31, 2021, or upon federal
44.20 approval, whichever is later. The commissioner of human services shall inform the revisor
44.21 of statutes when federal approval is obtained.

44.22 **Sec. 38. [256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

44.25 (b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical
44.26 nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists,
44.27 and may include dentists, individually enrolled dental hygienists, and dental therapists.

44.28 (c) "Health plan" means a managed care or county-based purchasing plan that is under
44.29 contract with the commissioner to deliver services to medical assistance enrollees under
44.30 section 256B.69.

45.1 (d) "High medical assistance utilization" means a medical assistance utilization rate
45.2 equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause
45.3 (6).

45.4 Subd. 2. **Federal approval required.** Each directed payment arrangement under this
45.5 section is contingent on federal approval and must conform with the requirements for
45.6 permissible directed managed care organization expenditures under section 256B.6928,
45.7 subdivision 5.

45.8 Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government
45.9 teaching hospitals with high medical assistance utilization and a level 1 trauma center and
45.10 the hospital's affiliated billing professionals, ambulance services, and clinics.

45.11 Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that
45.12 is eligible to perform intergovernmental transfers may make voluntary intergovernmental
45.13 transfers to the commissioner. The commissioner shall inform the nonstate governmental
45.14 entity of the intergovernmental transfers necessary to maximize the allowable directed
45.15 payments.

45.16 Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For
45.17 each federally approved directed payment arrangement that is a state-directed fee schedule
45.18 requirement, the commissioner shall determine a uniform adjustment factor to be applied
45.19 to each claim submitted by an eligible provider to a health plan. The commissioner shall
45.20 ensure that the application of the uniform adjustment factor maximizes the allowable directed
45.21 payments and does not result in payments exceeding federal limits, and may use a settle-up
45.22 process no less than annually to adjust health plan payments to comply with this requirement.
45.23 The commissioner shall apply the uniform adjustment to each submitted claim.

45.24 (b) For each federally approved directed payment arrangement that is a state-directed
45.25 fee schedule requirement, the commissioner must ensure that the total annual amount of
45.26 payments equals at least the sum of the annual value of the voluntary intergovernmental
45.27 transfers to the commissioner under subdivision 4 and federal financial participation.

45.28 (c) For each federally approved directed payment arrangement that is a state-directed
45.29 fee schedule requirement, the commissioner shall develop a plan for the initial
45.30 implementation of the state-directed fee schedule requirement to ensure that the eligible
45.31 provider receives the entire permissible value of the federally approved directed payment
45.32 arrangement. If federal approval of a directed payment arrangement under this subdivision
45.33 is retroactive, the commissioner shall make a onetime pro rata increase to the uniform

46.1 adjustment factor and the initial payments in order to include claims submitted between the
46.2 retroactive federal approval date and the period captured by the initial payments.

46.3 Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract,
46.4 each health plan shall submit to the commissioner payment information for each claim paid
46.5 to an eligible provider for services provided to a medical assistance enrollee.

46.6 Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each
46.7 health plan shall make directed payments to the eligible provider in an amount equal to the
46.8 payment amounts the plan received from the commissioner.

46.9 Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee
46.10 schedule requirement must align the state quality goals to Hennepin Healthcare medical
46.11 assistance patients, including unstably housed individuals, those with higher levels of social
46.12 and clinical risk, limited English proficiency patients, adults with serious chronic conditions,
46.13 or individuals of color. The directed payment arrangement will maintain quality and access
46.14 to a full range of health care delivery mechanisms for these patients, such as behavioral
46.15 health, emergent care, preventive care, hospitalization, transportation, interpretation, and
46.16 pharmaceutical. In partnership with the Department of Human Services, the Centers for
46.17 Medicare and Medicaid Services, and Hennepin Healthcare, mutually agreed upon measures
46.18 to demonstrate access to care must be identified and measured.

46.19 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
46.20 whichever is later, unless the federal approval provides for an effective date after July 1,
46.21 2021, but before the date of federal approval, in which case the federally approved effective
46.22 date applies.

46.23 Sec. 39. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

46.24 Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage
46.25 for prescription drugs from the prepaid managed care contracts entered into under this
46.26 section in order to increase savings to the state by collecting additional prescription drug
46.27 rebates. The contracts must maintain incentives for the managed care plan to manage drug
46.28 costs and utilization and may require that the managed care plans maintain an open drug
46.29 formulary. In order to manage drug costs and utilization, the contracts may authorize the
46.30 managed care plans to use preferred drug lists and prior authorization. This subdivision is
46.31 contingent on federal approval of the managed care contract changes and the collection of
46.32 additional prescription drug rebates.

47.1 (b) Managed care plans and county-based purchasing plans or the plan's subcontractor
 47.2 if the plan subcontracts with a third party to administer pharmacy services, including a
 47.3 pharmacy benefit manager, must comply with section 256B.0625, subdivision 13k, for
 47.4 purposes of contracting with dispensing providers to provide pharmacy services to medical
 47.5 assistance and MinnesotaCare enrollees.

47.6 Sec. 40. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision
 47.7 to read:

47.8 Subd. 6f. **Dental fee schedules.** (a) A managed care plan, county-based purchasing plan,
 47.9 or dental benefits administrator as defined under section 256B.0625, subdivision 9c,
 47.10 paragraph (a), must provide individual dental providers, upon request, the applicable fee
 47.11 schedules for covered dental services provided under the contract between the dental provider
 47.12 and the managed care plan, county-based purchasing plan, or dental benefits administrator.

47.13 (b) A managed care plan, county-based purchasing plan, or dental benefits administrator
 47.14 may fulfill this requirement by making the applicable fee schedules available through a
 47.15 secure web portal for the contracted dental provider to access.

47.16 Sec. 41. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

47.17 Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner
 47.18 shall not direct managed care organizations expenditures under the managed care contract,
 47.19 except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The
 47.20 exception under this paragraph includes the following situations:

47.21 (1) implementation of a value-based purchasing model for provider reimbursement,
 47.22 including pay-for-performance arrangements, bundled payments, or other service payments
 47.23 intended to recognize value or outcomes over volume of services;

47.24 (2) participation in a multipayer or medical assistance-specific delivery system reform
 47.25 or performance improvement initiative; or

47.26 (3) implementation of a minimum or maximum fee schedule, or a uniform dollar or
 47.27 percentage increase for network providers that provide a particular service. The maximum
 47.28 fee schedule must allow the managed care organization the ability to reasonably manage
 47.29 risk and provide discretion in accomplishing the goals of the contract.

47.30 (b) Any managed care contract that directs managed care organization expenditures as
 47.31 permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with
 47.32 Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial

48.1 soundness and generally accepted actuarial principles and practices; and have written
48.2 approval from the Centers for Medicare and Medicaid Services before implementation. To
48.3 obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

48.4 (1) is based on the utilization and delivery of services;

48.5 (2) directs expenditures equally, using the same terms of performance for a class of
48.6 providers providing service under the contract;

48.7 (3) is intended to advance at least one of the goals and objectives in the commissioner's
48.8 quality strategy;

48.9 (4) has an evaluation plan that measures the degree to which the arrangement advances
48.10 at least one of the goals in the commissioner's quality strategy;

48.11 (5) does not condition network provider participation on the network provider entering
48.12 into or adhering to an intergovernmental transfer agreement; and

48.13 (6) is not renewed automatically.

48.14 (c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the
48.15 commissioner shall:

48.16 (1) make participation in the value-based purchasing model, special delivery system
48.17 reform, or performance improvement initiative available, using the same terms of
48.18 performance, to a class of providers providing services under the contract related to the
48.19 model, reform, or initiative; and

48.20 (2) use a common set of performance measures across all payers and providers.

48.21 (d) The commissioner shall not set the amount or frequency of the expenditures or recoup
48.22 from the managed care organization any unspent funds allocated for these arrangements.

48.23 Sec. 42. Minnesota Statutes 2020, section 256B.75, is amended to read:

48.24 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

48.25 (a) For outpatient hospital facility fee payments for services rendered on or after October
48.26 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
48.27 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
48.28 which there is a federal maximum allowable payment. Effective for services rendered on
48.29 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
48.30 emergency room facility fees shall be increased by eight percent over the rates in effect on
48.31 December 31, 1999, except for those services for which there is a federal maximum allowable

49.1 payment. Services for which there is a federal maximum allowable payment shall be paid
49.2 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
49.3 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
49.4 upper limit. If it is determined that a provision of this section conflicts with existing or
49.5 future requirements of the United States government with respect to federal financial
49.6 participation in medical assistance, the federal requirements prevail. The commissioner
49.7 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
49.8 participation resulting from rates that are in excess of the Medicare upper limitations.

49.9 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
49.10 surgery hospital facility fee services for critical access hospitals designated under section
49.11 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
49.12 cost-finding methods and allowable costs of the Medicare program. Effective for services
49.13 provided on or after July 1, 2015, rates established for critical access hospitals under this
49.14 paragraph for the applicable payment year shall be the final payment and shall not be settled
49.15 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
49.16 year ending in 2017, the rate for outpatient hospital services shall be computed using
49.17 information from each hospital's Medicare cost report as filed with Medicare for the year
49.18 that is two years before the year that the rate is being computed. Rates shall be computed
49.19 using information from Worksheet C series until the department finalizes the medical
49.20 assistance cost reporting process for critical access hospitals. After the cost reporting process
49.21 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
49.22 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
49.23 related to rural health clinics and federally qualified health clinics, divided by ancillary
49.24 charges plus outpatient charges, excluding charges related to rural health clinics and federally
49.25 qualified health clinics.

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

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

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

50.9 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
 50.10 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
 50.11 hospital facility services before third-party liability and spenddown, is reduced three percent
 50.12 from the current statutory rates. Mental health services and facilities defined under section
 50.13 256.969, subdivision 16, are excluded from this paragraph.

50.14 Sec. 43. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

50.15 Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income,
 50.16 as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's
 50.17 ~~current income, or if income fluctuates month to month, the income for the 12-month~~
 50.18 ~~eligibility period~~ projected annual income for the applicable tax year.

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

50.20 Sec. 44. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

50.21 Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income
 50.22 limits under this section annually ~~each July 1 on January 1 as described in section 256B.056,~~
 50.23 ~~subdivision 1e~~ provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

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

50.25 Sec. 45. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

50.26 Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be
 50.27 redetermined on an annual basis, ~~in accordance with Code of Federal Regulations, title 42,~~
 50.28 ~~section 435.916 (a). The 12-month eligibility period begins the month of application.~~
 50.29 ~~Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to~~
 50.30 ~~implement renewals throughout the year according to guidance from the Centers for Medicare~~
 50.31 ~~and Medicaid Services.~~ The period of eligibility is the entire calendar year following the

51.1 year in which eligibility is redetermined. Eligibility redeterminations shall occur during the
51.2 open enrollment period for qualified health plans as specified in Code of Federal Regulations,
51.3 title 45, section 155.410(e)(3).

51.4 (b) Each new period of eligibility must take into account any changes in circumstances
51.5 that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

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

51.7 Sec. 46. Minnesota Statutes 2020, section 256L.15, is amended by adding a subdivision
51.8 to read:

51.9 **Subd. 5. Tobacco use premium surcharge.** (a) An enrollee who uses tobacco products
51.10 as defined in paragraph (e) and is not actively participating in a tobacco cessation program
51.11 must pay a tobacco premium surcharge in an amount that is equal to ten percent of the
51.12 enrollee's monthly premium. The tobacco use premium surcharge must be calculated on a
51.13 monthly basis and paid in accordance with section 256L.06, rounded up to the nearest dollar
51.14 amount. Nonpayment of the surcharge may result in disenrollment.

51.15 (b) Enrollees who initially apply or renew enrollment in the MinnesotaCare program on
51.16 or after July 1, 2021, must attest as part of the application or renewal process whether the
51.17 enrollee is using tobacco products and if so, whether the enrollee is actively participating
51.18 in a tobacco cessation program. Upon request of the commissioner, the enrollee must provide
51.19 documentation verifying that the enrollee is actively participating in tobacco cessation.

51.20 (c) If an enrollee indicates on the initial application or at renewal that the enrollee does
51.21 not use tobacco or is using tobacco products but is actively participating in a tobacco
51.22 cessation program, and it is determined that the enrollee was using tobacco products and
51.23 was not actively participating in a tobacco cessation program during the period of enrollment,
51.24 the enrollee must pay the total amount of the tobacco use premium surcharge that the enrollee
51.25 would have been required to pay as a tobacco user during that enrollment period. If the
51.26 enrollee fails to pay the surcharge amount due, the enrollee may be disenrolled and the
51.27 unpaid amount may be subject to recovery by the commissioner.

51.28 (d) Nonpayment of the surcharge amount owed by the enrollee under paragraph (a) or
51.29 (c) shall result in disenrollment effective for the calendar month following the month for
51.30 which the surcharge was due. Disenrollment for nonpayment of the surcharge must meet
51.31 the requirements in section 256L.06, subdivision 3, paragraphs (d) and (e).

52.1 (e) For purposes of this subdivision, the use of tobacco products means the use of a
 52.2 tobacco product four or more times per week within the past six months. Tobacco products
 52.3 include the use of cigarettes, cigars, pipe tobacco, chewing tobacco, or snuff.

52.4 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
 52.5 whichever is later. The commissioner of human services shall notify the revisor of statutes
 52.6 when federal approval is obtained.

52.7 Sec. 47. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

52.8 Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded
 52.9 from the gross revenues subject to the hospital, surgical center, or health care provider taxes
 52.10 under sections 295.50 to 295.59:

52.11 (1) payments received by a health care provider or the wholly owned subsidiary of a
 52.12 health care provider for care provided outside Minnesota;

52.13 (2) government payments received by the commissioner of human services for
 52.14 state-operated services;

52.15 (3) payments received by a health care provider for hearing aids and related equipment
 52.16 or prescription eyewear delivered outside of Minnesota; and

52.17 (4) payments received by an educational institution from student tuition, student activity
 52.18 fees, health care service fees, government appropriations, donations, or grants, and for
 52.19 services identified in and provided under an individualized education program as defined
 52.20 in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee
 52.21 for service payments and payments for extended coverage are taxable.

52.22 (b) The following payments are exempted from the gross revenues subject to hospital,
 52.23 surgical center, or health care provider taxes under sections 295.50 to 295.59:

52.24 (1) payments received for services provided under the Medicare program, including
 52.25 payments received from the government and organizations governed by sections 1833,
 52.26 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title
 52.27 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid
 52.28 by the Medicare enrollee, by Medicare supplemental coverage as described in section
 52.29 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal
 52.30 Social Security Act. Payments for services not covered by Medicare are taxable;

52.31 (2) payments received for home health care services;

53.1 (3) payments received from hospitals or surgical centers for goods and services on which
53.2 liability for tax is imposed under section 295.52 or the source of funds for the payment is
53.3 exempt under clause (1), (6), (9), (10), or (11);

53.4 (4) payments received from the health care providers for goods and services on which
53.5 liability for tax is imposed under this chapter or the source of funds for the payment is
53.6 exempt under clause (1), (6), (9), (10), or (11);

53.7 (5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax
53.8 under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs
53.9 otherwise exempt under this chapter;

53.10 (6) payments received from the chemical dependency fund under chapter 254B;

53.11 (7) payments received in the nature of charitable donations that are not designated for
53.12 providing patient services to a specific individual or group;

53.13 (8) payments received for providing patient services incurred through a formal program
53.14 of health care research conducted in conformity with federal regulations governing research
53.15 on human subjects. Payments received from patients or from other persons paying on behalf
53.16 of the patients are subject to tax;

53.17 (9) payments received from any governmental agency for services benefiting the public,
53.18 not including payments made by the government in its capacity as an employer or insurer
53.19 or payments made by the government for services provided under the MinnesotaCare
53.20 program or the medical assistance program governed by title XIX of the federal Social
53.21 Security Act, United States Code, title 42, sections 1396 to 1396v;

53.22 (10) payments received under the federal Employees Health Benefits Act, United States
53.23 Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990.
53.24 Enrollee deductibles, co-insurance, and co-payments are subject to tax;

53.25 (11) payments received under the federal Tricare program, Code of Federal Regulations,
53.26 title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are
53.27 subject to tax; and

53.28 (12) supplemental ~~or~~, enhanced, or directed payments authorized under section 256B.196
53.29 ~~or~~, 256B.197, or 256B.1973.

53.30 (c) Payments received by wholesale drug distributors for legend drugs sold directly to
53.31 veterinarians or veterinary bulk purchasing organizations are excluded from the gross
53.32 revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

54.1 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
54.2 31, 2020.

54.3 Sec. 48. **CAPITATION PAYMENT DELAY.**

54.4 (a) The commissioner of human services shall delay the medical assistance capitation
54.5 payment to managed care plans and county-based purchasing plans due in May 2023 until
54.6 July 1, 2023. The payment shall be made no earlier than July 1, 2023, and no later than July
54.7 31, 2023.

54.8 (b) The commissioner of human services shall delay the medical assistance capitation
54.9 payment to managed care plans and county-based purchasing plans due in May 2025 until
54.10 July 1, 2025. The payment shall be made no earlier than July 1, 2025, and no later than July
54.11 31, 2025.

54.12 Sec. 49. **DENTAL HOME DEMONSTRATION PROJECT PLAN.**

54.13 (a) The commissioner of human services shall develop a plan to implement a dental
54.14 home demonstration project. The demonstration project must create dental homes to provide
54.15 incentives to dental providers for the provision of patient-centered, high quality,
54.16 comprehensive, and coordinated dental care to medical assistance and MinnesotaCare
54.17 enrollees. The demonstration project must be designed to establish and evaluate alternative
54.18 models of delivery systems and payment methods that:

54.19 (1) emphasize, enhance, and encourage access to primary dental care by using dental
54.20 teams that include dentists, dental hygienists, dental therapists, advanced dental therapists,
54.21 and dental assistants;

54.22 (2) ensure enrollees with a consistent and ongoing contact with a dental provider or
54.23 dental team and coordination with the enrollee's medical care;

54.24 (3) decrease administrative burdens and create greater transparency and accountability;

54.25 (4) incorporate outcome measures on access, quality, cost of care and patient experience;
54.26 and

54.27 (5) establish value-based incentives to:

54.28 (i) provide flexibility in enrollment criteria in order to increase the number of dental
54.29 providers currently serving medical assistance and MinnesotaCare enrollees;

54.30 (ii) reduce disparities in access to dental services for high risk and medically and socially
54.31 complex patients; and

55.1 (iii) increase overall access to quality dental services.

55.2 (b) The commissioner shall develop outcome measures for the demonstration projects
55.3 that include measurements for access to preventive care, follow-up care after an oral health
55.4 evaluation, patient satisfaction, and administrative costs for delivering dental services.

55.5 (c) In developing the dental home demonstration project, the commissioner shall consult
55.6 with interested stakeholders including but not limited to representatives of:

55.7 (1) private practice dental clinics for which medical assistance and MinnesotaCare
55.8 enrollees comprise more than 25 percent of the clinic's patient load;

55.9 (2) nonprofit dental clinics with a primary focus on serving Indigenous communities
55.10 and other communities of color;

55.11 (3) nonprofit dental clinics with a primary focus on providing eldercare;

55.12 (4) nonprofit dental clinics with a primary focus on serving children;

55.13 (5) nonprofit dental clinics providing services in the seven-county metropolitan area;

55.14 (6) nonprofit dental clinics providing services outside of the seven-county metropolitan
55.15 area;

55.16 (7) multispecialty hospital-based dental clinics; and

55.17 (8) educational institutions operating dental programs.

55.18 (d) The commissioner of human services shall submit recommendations for the
55.19 establishment of a dental home demonstration project to the chairs and ranking minority
55.20 members of the legislative committees with jurisdiction over health and human services
55.21 policy and finance by February 1, 2022.

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

55.23 **Sec. 50. ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE.**

55.24 Notwithstanding Minnesota Statutes, section 256.011, subdivision 3, beginning January
55.25 1, 2022, any amount attributable to the enhanced Federal Medical Assistance Percentage
55.26 (FMAP) under section 6008 of the Families First Coronavirus Response Act shall be
55.27 deposited in the health care access fund.

56.1 Sec. 51. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

56.2 The commissioner of human services shall seek all necessary federal waivers and
56.3 approvals necessary to extend medical assistance postpartum coverage, as provided in
56.4 Minnesota Statutes, section 256B.055, subdivision 6.

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

56.6 Sec. 52. **OVERPAYMENTS FOR DURABLE MEDICAL EQUIPMENT,**
56.7 **PROSTHETICS, ORTHOTICS, OR SUPPLIES.**

56.8 (a) Notwithstanding any other law to the contrary, providers who received payment for
56.9 durable medical equipment, prosthetics, orthotics, or supplies between January 1, 2018, and
56.10 June 30, 2019, that were subject to the upper payment limits under United States Code, title
56.11 42, section 1396b(i)(27), shall not be required to repay any amount received in excess of
56.12 the allowable amount to either the state or the Centers for Medicare and Medicaid Services.

56.13 (b) The state shall repay with state funds any amount owed to the Centers for Medicare
56.14 and Medicaid Services for the federal financial participation amount received by the state
56.15 for payments identified in paragraph (a) in excess of the amount allowed effective January
56.16 1, 2018, and the state shall hold harmless the providers who received these payments from
56.17 recovery of both the state and federal share of the amount determined to have exceeded the
56.18 Medicare upper payment limit.

56.19 (c) Nothing in this section shall be construed to prohibit the commissioner from recouping
56.20 past overpayments due to false claims or for reasons other than exceeding the Medicare
56.21 upper payment limits or from recouping future overpayments including the recoupment of
56.22 payments that exceed the upper Medicare payment limits.

56.23 Sec. 53. **PROPOSED FORMULARY COMMITTEE.**

56.24 By March 1, 2022, the commissioner of human services, in consultation with relevant
56.25 professional associations and consumer groups, shall submit to the chairs and ranking
56.26 minority members of the legislative committees with jurisdiction over health and human
56.27 services a proposed reorganization of the Formulary Committee under Minnesota Statutes,
56.28 section 256B.0625, subdivision 13c, that includes:

56.29 (1) the proposed membership of the committee, including adequate representation of
56.30 consumers and health care professionals with expertise in clinical prescribing; and

57.1 (2) proposed policies and procedures for the operation of the committee that ensures
57.2 public input, including providing public notice and gathering public comments on the
57.3 committee's recommendations and proposed actions.

57.4 **Sec. 54. OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL; INITIAL**
57.5 **MEMBERSHIP TERMS.**

57.6 Notwithstanding Minnesota Statutes, section 256.042, subdivision 2, paragraph (c), the
57.7 initial term for members of the Opiate Epidemic Response Advisory Council established
57.8 under Minnesota Statutes, section 256.042, identified in Minnesota Statutes, section 256.042,
57.9 subdivision 2, paragraph (a), clauses (1), (3), (5), (7), (9), (11), (13), (15), and (17), ends
57.10 September 30, 2022. The initial term for members identified under Minnesota Statutes,
57.11 section 256.042, subdivision 2, paragraph (a), clauses (2), (4), (6), (8), (10), (12), (14), and
57.12 (16), ends September 30, 2023.

57.13 **Sec. 55. DIRECTION TO COMMISSIONER; DIRECTED PAYMENT**
57.14 **APPLICATION.**

57.15 The commissioner of human services, in consultation with Hennepin Healthcare System,
57.16 shall submit Section 438.6(c) Preprint to the Centers for Medicare and Medicaid Services
57.17 no later than July 31, 2021. The commissioner shall request from the Centers for Medicare
57.18 and Medicaid Services an effective date of January 1, 2022.

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

57.20 **Sec. 56. DIRECTIONS TO COMMISSIONER; SCREENING TOOL; SUBSTANCE**
57.21 **USE DISORDER REFORM EVALUATION; SUBSTANCE USE DISORDER**
57.22 **REFORM EDUCATION.**

57.23 (a) By July 1, 2022, the commissioner of human services shall develop or authorize a
57.24 tool for screening individuals for pretreatment coordination services and a template to
57.25 document an individual's screening result.

57.26 (b) By July 1, 2022, the commissioner of human services shall, in consultation with
57.27 counties and substance use disorder treatment providers, develop a tool to evaluate the
57.28 effects of substance use disorder treatment reform proposals enacted during the 2019 and
57.29 2021 legislative sessions, including access to services, appropriateness of services, and
57.30 accuracy of billing service units.

57.31 (c) By July 1, 2022, the commissioner of human services shall, in consultation with
57.32 counties and substance use disorder treatment providers, develop educational materials for

58.1 county staff, providers, and the general public regarding the content and timing of changes
 58.2 for implementation pursuant to substance use disorder treatment reform proposals enacted
 58.3 during the 2019 and 2021 legislative sessions.

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

58.5 Sec. 57. **FUNDING RECOMMENDATIONS FOR PRETREATMENT**
 58.6 **COORDINATION SERVICES.**

58.7 If federal approval is not obtained for pretreatment coordination services under Minnesota
 58.8 Statutes, section 256B.0625, subdivision 67, the commissioner of human services, in
 58.9 consultation with the counties, shall submit recommendations on a funding mechanism for
 58.10 pretreatment coordination services to the chairs and ranking minority members of the
 58.11 legislative committees with jurisdiction over health and human services policy and finance
 58.12 by March 15, 2022.

58.13 Sec. 58. **REVISOR INSTRUCTION.**

58.14 The revisor of statutes must change the term "Health Services Policy Committee" to
 58.15 "Health Services Advisory Council" wherever the term appears in Minnesota Statutes and
 58.16 may make any necessary changes to grammar or sentence structure to preserve the meaning
 58.17 of the text.

58.18 Sec. 59. **REPEALER.**

58.19 Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective July 1,
 58.20 2024.

58.21 **ARTICLE 2**

58.22 **HEALTH DEPARTMENT**

58.23 Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

58.24 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the
 58.25 e-Health Advisory Committee, shall develop uniform standards to be used for the
 58.26 interoperable electronic health records system for sharing and synchronizing patient data
 58.27 across systems. The standards must be compatible with federal efforts. The uniform standards
 58.28 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~
 58.29 ~~shall include an update on standards development as part of an annual report to the legislature.~~
 58.30 Individual health care providers in private practice with no other providers and health care

59.1 providers that do not accept reimbursement from a group purchaser, as defined in section
59.2 62J.03, subdivision 6, are excluded from the requirements of this section.

59.3 Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

59.4 Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an
59.5 e-Health Advisory Committee governed by section 15.059 to advise the commissioner on
59.6 the following matters:

59.7 (1) assessment of the adoption and effective use of health information technology by
59.8 the state, licensed health care providers and facilities, and local public health agencies;

59.9 (2) recommendations for implementing a statewide interoperable health information
59.10 infrastructure, to include estimates of necessary resources, and for determining standards
59.11 for clinical data exchange, clinical support programs, patient privacy requirements, and
59.12 maintenance of the security and confidentiality of individual patient data;

59.13 (3) recommendations for encouraging use of innovative health care applications using
59.14 information technology and systems to improve patient care and reduce the cost of care,
59.15 including applications relating to disease management and personal health management
59.16 that enable remote monitoring of patients' conditions, especially those with chronic
59.17 conditions; and

59.18 (4) other related issues as requested by the commissioner.

59.19 (b) The members of the e-Health Advisory Committee shall include the commissioners,
59.20 or commissioners' designees, of health, human services, administration, and commerce and
59.21 additional members to be appointed by the commissioner to include persons representing
59.22 Minnesota's local public health agencies, licensed hospitals and other licensed facilities and
59.23 providers, private purchasers, the medical and nursing professions, health insurers and health
59.24 plans, the state quality improvement organization, academic and research institutions,
59.25 consumer advisory organizations with an interest and expertise in health information
59.26 technology, and other stakeholders as identified by the commissioner to fulfill the
59.27 requirements of section 3013, paragraph (g), of the HITECH Act.

59.28 ~~(c) The commissioner shall prepare and issue an annual report not later than January 30~~
59.29 ~~of each year outlining progress to date in implementing a statewide health information~~
59.30 ~~infrastructure and recommending action on policy and necessary resources to continue the~~
59.31 ~~promotion of adoption and effective use of health information technology.~~

59.32 ~~(d)~~ This subdivision expires June 30, 2021.

60.1 Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

60.2 Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health
60.3 care providers must meet the following criteria when implementing an interoperable
60.4 electronic health records system within their hospital system or clinical practice setting.

60.5 (b) The electronic health record must be a qualified electronic health record.

60.6 (c) The electronic health record must be certified by the Office of the National
60.7 Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health
60.8 care providers if a certified electronic health record product for the provider's particular
60.9 practice setting is available. This criterion shall be considered met if a hospital or health
60.10 care provider is using an electronic health records system that has been certified within the
60.11 last three years, even if a more current version of the system has been certified within the
60.12 three-year period.

60.13 (d) The electronic health record must meet the standards established according to section
60.14 3004 of the HITECH Act as applicable.

60.15 (e) The electronic health record must have the ability to generate information on clinical
60.16 quality measures and other measures reported under sections 4101, 4102, and 4201 of the
60.17 HITECH Act.

60.18 (f) The electronic health record system must be connected to a state-certified health
60.19 information organization either directly or through a connection facilitated by a ~~state-certified~~
60.20 health data intermediary as defined in section 62J.498.

60.21 (g) A health care provider who is a prescriber or dispenser of legend drugs must have
60.22 an electronic health record system that meets the requirements of section 62J.497.

60.23 Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

60.24 Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in
60.25 consultation with the e-Health Advisory Committee, shall update the statewide
60.26 implementation plan required under subdivision 2 and released June 2008, to be consistent
60.27 with the updated federal HIT Strategic Plan released by the Office of the National Coordinator
60.28 ~~in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the~~
60.29 ~~requirements for a plan required under section 3013 of the HITECH Act~~ plans.

60.30 (b) The commissioner, in consultation with the e-Health Advisory Committee, shall
60.31 work to ensure coordination between state, regional, and national efforts to support and
60.32 accelerate efforts to effectively use health information technology to improve the quality

61.1 and coordination of health care and the continuity of patient care among health care providers,
61.2 to reduce medical errors, to improve population health, to reduce health disparities, and to
61.3 reduce chronic disease. The commissioner's coordination efforts shall include but not be
61.4 limited to:

61.5 ~~(1) assisting in the development and support of health information technology regional~~
61.6 ~~extension centers established under section 3012(c) of the HITECH Act to provide technical~~
61.7 ~~assistance and disseminate best practices;~~

61.8 ~~(2) providing supplemental information to the best practices gathered by regional centers~~
61.9 ~~to ensure that the information is relayed in a meaningful way to the Minnesota health care~~
61.10 ~~community;~~

61.11 ~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to
61.12 encourage implementation of admission, discharge and transfer alerts, and care summary
61.13 document exchange transactions and to evaluate the impact of health information technology
61.14 on cost and quality of care. Communications about available financial and technical support
61.15 shall include clear information about the interoperable health record requirements in
61.16 subdivision 1, including a separate statement in bold-face type clarifying the exceptions to
61.17 those requirements;

61.18 ~~(4)~~ (2) providing educational resources and technical assistance to health care providers
61.19 and patients related to state and national privacy, security, and consent laws governing
61.20 clinical health information, including the requirements in sections 144.291 to 144.298. In
61.21 carrying out these activities, the commissioner's technical assistance does not constitute
61.22 legal advice;

61.23 ~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health
61.24 information exchange, including the requirements in sections 144.291 to 144.298, and
61.25 making recommendations for modifications that would strengthen the ability of Minnesota
61.26 health care providers to securely exchange data in compliance with patient preferences and
61.27 in a way that is efficient and financially sustainable; and

61.28 ~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements
61.29 related to patient consent for release of health records for the purposes of treatment, payment,
61.30 and health care operations, as required in section 144.293, subdivision 2. The commissioner
61.31 shall provide a report to the legislature on the findings of this public input process no later
61.32 than February 1, 2017.

61.33 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
61.34 monitor national activity related to health information technology and shall coordinate

62.1 statewide input on policy development. The commissioner shall coordinate statewide
 62.2 responses to proposed federal health information technology regulations in order to ensure
 62.3 that the needs of the Minnesota health care community are adequately and efficiently
 62.4 addressed in the proposed regulations. The commissioner's responses may include, but are
 62.5 not limited to:

62.6 (1) reviewing and evaluating any standard, implementation specification, or certification
 62.7 criteria proposed by the national HIT standards ~~committee~~ committees;

62.8 (2) reviewing and evaluating policy proposed by ~~the national HIT policy committee~~
 62.9 committees relating to the implementation of a nationwide health information technology
 62.10 infrastructure; and

62.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~
 62.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~
 62.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~
 62.14 ~~62U; and~~

62.15 (4) ~~monitoring and responding to national activity related to privacy, security, and data~~
 62.16 ~~stewardship of electronic health information and individually identifiable health information.~~

62.17 (d) To the extent that the state is either required or allowed to apply, or designate an
 62.18 entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH~~
 62.19 ~~Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee
 62.20 and the commissioner of human services, shall be the lead applicant or sole designating
 62.21 authority. The commissioner shall make such designations consistent with the goals and
 62.22 objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

62.23 (e) The commissioner of human services shall apply for funding necessary to administer
 62.24 the incentive payments to providers authorized under title IV of the American Recovery
 62.25 and Reinvestment Act.

62.26 (f) ~~The commissioner shall include in the report to the legislature information on the~~
 62.27 ~~activities of this subdivision and provide recommendations on any relevant policy changes~~
 62.28 ~~that should be considered in Minnesota.~~

62.29 Sec. 5. Minnesota Statutes 2020, section 62J.498, is amended to read:

62.30 **62J.498 HEALTH INFORMATION EXCHANGE.**

62.31 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to
 62.32 62J.4982:

63.1 (b) "Clinical data repository" means a real time database that consolidates data from a
63.2 variety of clinical sources to present a unified view of a single patient and is used by a
63.3 ~~state-certified~~ health information exchange service provider to enable health information
63.4 exchange among health care providers that are not related health care entities as defined in
63.5 section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are
63.6 submitted to the commissioner for public health purposes required or permitted by law,
63.7 including any rules adopted by the commissioner.

63.8 (c) "Clinical transaction" means any meaningful use transaction or other health
63.9 information exchange transaction that is not covered by section 62J.536.

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

63.11 (e) "Health care provider" or "provider" means a health care provider or provider as
63.12 defined in section 62J.03, subdivision 8.

63.13 (f) "Health data intermediary" means an entity that provides the technical capabilities
63.14 or related products and services to enable health information exchange among health care
63.15 providers that are not related health care entities as defined in section 144.291, subdivision
63.16 2, paragraph (k). This includes but is not limited to health information service providers
63.17 (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries
63.18 as defined in section 62J.495.

63.19 (g) "Health information exchange" means the electronic transmission of health-related
63.20 information between organizations according to nationally recognized standards.

63.21 (h) "Health information exchange service provider" means a health data intermediary
63.22 or health information organization.

63.23 (i) "Health information organization" means an organization that oversees, governs, and
63.24 facilitates health information exchange among health care providers that are not related
63.25 health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve
63.26 coordination of patient care and the efficiency of health care delivery.

63.27 ~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical~~
63.28 ~~Health Act as defined in section 62J.495.~~

63.29 ~~(k)~~ (j) "Major participating entity" means:

63.30 (1) a participating entity that receives compensation for services that is greater than 30
63.31 percent of the health information organization's gross annual revenues from the health
63.32 information exchange service provider;

64.1 (2) a participating entity providing administrative, financial, or management services to
 64.2 the health information organization, if the total payment for all services provided by the
 64.3 participating entity exceeds three percent of the gross revenue of the health information
 64.4 organization; and

64.5 (3) a participating entity that nominates or appoints 30 percent or more of the board of
 64.6 directors or equivalent governing body of the health information organization.

64.7 ~~(h)~~ (k) "Master patient index" means an electronic database that holds unique identifiers
 64.8 of patients registered at a care facility and is used by a ~~state-certified~~ health information
 64.9 exchange service provider to enable health information exchange among health care providers
 64.10 that are not related health care entities as defined in section 144.291, subdivision 2, paragraph
 64.11 (k). This does not include data that are submitted to the commissioner for public health
 64.12 purposes required or permitted by law, including any rules adopted by the commissioner.

64.13 ~~(m) "Meaningful use" means use of certified electronic health record technology to~~
 64.14 ~~improve quality, safety, and efficiency and reduce health disparities; engage patients and~~
 64.15 ~~families; improve care coordination and population and public health; and maintain privacy~~
 64.16 ~~and security of patient health information as established by the Centers for Medicare and~~
 64.17 ~~Medicaid Services and the Minnesota Department of Human Services pursuant to sections~~
 64.18 ~~4101, 4102, and 4201 of the HITECH Act.~~

64.19 ~~(n) "Meaningful use transaction" means an electronic transaction that a health care~~
 64.20 ~~provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare~~
 64.21 ~~penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

64.22 ~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers,
 64.23 companies, or other organizations with which a health information organization ~~or health~~
 64.24 ~~data intermediary~~ has contracts or other agreements for the provision of health information
 64.25 exchange services:

64.26 (1) a health care facility licensed under sections 144.50 to 144.56, a nursing home
 64.27 licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise
 64.28 licensed under the laws of this state or registered with the commissioner;

64.29 (2) a health care provider, and any other health care professional otherwise licensed
 64.30 under the laws of this state or registered with the commissioner;

64.31 (3) a group, professional corporation, or other organization that provides the services of
 64.32 individuals or entities identified in clause (2), including but not limited to a medical clinic,

65.1 a medical group, a home health care agency, an urgent care center, and an emergent care
65.2 center;

65.3 (4) a health plan as defined in section 62A.011, subdivision 3; and

65.4 (5) a state agency as defined in section 13.02, subdivision 17.

65.5 ~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health
65.6 information exchange service providers agree to share in-kind services and resources to
65.7 allow for the pass-through of clinical transactions.

65.8 ~~(q) "State-certified health data intermediary" means a health data intermediary that has~~
65.9 ~~been issued a certificate of authority to operate in Minnesota.~~

65.10 ~~(r)~~ (n) "State-certified health information organization" means a health information
65.11 organization that has been issued a certificate of authority to operate in Minnesota.

65.12 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect
65.13 the public interest on matters pertaining to health information exchange. The commissioner
65.14 shall:

65.15 (1) review and act on applications from ~~health data intermediaries and~~ health information
65.16 organizations for certificates of authority to operate in Minnesota;

65.17 (2) require information to be provided as needed from health information exchange
65.18 service providers in order to meet requirements established under sections 62J.498 to
65.19 62J.4982;

65.20 ~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under
65.21 sections 62J.498 to 62J.4982;

65.22 ~~(3)~~ (4) respond to public complaints related to health information exchange services;

65.23 ~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines,
65.24 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

65.25 ~~(5)~~ (6) provide a biennial report on the status of health information exchange services
65.26 that includes but is not limited to:

65.27 (i) recommendations on actions necessary to ensure that health information exchange
65.28 services are adequate to meet the needs of Minnesota citizens and providers statewide;

65.29 (ii) recommendations on enforcement actions to ensure that health information exchange
65.30 service providers act in the public interest without causing disruption in health information
65.31 exchange services;

66.1 (iii) recommendations on updates to criteria for obtaining certificates of authority under
66.2 this section; and

66.3 (iv) recommendations on standard operating procedures for health information exchange,
66.4 including but not limited to the management of consumer preferences; and

66.5 ~~(6)~~ (7) other duties necessary to protect the public interest.

66.6 (b) As part of the application review process for certification under paragraph (a), prior
66.7 to issuing a certificate of authority, the commissioner shall:

66.8 (1) make all portions of the application classified as public data available to the public
66.9 for at least ten days while an application is under consideration. At the request of the
66.10 commissioner, the applicant shall participate in a public hearing by presenting an overview
66.11 of their application and responding to questions from interested parties; and

66.12 (2) consult with hospitals, physicians, and other providers prior to issuing a certificate
66.13 of authority.

66.14 (c) When the commissioner is actively considering a suspension or revocation of a
66.15 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data
66.16 that are collected, created, or maintained related to the suspension or revocation are classified
66.17 as confidential data on individuals and as protected nonpublic data in the case of data not
66.18 on individuals.

66.19 (d) The commissioner may disclose data classified as protected nonpublic or confidential
66.20 under paragraph (c) if disclosing the data will protect the health or safety of patients.

66.21 (e) After the commissioner makes a final determination regarding a suspension or
66.22 revocation of a certificate of authority, all minutes, orders for hearing, findings of fact,
66.23 conclusions of law, and the specification of the final disciplinary action, are classified as
66.24 public data.

66.25 Sec. 6. Minnesota Statutes 2020, section 62J.4981, is amended to read:

66.26 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
66.27 **INFORMATION EXCHANGE SERVICES.**

66.28 Subdivision 1. **Authority to require organizations to apply.** The commissioner shall
66.29 require ~~a health data intermediary or~~ a health information organization to apply for a
66.30 certificate of authority under this section. An applicant may continue to operate until the
66.31 commissioner acts on the application. If the application is denied, the applicant is considered

67.1 a health information exchange service provider whose certificate of authority has been
67.2 revoked under section 62J.4982, subdivision 2, paragraph (d).

67.3 ~~Subd. 2. Certificate of authority for health data intermediaries. (a) A health data~~
67.4 ~~intermediary must be certified by the state and comply with requirements established in this~~
67.5 ~~section.~~

67.6 ~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may~~
67.7 ~~apply to the commissioner for a certificate of authority to establish and operate as a health~~
67.8 ~~data intermediary in compliance with this section. No person shall establish or operate a~~
67.9 ~~health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase~~
67.10 ~~or receive advance or periodic consideration in conjunction with a health data intermediary~~
67.11 ~~contract unless the organization has a certificate of authority or has an application under~~
67.12 ~~active consideration under this section.~~

67.13 ~~(c) In issuing the certificate of authority, the commissioner shall determine whether the~~
67.14 ~~applicant for the certificate of authority has demonstrated that the applicant meets the~~
67.15 ~~following minimum criteria:~~

67.16 ~~(1) hold reciprocal agreements with at least one state-certified health information~~
67.17 ~~organization to access patient data, and for the transmission and receipt of clinical~~
67.18 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~
67.19 ~~5; and~~

67.20 ~~(2) participate in statewide shared health information exchange services as defined by~~
67.21 ~~the commissioner to support interoperability between state-certified health information~~
67.22 ~~organizations and state-certified health data intermediaries.~~

67.23 **Subd. 3. Certificate of authority for health information organizations.** (a) A health
67.24 information organization must obtain a certificate of authority from the commissioner and
67.25 demonstrate compliance with the criteria in paragraph (c).

67.26 (b) Notwithstanding any law to the contrary, an organization may apply for a certificate
67.27 of authority to establish and operate a health information organization under this section.
67.28 No person shall establish or operate a health information organization in this state, nor sell
67.29 or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in
67.30 conjunction with a health information organization or health information contract unless
67.31 the organization has a certificate of authority under this section.

68.1 (c) In issuing the certificate of authority, the commissioner shall determine whether the
68.2 applicant for the certificate of authority has demonstrated that the applicant meets the
68.3 following minimum criteria:

68.4 (1) the entity is a legally established organization;

68.5 (2) appropriate insurance, including liability insurance, for the operation of the health
68.6 information organization is in place and sufficient to protect the interest of the public and
68.7 participating entities;

68.8 (3) strategic and operational plans address governance, technical infrastructure, legal
68.9 and policy issues, finance, and business operations in regard to how the organization will
68.10 expand to support providers in achieving health information exchange goals over time;

68.11 (4) the entity addresses the parameters to be used with participating entities and other
68.12 health information exchange service providers for clinical transactions, compliance with
68.13 Minnesota law, and interstate health information exchange trust agreements;

68.14 (5) the entity's board of directors or equivalent governing body is composed of members
68.15 that broadly represent the health information organization's participating entities and
68.16 consumers;

68.17 (6) the entity maintains a professional staff responsible to the board of directors or
68.18 equivalent governing body with the capacity to ensure accountability to the organization's
68.19 mission;

68.20 (7) the organization is compliant with national certification and accreditation programs
68.21 designated by the commissioner;

68.22 (8) the entity maintains the capability to query for patient information based on national
68.23 standards. The query capability may utilize a master patient index, clinical data repository,
68.24 or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The
68.25 entity must be compliant with the requirements of section 144.293, subdivision 8, when
68.26 conducting clinical transactions;

68.27 (9) the organization demonstrates interoperability with all other state-certified health
68.28 information organizations using nationally recognized standards;

68.29 (10) the organization demonstrates compliance with all privacy and security requirements
68.30 required by state and federal law; and

69.1 (11) the organization uses financial policies and procedures consistent with generally
 69.2 accepted accounting principles and has an independent audit of the organization's financials
 69.3 on an annual basis.

69.4 (d) Health information organizations that have obtained a certificate of authority must:

69.5 (1) meet the requirements established for connecting to the National eHealth Exchange;

69.6 (2) annually submit strategic and operational plans for review by the commissioner that
 69.7 address:

69.8 (i) progress in achieving objectives included in previously submitted strategic and
 69.9 operational plans across the following domains: business and technical operations, technical
 69.10 infrastructure, legal and policy issues, finance, and organizational governance;

69.11 (ii) plans for ensuring the necessary capacity to support clinical transactions;

69.12 (iii) approach for attaining financial sustainability, including public and private financing
 69.13 strategies, and rate structures;

69.14 (iv) rates of adoption, utilization, and transaction volume, and mechanisms to support
 69.15 health information exchange; and

69.16 (v) an explanation of methods employed to address the needs of community clinics,
 69.17 critical access hospitals, and free clinics in accessing health information exchange services;

69.18 (3) enter into reciprocal agreements with all other state-certified health information
 69.19 organizations ~~and state-certified health data intermediaries~~ to enable access to patient data,
 69.20 and for the transmission and receipt of clinical transactions. Reciprocal agreements must
 69.21 meet the requirements in subdivision 5;

69.22 (4) participate in statewide shared health information exchange services as defined by
 69.23 the commissioner to support interoperability ~~between state-certified health information~~
 69.24 ~~organizations and state-certified health data intermediaries~~; and

69.25 (5) comply with additional requirements for the certification or recertification of health
 69.26 information organizations that may be established by the commissioner.

69.27 Subd. 4. **Application for certificate of authority for health information exchange**
 69.28 **service providers organizations.** (a) Each application for a certificate of authority shall
 69.29 be in a form prescribed by the commissioner and verified by an officer or authorized
 69.30 representative of the applicant. Each application shall include the following in addition to
 69.31 information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

70.1 (1) ~~for health information organizations only~~, a copy of the basic organizational document,
70.2 if any, of the applicant and of each major participating entity, such as the articles of
70.3 incorporation, or other applicable documents, and all amendments to it;

70.4 (2) ~~for health information organizations only~~, a list of the names, addresses, and official
70.5 positions of the following:

70.6 (i) all members of the board of directors or equivalent governing body, and the principal
70.7 officers and, if applicable, shareholders of the applicant organization; and

70.8 (ii) all members of the board of directors or equivalent governing body, and the principal
70.9 officers of each major participating entity and, if applicable, each shareholder beneficially
70.10 owning more than ten percent of any voting stock of the major participating entity;

70.11 (3) ~~for health information organizations only~~, the name and address of each participating
70.12 entity and the agreed-upon duration of each contract or agreement if applicable;

70.13 (4) a copy of each standard agreement or contract intended to bind the participating
70.14 entities and the health information ~~exchange service provider~~ organization. Contractual
70.15 provisions shall be consistent with the purposes of this section, in regard to the services to
70.16 be performed under the standard agreement or contract, the manner in which payment for
70.17 services is determined, the nature and extent of responsibilities to be retained by the health
70.18 information organization, and contractual termination provisions;

70.19 (5) a statement generally describing the health information ~~exchange service provider~~
70.20 organization, its health information exchange contracts, facilities, and personnel, including
70.21 a statement describing the manner in which the applicant proposes to provide participants
70.22 with comprehensive health information exchange services;

70.23 (6) a statement reasonably describing the geographic area or areas to be served and the
70.24 type or types of participants to be served;

70.25 (7) a description of the complaint procedures to be used as required under this section;

70.26 (8) a description of the mechanism by which participating entities will have an opportunity
70.27 to participate in matters of policy and operation;

70.28 (9) a copy of any pertinent agreements between the health information organization and
70.29 insurers, including liability insurers, demonstrating coverage is in place;

70.30 (10) a copy of the conflict of interest policy that applies to all members of the board of
70.31 directors or equivalent governing body and the principal officers of the health information
70.32 organization; and

71.1 (11) other information as the commissioner may reasonably require to be provided.

71.2 (b) Within 45 days after the receipt of the application for a certificate of authority, the
71.3 commissioner shall determine whether or not the application submitted meets the
71.4 requirements for completion in paragraph (a), and notify the applicant of any further
71.5 information required for the application to be processed.

71.6 (c) Within 90 days after the receipt of a complete application for a certificate of authority,
71.7 the commissioner shall issue a certificate of authority to the applicant if the commissioner
71.8 determines that the applicant meets the minimum criteria requirements of subdivision 2 ~~for~~
71.9 ~~health data intermediaries or subdivision 3 for health information organizations~~. If the
71.10 commissioner determines that the applicant is not qualified, the commissioner shall notify
71.11 the applicant and specify the reasons for disqualification.

71.12 (d) Upon being granted a certificate of authority to operate as a state-certified health
71.13 information organization ~~or state-certified health data intermediary~~, the organization must
71.14 operate in compliance with the provisions of this section. Noncompliance may result in the
71.15 imposition of a fine or the suspension or revocation of the certificate of authority according
71.16 to section 62J.4982.

71.17 Subd. 5. **Reciprocal agreements between health information exchange entities**
71.18 **organizations**. (a) Reciprocal agreements between two health information organizations
71.19 ~~or between a health information organization and a health data intermediary~~ must include
71.20 a fair and equitable model for charges between the entities that:

71.21 (1) does not impede the secure transmission of clinical transactions;

71.22 (2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted
71.23 according to nationally recognized standards where no additional value-added service is
71.24 rendered to the sending or receiving health information organization ~~or health data~~
71.25 ~~intermediary~~ either directly or on behalf of the client;

71.26 (3) is consistent with fair market value and proportionately reflects the value-added
71.27 services accessed as a result of the agreement; and

71.28 (4) prevents health care stakeholders from being charged multiple times for the same
71.29 service.

71.30 (b) Reciprocal agreements must include comparable quality of service standards that
71.31 ensure equitable levels of services.

71.32 (c) Reciprocal agreements are subject to review and approval by the commissioner.

72.1 (d) Nothing in this section precludes a state-certified health information organization or
 72.2 ~~state-certified health data intermediary~~ from entering into contractual agreements for the
 72.3 provision of value-added services ~~beyond meaningful use transactions.~~

72.4 Sec. 7. Minnesota Statutes 2020, section 62J.4982, is amended to read:

72.5 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

72.6 Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation
 72.7 of statute or rule applicable to a health information ~~exchange service provider~~ organization,
 72.8 levy an administrative penalty in an amount up to \$25,000 for each violation. In determining
 72.9 the level of an administrative penalty, the commissioner shall consider the following factors:

72.10 (1) the number of participating entities affected by the violation;

72.11 (2) the effect of the violation on participating entities' access to health information
 72.12 exchange services;

72.13 (3) if only one participating entity is affected, the effect of the violation on the patients
 72.14 of that entity;

72.15 (4) whether the violation is an isolated incident or part of a pattern of violations;

72.16 (5) the economic benefits derived by the health information organization ~~or a health data~~
 72.17 ~~intermediary~~ by virtue of the violation;

72.18 (6) whether the violation hindered or facilitated an individual's ability to obtain health
 72.19 care;

72.20 (7) whether the violation was intentional;

72.21 (8) whether the violation was beyond the direct control of the health information ~~exchange~~
 72.22 ~~service provider~~ organization;

72.23 (9) any history of prior compliance with the provisions of this section, including
 72.24 violations;

72.25 (10) whether and to what extent the health information ~~exchange service provider~~
 72.26 organization attempted to correct previous violations;

72.27 (11) how the health information ~~exchange service provider~~ organization responded to
 72.28 technical assistance from the commissioner provided in the context of a compliance effort;
 72.29 and

72.30 (12) the financial condition of the health information ~~exchange service provider~~
 72.31 organization including, but not limited to, whether the health information ~~exchange service~~

73.1 ~~provider~~ organization had financial difficulties that affected its ability to comply or whether
73.2 the imposition of an administrative monetary penalty would jeopardize the ability of the
73.3 health information ~~exchange service provider~~ organization to continue to deliver health
73.4 information exchange services.

73.5 The commissioner shall give reasonable notice in writing to the health information
73.6 ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for
73.7 it. A health information ~~exchange service provider~~ organization may have 15 days within
73.8 which to contest whether the facts found constitute a violation of sections 62J.4981 and
73.9 62J.4982, according to the contested case and judicial review provisions of sections 14.57
73.10 to 14.69.

73.11 (b) If the commissioner has reason to believe that a violation of section 62J.4981 or
73.12 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved
73.13 before commencing action under subdivision 2. The commissioner may notify the health
73.14 information ~~exchange service provider~~ organization and the representatives, or other persons
73.15 who appear to be involved in the suspected violation, to arrange a voluntary conference
73.16 with the alleged violators or their authorized representatives. The purpose of the conference
73.17 is to attempt to learn the facts about the suspected violation and, if it appears that a violation
73.18 has occurred or is threatened, to find a way to correct or prevent it. The conference is not
73.19 governed by any formal procedural requirements, and may be conducted as the commissioner
73.20 considers appropriate.

73.21 (c) The commissioner may issue an order directing a health information ~~exchange service~~
73.22 ~~provider~~ organization or a representative of a health information ~~exchange service provider~~
73.23 organization to cease and desist from engaging in any act or practice in violation of sections
73.24 62J.4981 and 62J.4982.

73.25 (d) Within 20 days after service of the order to cease and desist, a health information
73.26 ~~exchange service provider~~ organization may contest whether the facts found constitute a
73.27 violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial
73.28 review provisions of sections 14.57 to 14.69.

73.29 (e) In the event of noncompliance with a cease and desist order issued under this
73.30 subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other
73.31 appropriate relief in Ramsey County District Court.

73.32 Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner
73.33 may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~
73.34 health information organization under section 62J.4981 if the commissioner finds that:

74.1 (1) the health information ~~exchange service provider~~ organization is operating
74.2 significantly in contravention of its basic organizational document, or in a manner contrary
74.3 to that described in and reasonably inferred from any other information submitted under
74.4 section 62J.4981, unless amendments to the submissions have been filed with and approved
74.5 by the commissioner;

74.6 (2) the health information ~~exchange service provider~~ organization is unable to fulfill its
74.7 obligations to furnish comprehensive health information exchange services as required
74.8 under its health information exchange contract;

74.9 (3) the health information ~~exchange service provider~~ organization is no longer financially
74.10 solvent or may not reasonably be expected to meet its obligations to participating entities;

74.11 (4) the health information ~~exchange service provider~~ organization has failed to implement
74.12 the complaint system in a manner designed to reasonably resolve valid complaints;

74.13 (5) the health information ~~exchange service provider~~ organization, or any person acting
74.14 with its sanction, has advertised or merchandised its services in an untrue, misleading,
74.15 deceptive, or unfair manner;

74.16 (6) the continued operation of the health information ~~exchange service provider~~
74.17 organization would be hazardous to its participating entities or the patients served by the
74.18 participating entities; or

74.19 (7) the health information ~~exchange service provider~~ organization has otherwise failed
74.20 to substantially comply with section 62J.4981 or with any other statute or administrative
74.21 rule applicable to health information exchange service providers, or has submitted false
74.22 information in any report required under sections 62J.498 to 62J.4982.

74.23 (b) A certificate of authority shall be suspended or revoked only after meeting the
74.24 requirements of subdivision 3.

74.25 (c) If the certificate of authority of a health information ~~exchange service provider~~
74.26 organization is suspended, the health information ~~exchange service provider~~ organization
74.27 shall not, during the period of suspension, enroll any additional participating entities, and
74.28 shall not engage in any advertising or solicitation.

74.29 (d) If the certificate of authority of a health information ~~exchange service provider~~
74.30 organization is revoked, the organization shall proceed, immediately following the effective
74.31 date of the order of revocation, to wind up its affairs, and shall conduct no further business
74.32 except as necessary to the orderly conclusion of the affairs of the organization. The
74.33 organization shall engage in no further advertising or solicitation. The commissioner may,

75.1 by written order, permit further operation of the organization as the commissioner finds to
75.2 be in the best interest of participating entities, to the end that participating entities will be
75.3 given the greatest practical opportunity to access continuing health information exchange
75.4 services.

75.5 Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When
75.6 the commissioner has cause to believe that grounds for the denial, suspension, or revocation
75.7 of a certificate of authority exist, the commissioner shall notify the health information
75.8 ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension,
75.9 or revocation and setting a time within 20 days for a hearing on the matter.

75.10 (b) After a hearing before the commissioner at which the health information ~~exchange~~
75.11 ~~service provider~~ organization may respond to the grounds for denial, suspension, or
75.12 revocation, or upon the failure of the health information ~~exchange service provider~~
75.13 organization to appear at the hearing, the commissioner shall take action as deemed necessary
75.14 and shall issue written findings and mail them to the health information ~~exchange service~~
75.15 ~~provider~~ organization.

75.16 (c) If suspension, revocation, or administrative penalty is proposed according to this
75.17 section, the commissioner must deliver, or send by certified mail with return receipt
75.18 requested, to the health information ~~exchange service provider~~ organization written notice
75.19 of the commissioner's intent to impose a penalty. This notice of proposed determination
75.20 must include:

75.21 (1) a reference to the statutory basis for the penalty;

75.22 (2) a description of the findings of fact regarding the violations with respect to which
75.23 the penalty is proposed;

75.24 (3) the nature and amount of the proposed penalty;

75.25 (4) any circumstances described in subdivision 1, paragraph (a), that were considered
75.26 in determining the amount of the proposed penalty;

75.27 (5) instructions for responding to the notice, including a statement of the health
75.28 information ~~exchange service provider's~~ organization's right to a contested case proceeding
75.29 and a statement that failure to request a contested case proceeding within 30 calendar days
75.30 permits the imposition of the proposed penalty; and

75.31 (6) the address to which the contested case proceeding request must be sent.

75.32 Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice
75.33 of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the

76.1 certification and recertification of health information ~~exchange service providers~~
 76.2 organizations when implementing sections 62J.498 to 62J.4982.

76.3 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every
 76.4 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and
 76.5 62J.4982 as follows:

76.6 (1) filing an application for certificate of authority to operate as a health information
 76.7 organization, \$7,000; and

76.8 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~
 76.9 ~~\$7,000;~~

76.10 ~~(3) annual health information organization certificate fee, \$7,000; and~~

76.11 ~~(4) annual health data intermediary certificate fee, \$7,000.~~

76.12 (b) Fees collected under this section shall be deposited in the state treasury and credited
 76.13 to the state government special revenue fund.

76.14 (c) Administrative monetary penalties imposed under this subdivision shall be credited
 76.15 to an account in the special revenue fund and are appropriated to the commissioner for the
 76.16 purposes of sections 62J.498 to 62J.4982.

76.17 Sec. 8. Minnesota Statutes 2020, section 62J.84, subdivision 6, is amended to read:

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

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

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

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

76.28 (c) The commissioner shall not post to the department's website or a private entity
 76.29 contracting with the commissioner shall not post any information described in this section
 76.30 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
 76.31 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information

77.1 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
77.2 1836, as amended. If a manufacturer believes information should be withheld from public
77.3 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
77.4 that information and describe the legal basis in writing when the manufacturer submits the
77.5 information under this section. If the commissioner disagrees with the manufacturer's request
77.6 to withhold information from public disclosure, the commissioner shall provide the
77.7 manufacturer written notice that the information will be publicly posted 30 days after the
77.8 date of the notice.

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

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

77.19 Sec. 9. Minnesota Statutes 2020, section 144.05, is amended by adding a subdivision to
77.20 read:

77.21 Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the
77.22 commissioner of health to the legislature is mandated by statute and the enabling legislation
77.23 does not include a date for the submission of a final report, the mandate to submit the report
77.24 shall expire in accordance with this section.

77.25 (b) If the mandate requires the submission of an annual report and the mandate was
77.26 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate
77.27 requires the submission of a biennial or less frequent report and the mandate was enacted
77.28 before January 1, 2021, the mandate shall expire on January 1, 2024.

77.29 (c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years
77.30 after the date of enactment if the mandate requires the submission of an annual report and
77.31 shall expire five years after the date of enactment if the mandate requires the submission
77.32 of a biennial or less frequent report, unless the enacting legislation provides for a difference
77.33 expiration date.

78.1 (d) The commissioner shall submit a list to the chairs and ranking minority members of
78.2 the legislative committee with jurisdiction over health by February 15 of each year, beginning
78.3 February 15, 2022, of all reports set to expire during the following calendar year in
78.4 accordance with this section.

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

78.6 Sec. 10. **[144.064] THE VIVIAN ACT.**

78.7 Subdivision 1. **Short title.** This section shall be known and may be cited as the "Vivian
78.8 Act."

78.9 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
78.10 given them:

78.11 (1) "commissioner" means the commissioner of health;

78.12 (2) "health care practitioner" means a medical professional that provides prenatal or
78.13 postnatal care;

78.14 (3) "CMV" means the human herpesvirus cytomegalovirus, also called HCMV, human
78.15 herpesvirus 5, and HHV-5; and

78.16 (4) "congenital CMV" means the transmission of a CMV infection from a pregnant
78.17 mother to her fetus.

78.18 Subd. 3. **Commissioner duties.** (a) The commissioner shall make available to health
78.19 care practitioners, women who may become pregnant, expectant parents, and parents of
78.20 infants up-to-date and evidence-based information about congenital CMV that has been
78.21 reviewed by experts with knowledge of the disease. The information shall include the
78.22 following:

78.23 (1) the recommendation to consider testing for congenital CMV if the parent or legal
78.24 guardian of the infant elected not to have newborn screening performed under section
78.25 144.125, and the infant failed a newborn hearing screening or pregnancy history suggests
78.26 increased risk for congenital CMV infection;

78.27 (2) the incidence of CMV;

78.28 (3) the transmission of CMV to pregnant women and women who may become pregnant;

78.29 (4) birth defects caused by congenital CMV;

78.30 (5) available preventative measures to avoid the infection of women who are pregnant
78.31 or may become pregnant; and

79.1 (6) resources available for families of children born with congenital CMV.

79.2 (b) The commissioner shall follow existing department practice, inclusive of community
 79.3 engagement, to ensure that the information in paragraph (a) is culturally and linguistically
 79.4 appropriate for all recipients.

79.5 (c) The department shall establish an outreach program to:

79.6 (1) educate women who may become pregnant, expectant parents, and parents of infants
 79.7 about CMV; and

79.8 (2) raise awareness for CMV among health care providers who provide care to expectant
 79.9 mothers or infants.

79.10 Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

79.11 Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent
 79.12 to the annual fee upon issuance of the initial license.

79.13 (b) A licensee must pay an annual fee at least 60 days before the anniversary date of the
 79.14 issuance of the license. The annual fee is as follows:

	TYPE	<u>ANNUAL LICENSE FEE</u>
79.15		\$19,920
79.16		\$25,896
79.17	Academic broad scope - type A, B, or C	<u>\$25,896</u>
79.18	Academic broad scope - type B	19,920
79.19	Academic broad scope - type C	19,920
79.20	<u>Academic broad scope - type A, B, or C (4-8 locations)</u>	<u>\$31,075</u>
79.21	<u>Academic broad scope - type A, B, or C (9 or more locations)</u>	<u>\$36,254</u>
79.22		19,920
79.23	Medical broad scope - type A	<u>\$25,896</u>
79.24	<u>Medical broad scope- type A (4-8 locations)</u>	<u>\$31,075</u>
79.25	<u>Medical broad scope- type A (9 or more locations)</u>	<u>\$36,254</u>
79.26	Medical institution - diagnostic and therapeutic	3,680
79.27	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u> 79.28 <u>medicine, eye applicators, high dose rate afterloaders, and</u> 79.29 <u>medical therapy emerging technologies</u>	<u>\$4,784</u>
79.30		3,680
79.31	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u> 79.32 <u>medicine, eye applicators, high dose rate afterloaders, and</u> 79.33 <u>medical therapy emerging technologies (4-8 locations)</u>	<u>\$5,740</u>
79.34	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u> 79.35 <u>medicine, eye applicators, high dose rate afterloaders, and</u> 79.36 <u>medical therapy emerging technologies (9 or more locations)</u>	<u>\$6,697</u>
79.37	Medical institution - diagnostic (no written directives)	3,680

80.1	Medical private practice—diagnostic and therapeutic	3,680
80.2	Medical private practice—diagnostic (no written directives)	3,680
80.3	Eye applicators	3,680
80.4	Nuclear medical vans	3,680
80.5	High dose rate afterloader	3,680
80.6	Mobile high dose rate afterloader	3,680
80.7	Medical therapy—other emerging technology	3,680
80.8		8,960
80.9	Teletherapy	<u>\$11,648</u>
80.10		8,960
80.11	Gamma knife	<u>\$11,648</u>
80.12	Veterinary medicine	2,000 <u>\$2,600</u>
80.13	In vitro testing lab	2,000 <u>\$2,600</u>
80.14		8,800
80.15	Nuclear pharmacy	<u>\$11,440</u>
80.16	<u>Nuclear pharmacy (5 or more locations)</u>	<u>\$13,728</u>
80.17	Radiopharmaceutical distribution (10 CFR 32.72)	3,840 <u>\$4,992</u>
80.18	Radiopharmaceutical processing and distribution (10 CFR	8,800
80.19	32.72)	<u>\$11,440</u>
80.20	<u>Radiopharmaceutical processing and distribution (10 CFR</u>	<u>\$13,728</u>
80.21	<u>32.72) (5 or more locations)</u>	
80.22	Medical sealed sources - distribution (10 CFR 32.74)	3,840 <u>\$4,992</u>
80.23	Medical sealed sources - processing and distribution (10 CFR	8,800
80.24	32.74)	<u>\$11,440</u>
80.25	<u>Medical sealed sources - processing and distribution (10 CFR</u>	<u>\$13,728</u>
80.26	<u>32.74) (5 or more locations)</u>	
80.27	Well logging - sealed sources	3,760 <u>\$4,888</u>
80.28	Measuring systems - (fixed gauge, portable gauge, gas	
80.29	<u>chromatograph, other)</u>	2,000 <u>\$2,600</u>
80.30	Measuring systems—portable gauge	2,000
80.31	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
80.32	<u>chromatograph, other) (4-8 locations)</u>	<u>\$3,120</u>
80.33	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
80.34	<u>chromatograph, other) (9 or more locations)</u>	<u>\$3,640</u>
80.35	X-ray fluorescent analyzer	1,520 <u>\$1,976</u>
80.36	Measuring systems—gas chromatograph	2,000
80.37	Measuring systems—other	2,000
80.38	Broad scope Manufacturing and distribution - type A <u>broad</u>	19,920
80.39	<u>scope</u>	<u>\$25,896</u>
80.40	<u>Manufacturing and distribution - type A broad scope (4-8</u>	
80.41	<u>locations)</u>	<u>\$31,075</u>

81.1	<u>Manufacturing and distribution - type A broad scope (9 or more</u>		
81.2	<u>locations)</u>		\$36,254
81.3	Broad scope Manufacturing and distribution - type B <u>or C broad</u>		17,600
81.4	<u>scope</u>		\$22,880
81.5	Broad scope Manufacturing and distribution - type C		17,600
81.6	<u>Manufacturing and distribution - type B or C broad scope (4-8</u>		
81.7	<u>locations)</u>		\$27,456
81.8	<u>Manufacturing and distribution - type B or C broad scope (9</u>		
81.9	<u>or more locations)</u>		\$32,032
81.10	Manufacturing and distribution - other	5,280	\$6,864
81.11	<u>Manufacturing and distribution - other (4-8 locations)</u>		\$8,236
81.12	<u>Manufacturing and distribution - other (9 or more locations)</u>		\$9,609
81.13			18,640
81.14	Nuclear laundry		\$24,232
81.15	Decontamination services	4,960	\$6,448
81.16	Leak test services only	2,000	\$2,600
81.17	Instrument calibration service only, less than 100 curies	2,000	\$2,600
81.18	Instrument calibration service only, 100 curies or more		2,000
81.19	Service, maintenance, installation, source changes, etc.	4,960	\$6,448
81.20	Waste disposal service, prepackaged only	6,000	\$7,800
81.21			8,320
81.22	Waste disposal		\$10,816
81.23	Distribution - general licensed devices (sealed sources)	1,760	\$2,288
81.24	Distribution - general licensed material (unsealed sources)	1,120	\$1,456
81.25			9,840
81.26	Industrial radiography - fixed <u>or temporary</u> location		\$12,792
81.27	Industrial radiography - temporary job sites		9,840
81.28	<u>Industrial radiography - fixed or temporary location (5 or more</u>		
81.29	<u>locations)</u>		\$16,629
81.30	Irradiators, self-shielding, less than 10,000 curies	2,880	\$3,744
81.31	Irradiators, other, less than 10,000 curies	5,360	\$6,968
81.32	Irradiators, self-shielding, 10,000 curies or more		2,880
81.33			9,520
81.34	Research and development - type A, B, <u>or C</u> broad scope		\$12,376
81.35	Research and development - type B broad scope		9,520
81.36	Research and development - type C broad scope		9,520
81.37	<u>Research and development - type A, B, or C broad scope (4-8</u>		
81.38	<u>locations)</u>		\$14,851
81.39	<u>Research and development - type A, B, or C broad scope (9 or</u>		
81.40	<u>more locations)</u>		\$17,326
81.41	Research and development - other	4,480	\$5,824
81.42	Storage - no operations	2,000	\$2,600

82.1	Source material - shielding	584 <u>\$759</u>
82.2	Special nuclear material plutonium - neutron source in device	3,680 <u>\$4,784</u>
82.3	Pacemaker by-product and/or special nuclear material - medical	3,680 <u>\$4,784</u>
82.4	(institution)	
82.5	Pacemaker by-product and/or special nuclear material -	5,280 <u>\$6,864</u>
82.6	manufacturing and distribution	
82.7	Accelerator-produced radioactive material	3,840 <u>\$4,992</u>
82.8	Nonprofit educational institutions	300 <u>\$500</u>
82.9	General license registration	150

82.10 Sec. 12. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

82.11 Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a
 82.12 renewal application fee as follows: according to this subdivision.

82.13	TYPE	APPLICATION FEE
82.14		\$5,920
82.15	Academic broad scope - type A, B, or C	<u>\$6,808</u>
82.16	Academic broad scope - type B	5,920
82.17	Academic broad scope - type C	5,920
82.18	Medical broad scope - type A	3,920 <u>\$4,508</u>
82.19	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
82.20	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
82.21	<u>medical therapy emerging technologies</u>	<u>\$1,748</u>
82.22	Medical institution - diagnostic and therapeutic	1,520
82.23	Medical institution - diagnostic (no written directives)	1,520
82.24	Medical private practice - diagnostic and therapeutic	1,520
82.25	Medical private practice - diagnostic (no written directives)	1,520
82.26	Eye applicators	1,520
82.27	Nuclear medical vans	1,520
82.28	High dose rate afterloader	1,520
82.29	Mobile high dose rate afterloader	1,520
82.30	Medical therapy - other emerging technology	1,520
82.31	Teletherapy	5,520 <u>\$6,348</u>
82.32	Gamma knife	5,520 <u>\$6,348</u>
82.33	Veterinary medicine	960 <u>\$1,104</u>
82.34	In vitro testing lab	960 <u>\$1,104</u>
82.35	Nuclear pharmacy	4,880 <u>\$5,612</u>
82.36	Radiopharmaceutical distribution (10 CFR 32.72)	2,160 <u>\$2,484</u>
82.37	Radiopharmaceutical processing and distribution (10 CFR	
82.38	32.72)	4,880 <u>\$5,612</u>

83.1	Medical sealed sources - distribution (10 CFR 32.74)	2,160 <u>\$2,484</u>
83.2	Medical sealed sources - processing and distribution (10 CFR	4,880 <u>\$5,612</u>
83.3	32.74)	
83.4	Well logging - sealed sources	1,600 <u>\$1,840</u>
83.5	Measuring systems - (fixed gauge, portable gauge, gas	
83.6	<u>chromatograph, other)</u>	960 <u>\$1,104</u>
83.7	Measuring systems - portable gauge	960
83.8	X-ray fluorescent analyzer	584 <u>\$671</u>
83.9	Measuring systems - gas chromatograph	960
83.10	Measuring systems - other	960
83.11	Broad scope Manufacturing and distribution - type A, B, and	
83.12	<u>C broad scope</u>	5,920 <u>\$6,854</u>
83.13	Broad scope manufacturing and distribution - type B	5,920
83.14	Broad scope manufacturing and distribution - type C	5,920
83.15	Manufacturing and distribution - other	2,320 <u>\$2,668</u>
83.16		10,080
83.17	Nuclear laundry	<u>\$11,592</u>
83.18	Decontamination services	2,640 <u>\$3,036</u>
83.19	Leak test services only	960 <u>\$1,104</u>
83.20	Instrument calibration service only, less than 100 curies	960 <u>\$1,104</u>
83.21	Instrument calibration service only, 100 curies or more	960
83.22	Service, maintenance, installation, source changes, etc.	2,640 <u>\$3,036</u>
83.23	Waste disposal service, prepackaged only	2,240 <u>\$2,576</u>
83.24	Waste disposal	1,520 <u>\$1,748</u>
83.25	Distribution - general licensed devices (sealed sources)	880 <u>\$1,012</u>
83.26	Distribution - general licensed material (unsealed sources)	520 <u>\$598</u>
83.27	Industrial radiography - fixed <u>or temporary</u> location	2,640 <u>\$3,036</u>
83.28	Industrial radiography - temporary job sites	2,640
83.29	Irradiators, self-shielding, less than 10,000 curies	1,440 <u>\$1,656</u>
83.30	Irradiators, other, less than 10,000 curies	2,960 <u>\$3,404</u>
83.31	Irradiators, self-shielding, 10,000 curies or more	1,440
83.32	Research and development - type A, B, or C broad scope	4,960 <u>\$5,704</u>
83.33	Research and development - type B broad scope	4,960
83.34	Research and development - type C broad scope	4,960
83.35	Research and development - other	2,400 <u>\$2,760</u>
83.36	Storage - no operations	960 <u>\$1,104</u>
83.37	Source material - shielding	136 <u>\$156</u>
83.38	Special nuclear material plutonium - neutron source in device	1,200 <u>\$1,380</u>
83.39	Pacemaker by-product and/or special nuclear material - medical	1,200 <u>\$1,380</u>
83.40	(institution)	

84.1	Pacemaker by-product and/or special nuclear material -	2,320	<u>\$2,668</u>
84.2	manufacturing and distribution		
84.3	Accelerator-produced radioactive material	4,100	<u>\$4,715</u>
84.4	Nonprofit educational institutions	300	<u>\$345</u>
84.5	General license registration		0
84.6	Industrial radiographer certification		150

84.7 Sec. 13. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

84.8 Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition
 84.9 of a materials license issued by another agreement state or the United States Nuclear
 84.10 Regulatory Commission for a period of 180 days or less during a calendar year must pay
 84.11 ~~\$1,200~~ \$2,400. For a period of 181 days or more, the licensee must obtain a license under
 84.12 subdivision 4.

84.13 Sec. 14. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

84.14 Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~\$300~~ \$600 to
 84.15 amend a license as follows:

84.16 (1) to amend a license requiring review including, but not limited to, addition of isotopes,
 84.17 procedure changes, new authorized users, or a new radiation safety officer; and

84.18 (2) to amend a license requiring review and a site visit including, but not limited to,
 84.19 facility move or addition of processes.

84.20 Sec. 15. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision
 84.21 to read:

84.22 Subd. 10. Fees for general license registrations. A person required to register generally
 84.23 licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual
 84.24 registration fee of \$450.

84.25 Sec. 16. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

84.26 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer
 84.27 or other person in charge of each institution caring for infants 28 days or less of age, (2) the
 84.28 person required in pursuance of the provisions of section 144.215, to register the birth of a
 84.29 child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have
 84.30 administered to every infant or child in its care tests for heritable and congenital disorders
 84.31 according to subdivision 2 and rules prescribed by the state commissioner of health.

85.1 (b) Testing, recording of test results, reporting of test results, and follow-up of infants
85.2 with heritable congenital disorders, including hearing loss detected through the early hearing
85.3 detection and intervention program in section 144.966, shall be performed at the times and
85.4 in the manner prescribed by the commissioner of health.

85.5 (c) The fee to support the newborn screening program, including tests administered
85.6 under this section and section 144.966, shall be ~~\$135~~ \$177 per specimen. This fee amount
85.7 shall be deposited in the state treasury and credited to the state government special revenue
85.8 fund.

85.9 (d) The fee to offset the cost of the support services provided under section 144.966,
85.10 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury
85.11 and credited to the general fund.

85.12 Sec. 17. Minnesota Statutes 2020, section 144.125, subdivision 2, is amended to read:

85.13 Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall
85.14 periodically revise the list of tests to be administered for determining the presence of a
85.15 heritable or congenital disorder. Revisions to the list shall reflect advances in medical
85.16 science, new and improved testing methods, or other factors that will improve the public
85.17 health. In determining whether a test must be administered, the commissioner shall take
85.18 into consideration the adequacy of analytical methods to detect the heritable or congenital
85.19 disorder, the ability to treat or prevent medical conditions caused by the heritable or
85.20 congenital disorder, and the severity of the medical conditions caused by the heritable or
85.21 congenital disorder. The list of tests to be performed may be revised if the changes are
85.22 recommended by the advisory committee established under section 144.1255, approved by
85.23 the commissioner, and published in the State Register. The revision is exempt from the
85.24 rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

85.25 (b) Notwithstanding paragraph (a), a test to detect congenital human herpesvirus
85.26 cytomegalovirus shall be added to the list of tests to be administered under this section.

85.27 Sec. 18. **[144.1461] PREGNANCY AND CHILDBIRTH; MIDWIFE AND DOULA**
85.28 **CARE.**

85.29 In order to improve maternal and infant health as well as improving birth outcomes in
85.30 groups with the most significant disparities that include Black, Indigenous, and other
85.31 communities of color; rural communities; and people with low incomes, the commissioner
85.32 of health in partnership with patient groups and culturally based community organizations
85.33 shall, within existing appropriations:

86.1 (1) develop procedures and services designed for making midwife and doula services
 86.2 available to groups with the most maternal and infant mortality and morbidity disparities;

86.3 (2) promote racial, ethnic, and language diversity in the midwife and doula workforce
 86.4 that better aligns with the childbearing population in groups with the most significant
 86.5 maternal and infant mortality and morbidity disparities; and

86.6 (3) ensure that midwife and doula training and education is tailored to the specific needs
 86.7 of groups with the most significant maternal and infant mortality and morbidity disparities,
 86.8 including trauma-informed care, maternal mood disorders, intimate partner violence, and
 86.9 systemic racism.

86.10 Sec. 19. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

86.11 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
 86.12 a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist
 86.13 of the following members, all of whom must reside outside the seven-county metropolitan
 86.14 area, as defined in section 473.121, subdivision 2:

86.15 (1) two members from the house of representatives of the state of Minnesota, one from
 86.16 the majority party and one from the minority party;

86.17 (2) two members from the senate of the state of Minnesota, one from the majority party
 86.18 and one from the minority party;

86.19 (3) a volunteer member of an ambulance service based outside the seven-county
 86.20 metropolitan area;

86.21 (4) a representative of a hospital located outside the seven-county metropolitan area;

86.22 (5) a representative of a nursing home located outside the seven-county metropolitan
 86.23 area;

86.24 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

86.25 (7) a dentist licensed under chapter 150A;

86.26 (8) a midlevel practitioner;

86.27 ~~(8)~~ (9) a registered nurse or licensed practical nurse;

86.28 ~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented
 86.29 on the committee;

86.30 ~~(10)~~ (11) a representative of an institution of higher education located outside the
 86.31 seven-county metropolitan area that provides training for rural health care providers; and

87.1 ~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who
87.2 are mentally ill or developmentally disabled.

87.3 The commissioner will make recommendations for committee membership. Committee
87.4 members will be appointed by the governor. In making appointments, the governor shall
87.5 ensure that appointments provide geographic balance among those areas of the state outside
87.6 the seven-county metropolitan area. The chair of the committee shall be elected by the
87.7 members. The advisory committee is governed by section 15.059, except that the members
87.8 do not receive per diem compensation.

87.9 Sec. 20. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision
87.10 to read:

87.11 Subd. 3. Reporting safe place newborn births. A hospital that receives a safe place
87.12 newborn under section 145.902 shall report the birth of the newborn to the Office of Vital
87.13 Records within five days after receiving the newborn. The state registrar must register
87.14 information about the safe place newborn according to Minnesota Rules, part 4601.0600,
87.15 subpart 4, item C.

87.16 **EFFECTIVE DATE.** This section is effective August 1, 2021.

87.17 Sec. 21. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision
87.18 to read:

87.19 Subd. 4. Status of safe place birth registrations. (a) Information about the safe place
87.20 newborn registered under subdivision 3 shall constitute the record of birth for the child. The
87.21 birth record for the child is confidential data on individuals as defined in section 13.02,
87.22 subdivision 3. Information about the child's birth record or a child's birth certificate issued
87.23 from the child's birth record shall be disclosed only to the responsible social services agency
87.24 as defined in section 260C.007, subdivision 27a, or pursuant to court order.

87.25 (b) Pursuant to section 144.218, subdivision 6, if the safe place newborn was born in a
87.26 hospital and it is known that the child's record of birth was registered, the Office of Vital
87.27 Records shall replace the original birth record registered under section 144.215.

87.28 **EFFECTIVE DATE.** This section is effective August 1, 2021.

88.1 Sec. 22. Minnesota Statutes 2020, section 144.218, is amended by adding a subdivision
88.2 to read:

88.3 Subd. 6. **Safe place newborns.** If a hospital receives a safe place newborn under section
88.4 145.902 and it is known that the child's record of birth was registered, the hospital shall
88.5 report the newborn to the Office of Vital Records and identify the child's birth record. The
88.6 state registrar shall issue a replacement birth record for the child that is free of information
88.7 that identifies a parent. The prior vital record is confidential data on individuals as defined
88.8 in section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

88.9 **EFFECTIVE DATE.** This section is effective August 1, 2021.

88.10 Sec. 23. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

88.11 Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office
88.12 shall issue a certified birth or death record or a statement of no vital record found to an
88.13 individual upon the individual's proper completion of an attestation provided by the
88.14 commissioner and payment of the required fee:

88.15 (1) to a person who ~~has a tangible interest in the requested vital record. A person who~~
88.16 ~~has a tangible interest~~ is:

88.17 (i) the subject of the vital record;

88.18 (ii) a child of the subject;

88.19 (iii) the spouse of the subject;

88.20 (iv) a parent of the subject;

88.21 (v) the grandparent or grandchild of the subject;

88.22 (vi) if the requested record is a death record, a sibling of the subject;

88.23 ~~(vii) the party responsible for filing the vital record;~~

88.24 ~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

88.25 ~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy
88.26 is required for administration of the estate;

88.27 ~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is
88.28 deceased, by sworn affidavit of the fact that the certified copy is required for administration
88.29 of the estate;

89.1 ~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit
 89.2 of the fact that the certified copy is needed for the proper administration of the trust;

89.3 ~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary
 89.4 for the determination or protection of a personal or property right, pursuant to rules adopted
 89.5 by the commissioner; or

89.6 ~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches
 89.7 as required by section 259.83;

89.8 (2) to any local, state, tribal, or federal governmental agency upon request if the certified
 89.9 vital record is necessary for the governmental agency to perform its authorized duties;

89.10 (3) to an attorney representing the subject of the vital record or another person listed in
 89.11 clause (1), upon evidence of the attorney's license;

89.12 (4) pursuant to a court order issued by a court of competent jurisdiction. For purposes
 89.13 of this section, a subpoena does not constitute a court order; or

89.14 (5) to a representative authorized by a person under clauses (1) to (4).

89.15 (b) The state registrar or local issuance office shall also issue a certified death record to
 89.16 an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of
 89.17 the individual, a licensed mortician furnishes the registrar with a properly completed
 89.18 attestation in the form provided by the commissioner within 180 days of the time of death
 89.19 of the subject of the death record. This paragraph is not subject to the requirements specified
 89.20 in Minnesota Rules, part 4601.2600, subpart 5, item B.

89.21 Sec. 24. Minnesota Statutes 2020, section 144.226, subdivision 1, is amended to read:

89.22 Subdivision 1. **Which services are for fee.** (a) The fees for the following services shall
 89.23 be the following or an amount prescribed by rule of the commissioner:

89.24 (b) The fee for the administrative review and processing of a request for a certified vital
 89.25 record or a certification that the vital record cannot be found is \$9. The fee is payable at the
 89.26 time of application and is nonrefundable.

89.27 (c) The fee for processing a request for the replacement of a birth record for all events,
 89.28 except for safe place newborns pursuant to section 144.218, subdivision 6, and when filing
 89.29 a recognition of parentage pursuant to section 257.73, subdivision 1, is \$40. The fee is
 89.30 payable at the time of application and is nonrefundable.

90.1 (d) The fee for administrative review and processing of a request for the filing of a
90.2 delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of
90.3 application and is nonrefundable.

90.4 (e) The fee for administrative review and processing of a request for the amendment of
90.5 any vital record is \$40. The fee is payable at the time of application and is nonrefundable.

90.6 (f) The fee for administrative review and processing of a request for the verification of
90.7 information from vital records is \$9 when the applicant furnishes the specific information
90.8 to locate the vital record. When the applicant does not furnish specific information, the fee
90.9 is \$20 per hour for staff time expended. Specific information includes the correct date of
90.10 the event and the correct name of the subject of the record. Fees charged shall approximate
90.11 the costs incurred in searching and copying the vital records. The fee is payable at the time
90.12 of application and is nonrefundable.

90.13 (g) The fee for administrative review and processing of a request for the issuance of a
90.14 copy of any document on file pertaining to a vital record or statement that a related document
90.15 cannot be found is \$9. The fee is payable at the time of application and is nonrefundable.

90.16 **EFFECTIVE DATE.** This section is effective August 1, 2021.

90.17 Sec. 25. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

90.18 Subdivision 1. **Restricted construction or modification.** (a) The following construction
90.19 or modification may not be commenced:

90.20 (1) any erection, building, alteration, reconstruction, modernization, improvement,
90.21 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
90.22 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
90.23 to another, or otherwise results in an increase or redistribution of hospital beds within the
90.24 state; and

90.25 (2) the establishment of a new hospital.

90.26 (b) This section does not apply to:

90.27 (1) construction or relocation within a county by a hospital, clinic, or other health care
90.28 facility that is a national referral center engaged in substantial programs of patient care,
90.29 medical research, and medical education meeting state and national needs that receives more
90.30 than 40 percent of its patients from outside the state of Minnesota;

91.1 (2) a project for construction or modification for which a health care facility held an
91.2 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
91.3 certificate;

91.4 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
91.5 appeal results in an order reversing the denial;

91.6 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
91.7 section 2;

91.8 (5) a project involving consolidation of pediatric specialty hospital services within the
91.9 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
91.10 of pediatric specialty hospital beds among the hospitals being consolidated;

91.11 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
91.12 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
91.13 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
91.14 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
91.15 hospitals must be reinstated at the capacity that existed on each site before the relocation;

91.16 (7) the relocation or redistribution of hospital beds within a hospital building or
91.17 identifiable complex of buildings provided the relocation or redistribution does not result
91.18 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
91.19 one physical site or complex to another; or (iii) redistribution of hospital beds within the
91.20 state or a region of the state;

91.21 (8) relocation or redistribution of hospital beds within a hospital corporate system that
91.22 involves the transfer of beds from a closed facility site or complex to an existing site or
91.23 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
91.24 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
91.25 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
91.26 health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
91.27 redistribution does not involve the construction of a new hospital building;

91.28 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
91.29 County that primarily serves adolescents and that receives more than 70 percent of its
91.30 patients from outside the state of Minnesota;

91.31 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
91.32 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
91.33 and (ii) the total licensed capacity of the replacement hospital, either at the time of

92.1 construction of the initial building or as the result of future expansion, will not exceed 70
92.2 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

92.3 (11) the relocation of licensed hospital beds from an existing state facility operated by
92.4 the commissioner of human services to a new or existing facility, building, or complex
92.5 operated by the commissioner of human services; from one regional treatment center site
92.6 to another; or from one building or site to a new or existing building or site on the same
92.7 campus;

92.8 (12) the construction or relocation of hospital beds operated by a hospital having a
92.9 statutory obligation to provide hospital and medical services for the indigent that does not
92.10 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
92.11 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
92.12 Medical Center to Regions Hospital under this clause;

92.13 (13) a construction project involving the addition of up to 31 new beds in an existing
92.14 nonfederal hospital in Beltrami County;

92.15 (14) a construction project involving the addition of up to eight new beds in an existing
92.16 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

92.17 (15) a construction project involving the addition of 20 new hospital beds in an existing
92.18 hospital in Carver County serving the southwest suburban metropolitan area;

92.19 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
92.20 of up to two psychiatric facilities or units for children provided that the operation of the
92.21 facilities or units have received the approval of the commissioner of human services;

92.22 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
92.23 services in an existing hospital in Itasca County;

92.24 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
92.25 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
92.26 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
92.27 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

92.28 (19) a critical access hospital established under section 144.1483, clause (9), and section
92.29 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
92.30 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
92.31 to the extent that the critical access hospital does not seek to exceed the maximum number
92.32 of beds permitted such hospital under federal law;

93.1 (20) notwithstanding section 144.552, a project for the construction of a new hospital
93.2 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

93.3 (i) the project, including each hospital or health system that will own or control the entity
93.4 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
93.5 Council as of March 1, 2006;

93.6 (ii) the entity that will hold the new hospital license will be owned or controlled by one
93.7 or more not-for-profit hospitals or health systems that have previously submitted a plan or
93.8 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
93.9 have been found to be in the public interest by the commissioner of health as of April 1,
93.10 2005;

93.11 (iii) the new hospital's initial inpatient services must include, but are not limited to,
93.12 medical and surgical services, obstetrical and gynecological services, intensive care services,
93.13 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
93.14 services, and emergency room services;

93.15 (iv) the new hospital:

93.16 (A) will have the ability to provide and staff sufficient new beds to meet the growing
93.17 needs of the Maple Grove service area and the surrounding communities currently being
93.18 served by the hospital or health system that will own or control the entity that will hold the
93.19 new hospital license;

93.20 (B) will provide uncompensated care;

93.21 (C) will provide mental health services, including inpatient beds;

93.22 (D) will be a site for workforce development for a broad spectrum of health-care-related
93.23 occupations and have a commitment to providing clinical training programs for physicians
93.24 and other health care providers;

93.25 (E) will demonstrate a commitment to quality care and patient safety;

93.26 (F) will have an electronic medical records system, including physician order entry;

93.27 (G) will provide a broad range of senior services;

93.28 (H) will provide emergency medical services that will coordinate care with regional
93.29 providers of trauma services and licensed emergency ambulance services in order to enhance
93.30 the continuity of care for emergency medical patients; and

93.31 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
93.32 the control of the entity holding the new hospital license; and

94.1 (v) as of 30 days following submission of a written plan, the commissioner of health
94.2 has not determined that the hospitals or health systems that will own or control the entity
94.3 that will hold the new hospital license are unable to meet the criteria of this clause;

94.4 (21) a project approved under section 144.553;

94.5 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
94.6 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
94.7 is approved by the Cass County Board;

94.8 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
94.9 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
94.10 a separately licensed 13-bed skilled nursing facility;

94.11 (24) notwithstanding section 144.552, a project for the construction and expansion of a
94.12 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
94.13 who are under 21 years of age on the date of admission. The commissioner conducted a
94.14 public interest review of the mental health needs of Minnesota and the Twin Cities
94.15 metropolitan area in 2008. No further public interest review shall be conducted for the
94.16 construction or expansion project under this clause;

94.17 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
94.18 commissioner finds the project is in the public interest after the public interest review
94.19 conducted under section 144.552 is complete;

94.20 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
94.21 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
94.22 admission, if the commissioner finds the project is in the public interest after the public
94.23 interest review conducted under section 144.552 is complete;

94.24 (ii) this project shall serve patients in the continuing care benefit program under section
94.25 256.9693. The project may also serve patients not in the continuing care benefit program;
94.26 and

94.27 (iii) if the project ceases to participate in the continuing care benefit program, the
94.28 commissioner must complete a subsequent public interest review under section 144.552. If
94.29 the project is found not to be in the public interest, the license must be terminated six months
94.30 from the date of that finding. If the commissioner of human services terminates the contract
94.31 without cause or reduces per diem payment rates for patients under the continuing care
94.32 benefit program below the rates in effect for services provided on December 31, 2015, the

95.1 project may cease to participate in the continuing care benefit program and continue to
 95.2 operate without a subsequent public interest review;

95.3 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
 95.4 in Hennepin County that is exclusively for patients who are under 21 years of age on the
 95.5 date of admission; ~~or~~

95.6 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
 95.7 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
 95.8 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
 95.9 In addition, five unlicensed observation mental health beds shall be added; or

95.10 (29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing
 95.11 safety net, level I trauma center hospital in Ramsey County as designated under section
 95.12 383A.91, subdivision 5. The commissioner conducted a public interest review of the
 95.13 construction and expansion of this hospital in 2018. No further public interest review shall
 95.14 be conducted for the project under this clause.

95.15 Sec. 26. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES**
 95.16 **WITH YOUNG CHILDREN.**

95.17 Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section
 95.18 and have the meanings given them.

95.19 (b) "Evidence-based home visiting program" means a program that:

95.20 (1) is based on a clear, consistent program or model that is research-based and grounded
 95.21 in relevant, empirically based knowledge;

95.22 (2) is linked to program-determined outcomes and is associated with a national
 95.23 organization, institution of higher education, or national or state public health institute;

95.24 (3) has comprehensive home visitation standards that ensure high-quality service delivery
 95.25 and continuous quality improvement;

95.26 (4) has demonstrated significant, sustained positive outcomes; and

95.27 (5) either:

95.28 (i) has been evaluated using rigorous randomized controlled research designs and the
 95.29 evaluation results have been published in a peer-reviewed journal; or

95.30 (ii) is based on quasi-experimental research using two or more separate, comparable
 95.31 client samples.

96.1 (c) "Evidence-informed home visiting program" means a program that:

96.2 (1) has data or evidence demonstrating effectiveness at achieving positive outcomes for
96.3 pregnant women and young children; and

96.4 (2) either:

96.5 (i) has an active evaluation of the program; or

96.6 (ii) has a plan and timeline for an active evaluation of the program to be conducted.

96.7 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
96.8 full health potential and no individual is disadvantaged from achieving this potential.

96.9 (e) "Promising practice home visiting program" means a program that has shown
96.10 improvement toward achieving positive outcomes for pregnant women or young children.

96.11 Subd. 2. Grants for home visiting programs. (a) The commissioner of health shall
96.12 award grants to community health boards, nonprofit organizations, and Tribal nations to
96.13 start up or expand voluntary home visiting programs serving pregnant women and families
96.14 with young children. Home visiting programs supported under this section shall provide
96.15 voluntary home visits by early childhood professionals or health professionals, including
96.16 but not limited to nurses, social workers, early childhood educators, and trained
96.17 paraprofessionals. Grant money shall be used to:

96.18 (1) establish or expand evidence-based, evidence-informed, or promising practice home
96.19 visiting programs that address health equity and utilize community-driven health strategies;

96.20 (2) serve families with young children or pregnant women who have high needs or are
96.21 high-risk, including but not limited to a family with low income, a parent or pregnant woman
96.22 with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing
96.23 housing instability or domestic abuse; and

96.24 (3) improve program outcomes in two or more of the following areas:

96.25 (i) maternal and newborn health;

96.26 (ii) school readiness and achievement;

96.27 (iii) family economic self-sufficiency;

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

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

96.30 (vi) reduction in crime or domestic violence.

97.1 (b) Grants awarded to evidence-informed and promising practice home visiting programs
 97.2 must include money to evaluate program outcomes for up to four of the areas listed in
 97.3 paragraph (a), clause (3).

97.4 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
 97.5 priority to community health boards, nonprofit organizations, and Tribal nations seeking to
 97.6 expand home visiting services with community or regional partnerships.

97.7 (b) The commissioner shall allocate at least 75 percent of the grant money awarded each
 97.8 grant cycle to evidence-based home visiting programs that address health equity and up to
 97.9 25 percent of the grant money awarded each grant cycle to evidence-informed or promising
 97.10 practice home visiting programs that address health equity and utilize community-driven
 97.11 health strategies.

97.12 Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the
 97.13 annual appropriation under this section to provide training and technical assistance and to
 97.14 administer and evaluate the program. The commissioner may contract for training,
 97.15 capacity-building support for grantees or potential grantees, technical assistance, and
 97.16 evaluation support.

97.17 Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to
 97.18 establishing or expanding evidence-based home visiting programs shall, for grants awarded
 97.19 on or after July 1, 2021, be awarded according to this section. This section shall not govern
 97.20 grant awards of federal funds for home visiting programs and shall not govern grant awards
 97.21 using state general fund appropriations dedicated to establishing or expanding nurse-family
 97.22 partnership home visiting programs.

97.23 Sec. 27. Minnesota Statutes 2020, section 145.902, is amended to read:

97.24 **145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES;**
 97.25 **IMMUNITY.**

97.26 Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means a hospital
 97.27 licensed under sections 144.50 to 144.56, including the hospital where the newborn was
 97.28 born, a health care provider who provides urgent care medical services, or an ambulance
 97.29 service licensed under chapter 144E dispatched in response to a 911 call from a mother or
 97.30 a person with the mother's permission to relinquish a newborn infant.

97.31 (b) A safe place shall receive a newborn left with an employee on the premises of the
 97.32 safe place during its hours of operation, provided that:

98.1 (1) the newborn was born within seven days of being left at the safe place, as determined
98.2 within a reasonable degree of medical certainty; and

98.3 (2) the newborn is left in an unharmed condition.

98.4 (c) The safe place must not inquire as to the identity of the mother or the person leaving
98.5 the newborn or call the police, provided the newborn is unharmed when presented to the
98.6 hospital. The safe place may ask the mother or the person leaving the newborn about the
98.7 medical history of the mother or newborn and if the newborn may have lineage to an Indian
98.8 Tribe and, if known, the name of the Tribe but the mother or the person leaving the newborn
98.9 is not required to provide any information. The safe place may provide the mother or the
98.10 person leaving the newborn with information about how to contact relevant social service
98.11 agencies.

98.12 (d) A safe place that is a health care provider who provides urgent care medical services
98.13 shall dial 911, advise the dispatcher that the call is being made from a safe place for
98.14 newborns, and ask the dispatcher to send an ambulance or take other appropriate action to
98.15 transport the newborn to a hospital. An ambulance with whom a newborn is left shall
98.16 transport the newborn to a hospital for care. Hospitals must receive a newborn left with a
98.17 safe place and make the report as required in subdivision 2.

98.18 Subd. 2. **Reporting.** (a) Within 24 hours of receiving a newborn under this section, the
98.19 hospital must inform the responsible social service agency that a newborn has been left at
98.20 the hospital, but must not do so in the presence of the mother or the person leaving the
98.21 newborn. The hospital must provide necessary care to the newborn pending assumption of
98.22 legal responsibility by the responsible social service agency pursuant to section 260C.139,
98.23 subdivision 5.

98.24 (b) Within five days of receiving a newborn under this section, a hospital shall report
98.25 the newborn to the Office of Vital Records pursuant to section 144.216, subdivision 3. If a
98.26 hospital receives a safe place newborn under section 145.902 and it is known that the child's
98.27 record of birth was registered because the newborn was born at that hospital, the hospital
98.28 shall report the newborn to the Office of Vital Records and identify the child's birth record.
98.29 The state registrar shall issue a replacement birth record for the child pursuant to section
98.30 144.218, subdivision 6.

98.31 Subd. 3. **Immunity.** (a) A safe place with responsibility for performing duties under
98.32 this section, and any employee, doctor, ambulance personnel, or other medical professional
98.33 working at the safe place, are immune from any criminal liability that otherwise might result

99.1 from their actions, if they are acting in good faith in receiving a newborn, and are immune
 99.2 from any civil liability that otherwise might result from merely receiving a newborn.

99.3 (b) A safe place performing duties under this section, or an employee, doctor, ambulance
 99.4 personnel, or other medical professional working at the safe place who is a mandated reporter
 99.5 under chapter 260E, is immune from any criminal or civil liability that otherwise might
 99.6 result from the failure to make a report under that section if the person is acting in good
 99.7 faith in complying with this section.

99.8 **EFFECTIVE DATE.** This section is effective August 1, 2021.

99.9 Sec. 28. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

99.10 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,
 99.11 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260
 99.12 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable
 99.13 asbestos-containing material on other facility components, or, if linear feet or square feet
 99.14 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or
 99.15 off all facility components in one facility. In the case of single or multifamily residences,
 99.16 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than
 99.17 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater
 99.18 than six but less than 160 square feet of friable asbestos-containing material on other facility
 99.19 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot
 99.20 but less than 35 cubic feet of friable asbestos-containing material on or off all facility
 99.21 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~
 99.22 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~
 99.23 ~~single family residences and buildings with no more than four dwelling units.~~

99.24 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,
 99.25 or encapsulation operations; and an air quality monitoring specified in rule to assure that
 99.26 the abatement and adjacent areas are not contaminated with asbestos fibers during the project
 99.27 and after completion.

99.28 For purposes of this subdivision, the quantity of ~~asbestos-containing~~ material applies
 99.29 separately for every project.

99.30 Sec. 29. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

99.31 Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72
 99.32 shall, before receipt of the license and before causing asbestos-related work to be performed,
 99.33 pay the commissioner an annual license fee of \$100 \$105.

100.1 Sec. 30. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

100.2 Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker
 100.3 or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner
 100.4 a certification fee of ~~\$50~~ \$52.50 before the issuance of the certificate. ~~The commissioner~~
 100.5 ~~may establish by rule fees required before the issuance of~~ An individual required to be
 100.6 certified as an asbestos inspector, asbestos management planner, and asbestos project
 100.7 designer certificates required under section 326.73, subdivisions 2, 3, and 4, shall pay the
 100.8 commissioner a certification fee of \$105 before the issuance of the certificate.

100.9 Sec. 31. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

100.10 Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person
 100.11 shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs
 100.12 of the asbestos-related work. For asbestos-related work performed in single or multifamily
 100.13 residences, of greater than ten but less than 260 linear feet of asbestos-containing material
 100.14 on pipes, or greater than six but less than 160 square feet of asbestos-containing material
 100.15 on other facility components, a person shall pay a project permit fee of \$35 to the
 100.16 commissioner.

100.17 Sec. 32. **DEVELOPMENT OF CURRICULUM.**

100.18 Of the appropriation in fiscal year 2022 to the commissioner of health for health
 100.19 disparities grants under Minnesota Statutes, section 145.928, \$275,000 shall be allocated
 100.20 for a grant to the University of Minnesota School of Public Health's Center for Antiracism
 100.21 Research for Health Equity, to develop a model curriculum on antiracism and implicit bias
 100.22 for hospitals with obstetric care and birth centers to use to provide continuing education to
 100.23 staff who care for pregnant or postpartum patients. The model curriculum must be
 100.24 evidence-based. This is a onetime allocation.

100.25

ARTICLE 3

100.26

HEALTH OCCUPATION AND HEALTH RELATED LICENSING BOARDS

100.27 Section 1. Minnesota Statutes 2020, section 144E.001, is amended by adding a subdivision
 100.28 to read:

100.29 Subd. 16. **Education program primary instructor or primary instructor.** "Education
 100.30 program primary instructor" or "primary instructor" means an individual, as approved by
 100.31 the board, who serves as the lead instructor of an emergency medical care initial certification
 100.32 course and who is responsible for planning or conducting the course according to the most

101.1 current version of the National EMS Education Standards by the NHTSA, United States
101.2 Department of Transportation.

101.3 Sec. 2. Minnesota Statutes 2020, section 144E.27, is amended to read:

101.4 **144E.27 EDUCATION PROGRAMS; BOARD APPROVAL REGISTRATION**
101.5 **OF EMR.**

101.6 Subdivision 1. **Education program instructor.** An education program instructor must
101.7 be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant,
101.8 or registered nurse.

101.9 Subd. 1a. **Approval required.** (a) All education programs for an emergency medical
101.10 responder must be approved by the board.

101.11 (b) To be approved by the board, an education program must:

101.12 (1) submit an application prescribed by the board that includes:

101.13 (i) type and length of course to be offered;

101.14 (ii) names, addresses, and qualifications of the program medical director, program
101.15 education coordinator, and instructors;

101.16 (iii) admission criteria for students; and

101.17 (iv) materials and equipment to be used;

101.18 (2) for each course, implement the most current version of the United States Department
101.19 of Transportation EMS Education Standards, or its equivalent as determined by the board
101.20 applicable to Emergency Medical Responder registration education;

101.21 (3) have a program medical director and a program coordinator;

101.22 (4) have at least one instructor for every ten students at the practical skill stations;

101.23 (5) retain documentation of program approval by the board, course outline, and student
101.24 information; and

101.25 (6) submit the appropriate fee as required under section 144E.29.

101.26 (c) The National EMS Education Standards by the NHTSA, United States Department
101.27 of Transportation contains the minimal entry level of knowledge and skills for emergency
101.28 medical responders. Medical directors of emergency medical responder groups may expand
101.29 the knowledge and skill set.

102.1 Subd. 2. **Registration requirements.** To be eligible for registration with the board as
102.2 an emergency medical responder, an individual shall complete a board-approved application
102.3 form and:

102.4 (1) successfully complete a board-approved initial emergency medical responder
102.5 education program. Registration under this clause is valid for two years and expires on
102.6 October 31; or

102.7 (2) be credentialed as an emergency medical responder by the National Registry of
102.8 Emergency Medical Technicians. Registration under this clause expires the same day as
102.9 the National Registry credential.

102.10 Subd. 2a. **Registration expiration dates.** Emergency medical responder registration
102.11 expiration dates are as follows:

102.12 (1) for initial registration granted between January 1 and June 30 of an even-numbered
102.13 year, the expiration date is October 31 of the next even-numbered year;

102.14 (2) for initial registration granted between July 1 and December 31 of an even-numbered
102.15 year, the expiration date is October 31 of the second odd-numbered year;

102.16 (3) for initial registration granted between January 1 and June 30 of an odd-numbered
102.17 year, the expiration date is October 31 of the next odd-numbered year; and

102.18 (4) for initial registration granted between July 1 and December 31 of an odd-numbered
102.19 year, the expiration date is October 31 of the second even-numbered year.

102.20 Subd. 3. **Renewal.** (a) The board may renew the registration of an emergency medical
102.21 responder who:

102.22 (1) successfully completes a board-approved refresher course; ~~and~~

102.23 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
102.24 board or the licensee's medical director; and

102.25 (3) submits a completed renewal application to the board before the registration expiration
102.26 date.

102.27 (b) The board may renew the lapsed registration of an emergency medical responder
102.28 who:

102.29 (1) successfully completes a board-approved refresher course; ~~and~~

102.30 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
102.31 board or the licensee's medical director; and

103.1 (3) submits a completed renewal application to the board within 12 months after the
103.2 registration expiration date.

103.3 Subd. 5. **Denial, suspension, revocation.** (a) The board may deny, suspend, revoke,
103.4 place conditions on, or refuse to renew the registration as an emergency medical responder
103.5 of an individual who the board determines:

103.6 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an
103.7 agreement for corrective action, or an order that the board issued or is otherwise empowered
103.8 to enforce;

103.9 (2) misrepresents or falsifies information on an application form for registration;

103.10 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
103.11 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
103.12 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
103.13 alcohol;

103.14 (4) is actually or potentially unable to provide emergency medical services with
103.15 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,
103.16 or any other material, or as a result of any mental or physical condition;

103.17 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
103.18 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,
103.19 welfare, or safety of the public;

103.20 (6) maltreats or abandons a patient;

103.21 (7) violates any state or federal controlled substance law;

103.22 (8) engages in unprofessional conduct or any other conduct which has the potential for
103.23 causing harm to the public, including any departure from or failure to conform to the
103.24 minimum standards of acceptable and prevailing practice without actual injury having to
103.25 be established;

103.26 (9) provides emergency medical services under lapsed or nonrenewed credentials;

103.27 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
103.28 jurisdiction or by another regulatory authority;

103.29 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
103.30 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
103.31 to a patient; or

104.1 (12) makes a false statement or knowingly provides false information to the board, or
104.2 fails to cooperate with an investigation of the board as required by section 144E.30.

104.3 (b) Before taking action under paragraph (a), the board shall give notice to an individual
104.4 of the right to a contested case hearing under chapter 14. If an individual requests a contested
104.5 case hearing within 30 days after receiving notice, the board shall initiate a contested case
104.6 hearing according to chapter 14.

104.7 (c) The administrative law judge shall issue a report and recommendation within 30
104.8 days after closing the contested case hearing record. The board shall issue a final order
104.9 within 30 days after receipt of the administrative law judge's report.

104.10 (d) After six months from the board's decision to deny, revoke, place conditions on, or
104.11 refuse renewal of an individual's registration for disciplinary action, the individual shall
104.12 have the opportunity to apply to the board for reinstatement.

104.13 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,
104.14 the board may temporarily suspend the registration of an individual as an emergency
104.15 responder after conducting a preliminary inquiry to determine whether the board believes
104.16 that the individual has violated a statute or rule that the board is empowered to enforce and
104.17 determining that the continued provision of service by the individual would create an
104.18 imminent risk to public health or harm to others.

104.19 (b) A temporary suspension order prohibiting an individual from providing emergency
104.20 medical care shall give notice of the right to a preliminary hearing according to paragraph
104.21 (d) and shall state the reasons for the entry of the temporary suspension order.

104.22 (c) Service of a temporary suspension order is effective when the order is served on the
104.23 individual personally or by certified mail, which is complete upon receipt, refusal, or return
104.24 for nondelivery to the most recent address provided to the board for the individual.

104.25 (d) At the time the board issues a temporary suspension order, the board shall schedule
104.26 a hearing, to be held before a group of its members designated by the board, that shall begin
104.27 within 60 days after issuance of the temporary suspension order or within 15 working days
104.28 of the date of the board's receipt of a request for a hearing from the individual, whichever
104.29 is sooner. The hearing shall be on the sole issue of whether there is a reasonable basis to
104.30 continue, modify, or lift the temporary suspension. A hearing under this paragraph is not
104.31 subject to chapter 14.

104.32 (e) Evidence presented by the board or the individual may be in the form of an affidavit.
104.33 The individual or the individual's designee may appear for oral argument.

105.1 (f) Within five working days of the hearing, the board shall issue its order and, if the
105.2 suspension is continued, notify the individual of the right to a contested case hearing under
105.3 chapter 14.

105.4 (g) If an individual requests a contested case hearing within 30 days after receiving
105.5 notice under paragraph (f), the board shall initiate a contested case hearing according to
105.6 chapter 14. The administrative law judge shall issue a report and recommendation within
105.7 30 days after the closing of the contested case hearing record. The board shall issue a final
105.8 order within 30 days after receipt of the administrative law judge's report.

105.9 Sec. 3. Minnesota Statutes 2020, section 144E.27, subdivision 2, is amended to read:

105.10 Subd. 2. **Registration.** To be eligible for registration with the board as an emergency
105.11 medical responder, an individual shall ~~complete a board-approved application form and:~~

105.12 (1) ~~successfully complete a board-approved initial emergency medical responder~~
105.13 ~~education program. Registration under this clause is valid for two years and expires on~~
105.14 ~~October 31~~ the United States Department of Transportation course, or its equivalent as
105.15 approved by the board, specific to the emergency medical responder classification; or

105.16 (2) be credentialed as an emergency medical responder by the National Registry of
105.17 Emergency Medical Technicians. ~~Registration under this clause expires the same day as~~
105.18 ~~the National Registry credential; and~~

105.19 (3) complete a board-approved application form.

105.20 Sec. 4. Minnesota Statutes 2020, section 144E.28, subdivision 1, is amended to read:

105.21 Subdivision 1. **Requirements.** To be eligible for certification by the board as an EMT,
105.22 AEMT, or paramedic, an individual shall:

105.23 (1) successfully complete the United States Department of Transportation course, or its
105.24 equivalent as approved by the board, specific to the EMT, AEMT, or paramedic classification;

105.25 (2) ~~pass the written and practical examinations approved by the board and administered~~
105.26 ~~by the board or its designee;~~ obtain National Registry of Emergency Medical Technicians
105.27 certification specific to the EMT, AEMT, or paramedic classification; and

105.28 (3) complete a board-approved application form.

106.1 Sec. 5. Minnesota Statutes 2020, section 144E.28, subdivision 3, is amended to read:

106.2 Subd. 3. **Reciprocity.** The board may certify an individual who possesses a current
 106.3 National Registry of Emergency Medical Technicians ~~registration~~ certification from another
 106.4 jurisdiction if the individual submits a board-approved application form. The board
 106.5 certification classification shall be the same as the National Registry's classification.
 106.6 Certification shall be for the duration of the applicant's ~~registration~~ certification period in
 106.7 another jurisdiction, not to exceed two years.

106.8 Sec. 6. Minnesota Statutes 2020, section 144E.28, subdivision 7, is amended to read:

106.9 Subd. 7. **Renewal.** (a) Before the expiration date of certification, an applicant for renewal
 106.10 of certification as an EMT shall:

106.11 (1) successfully complete a course in cardiopulmonary resuscitation that is approved by
 106.12 the board or the licensee's medical director;

106.13 ~~(2) take the United States Department of Transportation EMT refresher course and~~
 106.14 ~~successfully pass the practical skills test portion of the course, or successfully complete 48~~
 106.15 ~~hours of continuing education in EMT programs that are consistent with the United States~~
 106.16 ~~Department of Transportation National EMS Education Standards or its equivalent as~~
 106.17 ~~approved by the board or as approved by the licensee's medical director and pass a practical~~
 106.18 ~~skills test approved by the board and administered by an education program approved by~~
 106.19 ~~the board. The cardiopulmonary resuscitation course and practical skills test may be included~~
 106.20 ~~as part of the refresher course or continuing education renewal requirements; and~~ satisfy
 106.21 one of the following requirements:

106.22 (i) maintain National Registry of Emergency Medical Technicians certification following
 106.23 the requirements of the National Continued Competency Program, or its equivalent as
 106.24 approved by the board. The cardiopulmonary resuscitation course required under clause (1)
 106.25 shall count toward the continuing education requirements for renewal; or

106.26 (ii) for an individual who only holds Minnesota EMT certification and held the
 106.27 certification prior to April 1, 2021, maintain Minnesota certification by completing the
 106.28 required hours of continuing education as determined in the National Continued Competency
 106.29 Program of the National Registry of Emergency Medical Technicians, or its equivalent as
 106.30 approved by the board. The cardiopulmonary resuscitation course required under clause (1)
 106.31 shall count toward the continuing education requirements for renewal. This item expires
 106.32 April 1, 2036; and

106.33 (3) complete a board-approved application form.

107.1 (b) Before the expiration date of certification, an applicant for renewal of certification
107.2 as an AEMT or paramedic shall:

107.3 (1) for an AEMT, successfully complete a course in cardiopulmonary resuscitation that
107.4 is approved by the board or the licensee's medical director, and for a paramedic, successfully
107.5 complete a course in advanced cardiac life support that is approved by the board or the
107.6 licensee's medical director;

107.7 ~~(2) successfully complete 48 hours of continuing education in emergency medical training~~
107.8 ~~programs, appropriate to the level of the applicant's AEMT or paramedic certification, that~~
107.9 ~~are consistent with the United States Department of Transportation National EMS Education~~
107.10 ~~Standards or its equivalent as approved by the board or as approved by the licensee's medical~~
107.11 ~~director. An applicant may take the United States Department of Transportation Emergency~~
107.12 ~~Medical Technician refresher course or its equivalent without the written or practical test~~
107.13 ~~as approved by the board, and as appropriate to the applicant's level of certification, as part~~
107.14 ~~of the 48 hours of continuing education. Each hour of the refresher course, the~~
107.15 ~~cardiopulmonary resuscitation course, and the advanced cardiac life support course counts~~
107.16 ~~toward the 48-hour continuing education requirement; and~~ satisfy one of the following
107.17 requirements:

107.18 (i) maintain National Registry of Emergency Medical Technicians certification following
107.19 the requirements of the National Continued Competency Program, or its equivalent as
107.20 approved by the board. The cardiopulmonary resuscitation course or advanced cardiac life
107.21 support course required under clause (1) shall count toward the continuing education
107.22 requirements for renewal; or

107.23 (ii) for an individual who only holds Minnesota AEMT or paramedic certification and
107.24 held the certification prior to April 1, 2021, maintain Minnesota certification by completing
107.25 the required hours of continuing education as determined in the National Continued
107.26 Competency Program of the National Registry of Emergency Medical Technicians, or its
107.27 equivalent as approved by the board. The cardiopulmonary resuscitation course or advanced
107.28 cardiac life support course required under clause (1) shall count toward the continuing
107.29 education requirements for renewal. This item expires April 1, 2036; and

107.30 (3) complete a board-approved application form.

107.31 (c) Certification shall be renewed every two years.

107.32 (d) If the applicant does not meet the renewal requirements under this subdivision, the
107.33 applicant's certification expires.

108.1 Sec. 7. Minnesota Statutes 2020, section 144E.28, subdivision 8, is amended to read:

108.2 Subd. 8. **Reinstatement.** (a) Within ~~four~~ two years of a certification expiration date, a
108.3 person whose certification has expired under subdivision 7, paragraph (d), may have the
108.4 certification reinstated upon submission of:

108.5 (1) evidence to the board of training equivalent to the continuing education requirements
108.6 of subdivision 7; and

108.7 (2) a board-approved application form.

108.8 (b) If more than ~~four~~ two years have passed since a certificate expiration date, an applicant
108.9 must complete the initial certification process required under subdivision 1.

108.10 Sec. 8. Minnesota Statutes 2020, section 144E.283, is amended to read:

108.11 **144E.283 PRIMARY INSTRUCTOR QUALIFICATIONS.**

108.12 ~~(a) An emergency medical technician education program primary instructor must:~~

108.13 (1) possess ~~valid~~ current Minnesota certification, registration, or licensure as one of the
108.14 following, at a level that is equivalent to or higher than the level of certification or registration
108.15 being taught:

108.16 (i) an EMR, EMT, AEMT, or paramedic;

108.17 (ii) a physician, with certification in adult or pediatric emergency medicine from the
108.18 American Board of Emergency Medicine or the American Board of Osteopathic Emergency
108.19 Medicine, with certification in an emergency medical services subspecialty, or serving as
108.20 a medical director of a licensed ambulance service;

108.21 (iii) a physician assistant, with experience in emergency medicine; or

108.22 (iv) a registered nurse with certification in adult or pediatric prehospital nursing from
108.23 (A) the Board of Certification for Emergency Nursing, including certified flight registered
108.24 nurse or certified transport registered nurse, or (B) the National Certification Corporation,
108.25 including certified in neonatal pediatric transport;

108.26 (2) ~~have two years of active emergency medical practical experience~~ if required under
108.27 this chapter for Minnesota certification or registration, possess National Registry of
108.28 Emergency Medical Technicians certification or registration as an EMR, EMT, AEMT, or
108.29 paramedic, at a level that is equivalent to or higher than the level of certification or
108.30 registration being taught;

108.31 (3) satisfy one of the following requirements:

109.1 (i) hold at least an associate's degree and have been certified for at least three years at a
 109.2 level that is equivalent to or higher than the level of certification or registration being taught;
 109.3 or

109.4 (ii) have been certified for at least five years at a level that is equivalent to or higher
 109.5 than the level of certification or registration being taught;

109.6 ~~(3)~~ (4) be recommended by a medical director of a licensed hospital, ambulance service,
 109.7 or education program approved by the board;

109.8 ~~(4)~~ (5) satisfy one of the following requirements:

109.9 (i) successfully complete the United States Department of Transportation Emergency
 109.10 Medical Services Instructor Education Program or its equivalent as approved by the board
 109.11 course; and

109.12 (ii) successfully complete the National Association of EMS Educators Instructor level
 109.13 1 course;

109.14 (iii) successfully complete the Fire Instructor I course;

109.15 (iv) hold at least a bachelor's degree in education;

109.16 (v) hold at least a master's degree in a related field of study;

109.17 (vi) have been vetted through the Minnesota State faculty credentialing process; or

109.18 (vii) successfully complete an equivalent course or hold an equivalent degree as approved
 109.19 by the board;

109.20 ~~(5)~~ (6) complete eight hours of continuing education in educational topics every two
 109.21 years, with documentation filed with the education program coordinator;:

109.22 (7) complete a board-approved application form; and

109.23 (8) receive board approval as a primary instructor.

109.24 ~~(b) An emergency medical responder instructor must possess valid registration,~~
 109.25 ~~certification, or licensure as an EMR, EMT, AEMT, paramedic, physician, physician~~
 109.26 ~~assistant, or registered nurse.~~

109.27 Sec. 9. Minnesota Statutes 2020, section 144E.285, subdivision 1, is amended to read:

109.28 Subdivision 1. **Approval required.** (a) All education programs for an EMR, EMT,
 109.29 AEMT, or paramedic must be approved by the board.

109.30 (b) To be approved by the board, an education program must:

- 110.1 (1) submit an application prescribed by the board that includes:
- 110.2 (i) type ~~and length~~ of course to be offered;
- 110.3 (ii) names, addresses, and qualifications of the program medical director, program
110.4 education coordinator, and instructors;
- 110.5 ~~(iii) names and addresses of clinical sites, including a contact person and telephone
110.6 number;~~
- 110.7 ~~(iv)~~ (iii) admission criteria for students; and
- 110.8 ~~(v)~~ (iv) materials and equipment to be used;
- 110.9 (2) for each course, implement the most current version of the United States Department
110.10 of Transportation EMS Education Standards, or its equivalent as determined by the board
110.11 applicable to EMR, EMT, AEMT, or paramedic education;
- 110.12 (3) have a program medical director and a program coordinator;
- 110.13 (4) utilize primary instructors who meet the requirements of section 144E.283 for teaching
110.14 at least 50 percent of the course content. The remaining 50 percent of the course may be
110.15 taught by guest lecturers approved by the education program coordinator or medical director;
- 110.16 ~~(5) have at least one instructor for every ten students at the practical skill stations;~~
- 110.17 ~~(6) maintain a written agreement with a licensed hospital or licensed ambulance service
110.18 designating a clinical training site;~~
- 110.19 ~~(7)~~ (5) retain documentation of program approval by the board, course outline, and
110.20 student information;
- 110.21 ~~(8)~~ (6) notify the board of the starting date of a course prior to the beginning of a course;
110.22 and
- 110.23 ~~(9)~~ (7) submit the appropriate fee as required under section 144E.29; and.
- 110.24 ~~(10) maintain a minimum average yearly pass rate as set by the board on an annual basis.
110.25 The pass rate will be determined by the percent of candidates who pass the exam on the
110.26 first attempt. An education program not meeting this yearly standard shall be placed on
110.27 probation and shall be on a performance improvement plan approved by the board until
110.28 meeting the pass rate standard. While on probation, the education program may continue
110.29 providing classes if meeting the terms of the performance improvement plan as determined
110.30 by the board. If an education program having probation status fails to meet the pass rate~~

111.1 ~~standard after two years in which an EMT initial course has been taught, the board may~~
111.2 ~~take disciplinary action under subdivision 5.~~

111.3 Sec. 10. Minnesota Statutes 2020, section 144E.285, is amended by adding a subdivision
111.4 to read:

111.5 Subd. 1a. **EMR requirements.** The National EMS Education Standards established by
111.6 the NHTSA, United States Department of Transportation, specifies the minimum
111.7 requirements for knowledge and skills for emergency medical responders. A medical director
111.8 of an emergency medical responder education group may establish additional knowledge
111.9 and skill requirements for EMRs.

111.10 Sec. 11. Minnesota Statutes 2020, section 144E.285, is amended by adding a subdivision
111.11 to read:

111.12 Subd. 1b. **EMT requirements.** In addition to the requirements under subdivision 1,
111.13 paragraph (b), an education program applying for approval to teach EMTs must:

111.14 (1) in the application prescribed by the board, include names and addresses of clinical
111.15 sites, including a contact person and telephone number;

111.16 (2) maintain a written agreement with a licensed hospital or licensed ambulance service
111.17 designating a clinical training site; and

111.18 (3) maintain a minimum average yearly pass rate as set by the board. An education
111.19 program not meeting the standard in this subdivision shall be placed on probation and must
111.20 comply with a performance improvement plan approved by the board until the program
111.21 meets the pass-rate standard. While on probation, the education program may continue to
111.22 provide classes if the program meets the terms of the performance improvement plan, as
111.23 determined by the board. If an education program that is on probation status fails to meet
111.24 the pass-rate standard after two years in which an EMT initial course has been taught, the
111.25 board may take disciplinary action under subdivision 5.

111.26 Sec. 12. Minnesota Statutes 2020, section 144E.285, subdivision 2, is amended to read:

111.27 Subd. 2. **AEMT and paramedic requirements.** (a) In addition to the requirements
111.28 under subdivision 1, paragraph (b), an education program applying for approval to teach
111.29 AEMTs and paramedics must:

111.30 (1) be administered by an educational institution accredited by the Commission of
111.31 Accreditation of Allied Health Education Programs (CAAHEP);₂

112.1 (2) in the application prescribed by the board, include names and addresses of clinical
 112.2 sites, including a contact person and telephone number; and

112.3 (3) maintain a written agreement with a licensed hospital or licensed ambulance service
 112.4 designating a clinical training site.

112.5 (b) An AEMT and paramedic education program that is administered by an educational
 112.6 institution not accredited by CAAHEP, but that is in the process of completing the
 112.7 accreditation process, may be granted provisional approval by the board upon verification
 112.8 of submission of its self-study report and the appropriate review fee to CAAHEP.

112.9 (c) An educational institution that discontinues its participation in the accreditation
 112.10 process must notify the board immediately and provisional approval shall be withdrawn.

112.11 ~~(d) This subdivision does not apply to a paramedic education program when the program~~
 112.12 ~~is operated by an advanced life support ambulance service licensed by the Emergency~~
 112.13 ~~Medical Services Regulatory Board under this chapter, and the ambulance service meets~~
 112.14 ~~the following criteria:~~

112.15 ~~(1) covers a rural primary service area that does not contain a hospital within the primary~~
 112.16 ~~service area or contains a hospital within the primary service area that has been designated~~
 112.17 ~~as a critical access hospital under section 144.1483, clause (9);~~

112.18 ~~(2) has tax-exempt status in accordance with the Internal Revenue Code, section~~
 112.19 ~~501(c)(3);~~

112.20 ~~(3) received approval before 1991 from the commissioner of health to operate a paramedic~~
 112.21 ~~education program;~~

112.22 ~~(4) operates an AEMT and paramedic education program exclusively to train paramedics~~
 112.23 ~~for the local ambulance service; and~~

112.24 ~~(5) limits enrollment in the AEMT and paramedic program to five candidates per~~
 112.25 ~~biennium.~~

112.26 Sec. 13. Minnesota Statutes 2020, section 144E.285, subdivision 4, is amended to read:

112.27 Subd. 4. **Reapproval.** An education program shall apply to the board for reapproval at
 112.28 least three months prior to the expiration date of its approval and must:

112.29 (1) submit an application prescribed by the board specifying any changes from the
 112.30 information provided for prior approval and any other information requested by the board
 112.31 to clarify incomplete or ambiguous information presented in the application; ~~and~~

- 113.1 (2) comply with the requirements under subdivision 1, paragraph (b), clauses (2) to ~~(10)~~;
- 113.2 (7);
- 113.3 (3) be subject to a site visit;
- 113.4 (4) for education programs that teach EMTs, comply with the requirements in subdivision
- 113.5 1b; and
- 113.6 (5) for education programs that teach AEMTs and paramedics, comply with the
- 113.7 requirements in subdivision 2 and maintain accreditation with the CAAHEP.

113.8 Sec. 14. Minnesota Statutes 2020, section 148.995, subdivision 2, is amended to read:

113.9 Subd. 2. **Certified doula.** "Certified doula" means an individual who has received a

113.10 certification to perform doula services from the International Childbirth Education

113.11 Association, the Doulas of North America (DONA), the Association of Labor Assistants

113.12 and Childbirth Educators (ALACE), Birthworks, the Childbirth and Postpartum Professional

113.13 Association (CAPP), Childbirth International, the International Center for Traditional

113.14 Childbearing, ~~or~~ Commonsense Childbirth, Inc., Modern Doula Education (MDE), or an

113.15 organization designated by the commissioner under section 148.9965.

113.16 Sec. 15. Minnesota Statutes 2020, section 148.996, subdivision 2, is amended to read:

113.17 Subd. 2. **Qualifications.** The commissioner shall include on the registry any individual

113.18 who:

113.19 (1) submits an application on a form provided by the commissioner. The form must

113.20 include the applicant's name, address, and contact information;

113.21 (2) ~~maintains~~ submits evidence of maintaining a current certification from one of the

113.22 organizations listed in section 148.995, subdivision 2, or from an organization designated

113.23 by the commissioner under section 148.9965; and

113.24 (3) pays the fees required under section 148.997.

113.25 Sec. 16. Minnesota Statutes 2020, section 148.996, subdivision 4, is amended to read:

113.26 Subd. 4. **Renewal.** Inclusion on the registry maintained by the commissioner is valid

113.27 for three years, provided the doula meets the requirement in subdivision 2, clause (2), during

113.28 the entire period. At the end of the three-year period, the certified doula may submit a new

113.29 application to remain on the doula registry by meeting the requirements described in

113.30 subdivision 2.

114.1 Sec. 17. Minnesota Statutes 2020, section 148.996, is amended by adding a subdivision
114.2 to read:

114.3 Subd. 6. **Removal from registry.** (a) If the commissioner determines that a doula
114.4 included on the registry does not meet the requirement in subdivision 2, clause (2), the
114.5 commissioner shall notify the affected doula that the doula no longer meets the requirement
114.6 in subdivision 2, clause (2), specify steps the doula must take to maintain inclusion on the
114.7 registry, and specify the effect of failing to take such steps. The commissioner must provide
114.8 this notice by first class mail to the address on file with the commissioner for the affected
114.9 doula.

114.10 (b) Following the provision of notice under paragraph (a), the commissioner shall remove
114.11 from the registry any doula who no longer meets the requirement in subdivision 2, clause
114.12 (2), and who does not take the steps specified by the commissioner to maintain inclusion
114.13 on the registry.

114.14 Sec. 18. [148.9965] DESIGNATION OF DOULA CERTIFICATION
114.15 ORGANIZATIONS BY COMMISSIONER.

114.16 Subdivision 1. **Review and designation by commissioner.** The commissioner shall
114.17 periodically review the doula certification organizations listed in section 148.995, subdivision
114.18 2, or designated by the commissioner under this section. The commissioner may: (1)
114.19 designate additional organizations from which individuals, if maintaining current doula
114.20 certification from such an organization, are eligible for inclusion on the registry of certified
114.21 doulas; and (2) remove the designation of a doula certification organization previously
114.22 designated by the commissioner.

114.23 Subd. 2. **Designation.** A doula certification organization seeking designation under this
114.24 section shall provide the commissioner with evidence that the organization satisfies
114.25 designation criteria established by the commissioner. If the commissioner designates a doula
114.26 certification organization under this section, the commissioner shall provide notice of the
114.27 designation by publication in the State Register and on the Department of Health website
114.28 for the registry of certified doulas and shall specify the date after which a certification by
114.29 the organization authorizes a doula certified by the organization to be included on the
114.30 registry.

114.31 Subd. 3. **Removal of designation.** (a) The commissioner may remove the designation
114.32 of a doula certification organization previously designated by the commissioner under this
114.33 section upon a determination by the commissioner that the organization does not meet the
114.34 commissioner's criteria for designation. If the commissioner removes a designation, the

115.1 commissioner shall provide notice of the removal by publication in the State Register and
115.2 shall specify the date after which a certification by the organization no longer authorizes a
115.3 doula certified by the organization to be included on the registry.

115.4 (b) Following removal of a designation, the Department of Health website for the registry
115.5 of certified doulas shall be modified to reflect the removal.

115.6 Sec. 19. Minnesota Statutes 2020, section 151.01, subdivision 29, is amended to read:

115.7 Subd. 29. ~~Legend Medical gas.~~ "Legend Medical gas" means ~~a liquid or gaseous~~
115.8 ~~substance used for medical purposes and that is required by federal law to be dispensed~~
115.9 ~~only pursuant to the prescription of a licensed practitioner~~ any gas or liquid manufactured
115.10 or stored in a liquefied, nonliquefied, or cryogenic state that:

115.11 (1) has a chemical or physical action in or on the human body or animals or is used in
115.12 conjunction with medical gas equipment; and

115.13 (2) is intended to be used for the diagnosis, cure, mitigation, treatment, or prevention of
115.14 disease.

115.15 Sec. 20. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
115.16 read:

115.17 Subd. 29a. **Medical gas manufacturer.** "Medical gas manufacturer" means any person:

115.18 (1) originally manufacturing a medical gas by chemical reaction, physical separation,
115.19 compression of atmospheric air, purification, or other means;

115.20 (2) filling a medical gas into a dispensing container via gas to gas, liquid to gas, or liquid
115.21 to liquid processes;

115.22 (3) combining two or more medical gases into a container to form a medically appropriate
115.23 mixture; or

115.24 (4) filling a medical gas via liquid to liquid into a final use container at the point of use.

115.25 Sec. 21. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
115.26 read:

115.27 Subd. 29b. **Medical gas wholesaler.** "Medical gas wholesaler" means any person who
115.28 sells a medical gas to another business or entity for the purpose of reselling or providing
115.29 that medical gas to the ultimate consumer or patient.

116.1 Sec. 22. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
116.2 read:

116.3 Subd. 29c. **Medical gas dispenser.** "Medical gas dispenser" means any person, other
116.4 than a licensed practitioner or pharmacy, who sells or provides a medical gas directly to the
116.5 ultimate consumer or patient via a valid prescription.

116.6 Sec. 23. [151.191] LICENSING MEDICAL GAS FACILITIES; FEES;
116.7 PROHIBITIONS.

116.8 Subdivision 1. **Medical gas manufacturers; requirements.** (a) No person shall act as
116.9 a medical gas manufacturer without first obtaining a license from the board and paying any
116.10 applicable fee specified in section 151.065.

116.11 (b) Application for a medical gas manufacturer license under this section must be made
116.12 in a manner specified by the board.

116.13 (c) A license must not be issued or renewed for a medical gas manufacturer unless the
116.14 applicant agrees to operate in a manner prescribed by federal and state law and according
116.15 to Minnesota Rules.

116.16 (d) A license must not be issued or renewed for a medical gas manufacturer that is
116.17 required to be licensed or registered by the state in which it is physically located unless the
116.18 applicant supplies the board with proof of licensure or registration. The board may establish
116.19 standards for the licensure of a medical gas manufacturer that is not required to be licensed
116.20 or registered by the state in which it is physically located.

116.21 (e) The board must require a separate license for each facility located within the state at
116.22 which medical gas manufacturing occurs and for each facility located outside of the state
116.23 at which medical gases that are shipped into the state are manufactured.

116.24 (f) Prior to the issuance of an initial or renewed license for a medical gas manufacturing
116.25 facility, the board may require the facility to pass an inspection conducted by an authorized
116.26 representative of the board. In the case of a medical gas manufacturing facility located
116.27 outside of the state, the board may require the applicant to pay the cost of the inspection,
116.28 in addition to the license fee in section 151.065, unless the applicant furnishes the board
116.29 with a report, issued by the appropriate regulatory agency of the state in which the facility
116.30 is located, of an inspection that has occurred within the 24 months immediately preceding
116.31 receipt of the license application by the board. The board may deny licensure unless the
116.32 applicant submits documentation satisfactory to the board that any deficiencies noted in an
116.33 inspection report have been corrected.

117.1 (g) A duly licensed medical gas manufacturing facility may also wholesale or dispense
117.2 any medical gas that is manufactured by the licensed facility, or manufactured or wholesaled
117.3 by another properly licensed medical gas facility, without also obtaining a medical gas
117.4 wholesaler license or medical gas dispenser registration.

117.5 (h) The filling of a medical gas into a final use container, at the point of use and by liquid
117.6 to liquid transfer, is permitted as long as the facility used as the base of operations is duly
117.7 licensed as a medical gas manufacturer.

117.8 Subd. 2. **Medical gas wholesalers; requirements.** (a) No person shall act as a medical
117.9 gas wholesaler without first obtaining a license from the board and paying any applicable
117.10 fee specified in section 151.065.

117.11 (b) Application for a medical gas wholesaler license under this section must be made in
117.12 a manner specified by the board.

117.13 (c) A license must not be issued or renewed for a medical gas wholesaler unless the
117.14 applicant agrees to operate in a manner prescribed by federal and state law and according
117.15 to Minnesota Rules.

117.16 (d) A license must not be issued or renewed for a medical gas wholesaler that is required
117.17 to be licensed or registered by the state in which it is physically located unless the applicant
117.18 supplies the board with proof of licensure or registration. The board may establish standards
117.19 for the licensure of a medical gas wholesaler that is not required to be licensed or registered
117.20 by the state in which it is physically located.

117.21 (e) The board must require a separate license for each facility located within the state at
117.22 which medical gas wholesaling occurs and for each facility located outside of the state from
117.23 which medical gases that are shipped into the state are wholesaled.

117.24 (f) Prior to the issuance of an initial or renewed license for a medical gas wholesaling
117.25 facility, the board may require the facility to pass an inspection conducted by an authorized
117.26 representative of the board. In the case of a medical gas wholesaling facility located outside
117.27 of the state, the board may require the applicant to pay the cost of the inspection, in addition
117.28 to the license fee in section 151.065, unless the applicant furnishes the board with a report,
117.29 issued by the appropriate regulatory agency of the state in which the facility is located, of
117.30 an inspection that has occurred within the 24 months immediately preceding receipt of the
117.31 license application by the board. The board may deny licensure unless the applicant submits
117.32 documentation satisfactory to the board that any deficiencies noted in an inspection report
117.33 have been corrected.

118.1 (g) A duly licensed medical gas wholesaling facility may also dispense any medical gas
118.2 that is manufactured or wholesaled by another properly licensed medical gas facility.

118.3 Subd. 3. **Medical gas dispensers; requirements.** (a) A person or establishment not
118.4 licensed as a pharmacy, practitioner, medical gas manufacturer, or medical gas dispenser
118.5 must not engage in the dispensing of medical gases without first obtaining a registration
118.6 from the board and paying the applicable fee specified in section 151.065. The registration
118.7 must be displayed in a conspicuous place in the business for which it is issued and expires
118.8 on the date set by the board.

118.9 (b) Application for a medical gas dispenser registration under this section must be made
118.10 in a manner specified by the board.

118.11 (c) A registration must not be issued or renewed for a medical gas dispenser located
118.12 within the state unless the applicant agrees to operate in a manner prescribed by federal and
118.13 state law and according to the rules adopted by the board. A license must not be issued for
118.14 a medical gas dispenser located outside of the state unless the applicant agrees to operate
118.15 in a manner prescribed by federal law and, when dispensing medical gases for residents of
118.16 this state, the laws of this state and Minnesota Rules.

118.17 (d) A registration must not be issued or renewed for a medical gas dispenser that is
118.18 required to be licensed or registered by the state in which it is physically located unless the
118.19 applicant supplies the board with proof of the licensure or registration. The board may
118.20 establish standards for the registration of a medical gas dispenser that is not required to be
118.21 licensed or registered by the state in which it is physically located.

118.22 (e) The board must require a separate registration for each medical gas dispenser located
118.23 within the state and for each facility located outside of the state from which medical gases
118.24 are dispensed to residents of this state.

118.25 (f) Prior to the issuance of an initial or renewed registration for a medical gas dispenser,
118.26 the board may require the medical gas dispenser to pass an inspection conducted by an
118.27 authorized representative of the board. In the case of a medical gas dispenser located outside
118.28 of the state, the board may require the applicant to pay the cost of the inspection, in addition
118.29 to the license fee in section 151.065, unless the applicant furnishes the board with a report,
118.30 issued by the appropriate regulatory agency of the state in which the facility is located, of
118.31 an inspection that has occurred within the 24 months immediately preceding receipt of the
118.32 license application by the board. The board may deny licensure unless the applicant submits
118.33 documentation satisfactory to the board that any deficiencies noted in an inspection report
118.34 have been corrected.

119.1 (g) A facility holding a medical gas dispenser registration must not engage in the
119.2 manufacturing or wholesaling of medical gases, except that a medical gas dispenser may
119.3 transfer medical gases from one of its duly registered facilities to other duly registered
119.4 medical gas manufacturing, wholesaling, or dispensing facilities owned or operated by that
119.5 same company, without requiring a medical gas wholesaler license.

119.6 Sec. 24. **REVISOR INSTRUCTION.**

119.7 In Minnesota Statutes, the revisor of statutes shall recode as Minnesota Statutes, section
119.8 144E.28, subdivision 8a, the community emergency medical technician certification
119.9 requirements that are currently coded as Minnesota Statutes, section 144E.275, subdivision
119.10 7, and shall revise any necessary cross-references consistent with that recoding.

119.11 Sec. 25. **REPEALER.**

119.12 Minnesota Statutes 2020, sections 144E.27, subdivisions 1 and 1a; and 151.19,
119.13 subdivision 3, are repealed.

119.14

ARTICLE 4

119.15

PRESCRIPTION DRUGS AND OPIATES

119.16 Section 1. Minnesota Statutes 2020, section 16A.151, subdivision 2, is amended to read:

119.17 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
119.18 injured persons or entities, this section does not prohibit distribution of money to the specific
119.19 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
119.20 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
119.21 to those persons or entities because they cannot readily be located or identified or because
119.22 the cost of distributing the money would outweigh the benefit to the persons or entities, the
119.23 money must be paid into the general fund.

119.24 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
119.25 may be deposited in that fund.

119.26 (c) This section does not prohibit a state official from distributing money to a person or
119.27 entity other than the state in litigation or potential litigation in which the state is a defendant
119.28 or potential defendant.

119.29 (d) State agencies may accept funds as directed by a federal court for any restitution or
119.30 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States
119.31 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue

120.1 account and are appropriated to the commissioner of the agency for the purpose as directed
120.2 by the federal court.

120.3 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph
120.4 (t), may be deposited as provided in section 16A.98, subdivision 12.

120.5 (f) Any money received by the state resulting from a settlement agreement or an assurance
120.6 of discontinuance entered into by the attorney general of the state, or a court order in litigation
120.7 brought by the attorney general of the state, on behalf of the state or a state agency, against
120.8 one or more opioid manufacturers or opioid wholesale drug distributors or consulting firms
120.9 working for an opioid manufacturer or opioid wholesale drug distributor related to alleged
120.10 violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this
120.11 state or other alleged illegal actions that contributed to the excessive use of opioids, must
120.12 be deposited in a separate account in the state treasury and the commissioner shall notify
120.13 the chairs and ranking minority members of the Finance Committee in the senate and the
120.14 Ways and Means Committee in the house of representatives that an account has been created.
120.15 Notwithstanding section 11A.20, all investment income and all investment losses attributable
120.16 to the investment of this account shall be credited to the account. This paragraph does not
120.17 apply to attorney fees and costs awarded to the state or the Attorney General's Office, to
120.18 contract attorneys hired by the state or Attorney General's Office, or to other state agency
120.19 attorneys. If the licensing fees under section 151.065, subdivision 1, clause (16), and
120.20 subdivision 3, clause (14), are reduced and the registration fee under section 151.066,
120.21 subdivision 3, is repealed in accordance with section 256.043, subdivision 4, then the
120.22 commissioner shall transfer from the separate account created in this paragraph to the opiate
120.23 epidemic response fund under section 256.043 an amount that ensures that \$20,940,000
120.24 each fiscal year is available for distribution in accordance with section 256.043, ~~subdivisions~~
120.25 ~~2 and~~ subdivision 3.

120.26 (g) Notwithstanding paragraph (f), if money is received from a settlement agreement or
120.27 an assurance of discontinuance entered into by the attorney general of the state or a court
120.28 order in litigation brought by the attorney general of the state on behalf of the state or a state
120.29 agency against a consulting firm working for an opioid manufacturer or opioid wholesale
120.30 drug distributor and deposited into the separate account created under paragraph (f), the
120.31 commissioner shall annually transfer from the separate account to the opiate epidemic
120.32 response fund under section 256.043 an amount equal to the estimated amount submitted
120.33 to the commissioner by the Board of Pharmacy in accordance with section 151.066,
120.34 subdivision 3, paragraph (b). The amount transferred shall be included in the amount available
120.35 for distribution in accordance with section 256.043, subdivision 3. This transfer shall occur

121.1 each year until the registration fee under section 151.066, subdivision 3, is repealed in
121.2 accordance with section 256.043, subdivision 4, or the money deposited in the account in
121.3 accordance with this paragraph has been transferred, whichever occurs first.

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

121.5 Sec. 2. **[62J.85] PRESCRIPTION DRUG MANUFACTURER IMPORTATION**
121.6 **PATHWAY PLAN.**

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

121.9 (b) "Drug product" or "drug" means a prescription drug or biological product that is
121.10 intended for human use and regulated as a drug except where specific reference is made to
121.11 a drug approved under section 505 of the federal Food, Drug, and Cosmetic Act, United
121.12 States Code, title 21, section 355, or biological product approved under section 351 of the
121.13 federal Public Health Act, United States Code, title 42, section 262. Drug product or drug
121.14 does not include biological products that are intended for transfusions, including blood or
121.15 blood products; or allogeneic-, cellular-, or tissue-based products.

121.16 (c) "FD&C Act" means the federal Food, Drug, and Cosmetic Act, United States Code,
121.17 title 21, section 301, et seq.

121.18 (d) "Importation guidance" means the draft guidance released by the federal Food and
121.19 Drug Administration (FDA) titled "Importation of Certain FDA-Approved Human
121.20 Prescription Drugs, Including Biological Products, Under Section 801(d)(1)(B) of the Federal
121.21 Food, Drug, and Cosmetic Act; Draft Guidance for the Industry," which if finalized allows
121.22 for the importation of MMA products.

121.23 (e) "Manufacturer" means the entity that is the holder of the New Drug Application or
121.24 Biologics License Application for the drug product.

121.25 (f) "Multimarket-approved product" or "MMA product" means a FDA-approved drug
121.26 product that:

121.27 (1) was manufactured outside the United States and authorized for marketing by another
121.28 country's regulatory authority;

121.29 (2) is subject to a new drug application or biologics license application;

121.30 (3) is imported into the United States and is authorized by the manufacturer to be
121.31 marketed in the United States; and

122.1 (4) continues to meet the quality standards for marketing in its originally intended foreign
122.2 market.

122.3 Subd. 2. **Application.** This section applies to any MMA product in which the
122.4 manufacturer of the product has obtained a new National Drug Code (NDC) for the MMA
122.5 product and has imported the MMA product in compliance with the FD&C Act and any
122.6 importation guidance finalized by the FDA.

122.7 Subd. 3. **Incentives.** (a) In order to facilitate importation of drugs pursuant to importation
122.8 guidance finalized by the FDA, any MMA product offered for sale in Minnesota at a cost
122.9 that is at least 23 percent lower than the wholesale acquisition cost for the FDA-approved
122.10 product manufactured in the United States shall be:

122.11 (1) included on the uniform preferred drug list and covered under the medical assistance
122.12 and MinnesotaCare programs; and

122.13 (2) a covered drug under the state employee group insurance program pursuant to chapter
122.14 43A.

122.15 (b) A health plan company must provide coverage for each MMA product that meets
122.16 the requirements in paragraph (a) if the manufacturer's FDA-approved drug product
122.17 manufactured in the United States is covered by the health plan company and the health
122.18 plan company must not impose any enrollee cost-sharing requirements for the covered
122.19 MMA product.

122.20 (c) This subdivision shall not become effective for MMA products that are offered for
122.21 sale in Minnesota in accordance with paragraph (a) unless affirmative action is taken by
122.22 the legislature.

122.23 Sec. 3. Minnesota Statutes 2020, section 62W.11, is amended to read:

122.24 **62W.11 GAG CLAUSE PROHIBITION.**

122.25 (a) No contract between a pharmacy benefit manager or health carrier and a pharmacy
122.26 or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing
122.27 to an enrollee any health care information that the pharmacy or pharmacist deems appropriate
122.28 regarding the nature of treatment; the risks or alternatives; the availability of alternative
122.29 therapies, consultations, or tests; the decision of utilization reviewers or similar persons to
122.30 authorize or deny services; the process that is used to authorize or deny health care services
122.31 or benefits; or information on financial incentives and structures used by the health carrier
122.32 or pharmacy benefit manager.

123.1 (b) A pharmacy or pharmacist must provide to an enrollee information regarding the
 123.2 enrollee's total cost for each prescription drug dispensed where part or all of the cost of the
 123.3 prescription is being paid or reimbursed by the employer-sponsored plan or by a health
 123.4 carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

123.5 (c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
 123.6 pharmacy from discussing information regarding the total cost for pharmacy services for a
 123.7 prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual
 123.8 and customary price ~~of for~~ for the prescription drug, the pharmacy's acquisition cost for the
 123.9 prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit
 123.10 manager or health carrier for the prescription drug.

123.11 (d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from
 123.12 discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a
 123.13 prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for
 123.14 a prescription drug.

123.15 ~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
 123.16 pharmacy from discussing the availability of any therapeutically equivalent alternative
 123.17 prescription drugs or alternative methods for purchasing the prescription drug, including
 123.18 but not limited to paying out-of-pocket the pharmacy's usual and customary price when that
 123.19 amount is less expensive to the enrollee than the amount the enrollee is required to pay for
 123.20 the prescription drug under the enrollee's health plan.

123.21 Sec. 4. Minnesota Statutes 2020, section 151.065, subdivision 1, is amended to read:

123.22 Subdivision 1. **Application fees.** Application fees for licensure and registration are as
 123.23 follows:

123.24 (1) pharmacist licensed by examination, \$175;

123.25 (2) pharmacist licensed by reciprocity, \$275;

123.26 (3) pharmacy intern, \$50;

123.27 (4) pharmacy technician, \$50;

123.28 (5) pharmacy, \$260;

123.29 (6) drug wholesaler, legend drugs only, \$5,260;

123.30 (7) drug wholesaler, legend and nonlegend drugs, \$5,260;

123.31 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;

- 124.1 (9) drug wholesaler, medical gases, ~~\$5,260 for the first facility and \$260 for each~~
124.2 ~~additional facility;~~
- 124.3 (10) third-party logistics provider, \$260;
- 124.4 (11) drug manufacturer, nonopiate legend drugs only, \$5,260;
- 124.5 (12) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;
- 124.6 (13) drug manufacturer, nonlegend or veterinary legend drugs, \$5,260;
- 124.7 (14) drug manufacturer, medical gases, ~~\$5,260 for the first facility and \$260 for each~~
124.8 ~~additional facility;~~
- 124.9 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;
- 124.10 (16) drug manufacturer of opiate-containing controlled substances listed in section
124.11 152.02, subdivisions 3 to 5, \$55,260;
- 124.12 (17) medical gas dispenser, \$260;
- 124.13 (18) controlled substance researcher, \$75; and
- 124.14 (19) pharmacy professional corporation, \$150.

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

124.16 Sec. 5. Minnesota Statutes 2020, section 151.065, subdivision 3, is amended to read:

124.17 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as
124.18 follows:

- 124.19 (1) pharmacist, \$175;
- 124.20 (2) pharmacy technician, \$50;
- 124.21 (3) pharmacy, \$260;
- 124.22 (4) drug wholesaler, legend drugs only, \$5,260;
- 124.23 (5) drug wholesaler, legend and nonlegend drugs, \$5,260;
- 124.24 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, \$5,260;
- 124.25 (7) drug wholesaler, medical gases, ~~\$5,260 for the first facility and \$260 for each~~
124.26 ~~additional facility;~~
- 124.27 (8) third-party logistics provider, \$260;
- 124.28 (9) drug manufacturer, nonopiate legend drugs only, \$5,260;

- 125.1 (10) drug manufacturer, nonopiate legend and nonlegend drugs, \$5,260;
- 125.2 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, \$5,260;
- 125.3 (12) drug manufacturer, medical gases, ~~\$5,260 for the first facility and \$260 for each~~
- 125.4 ~~additional facility;~~
- 125.5 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, \$5,260;
- 125.6 (14) drug manufacturer of opiate-containing controlled substances listed in section
- 125.7 152.02, subdivisions 3 to 5, \$55,260;
- 125.8 (15) medical gas dispenser, \$260;
- 125.9 (16) controlled substance researcher, \$75; and
- 125.10 (17) pharmacy professional corporation, \$100.

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

125.12 Sec. 6. Minnesota Statutes 2020, section 151.065, subdivision 7, is amended to read:

125.13 Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the

125.14 exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state

125.15 government special revenue fund.

125.16 (b) \$5,000 of each fee collected under subdivision 1, clauses (6) to ~~(9)~~ (8), ~~and~~ (11) to

125.17 (13), and (15), and subdivision 3, clauses (4) to ~~(7)~~ (6), ~~and~~ (9) to (11), and (13), and \$55,000

125.18 of each fee collected under subdivision 1, clause (16), and subdivision 3, clause (14), shall

125.19 be deposited in the opiate epidemic response fund established in section 256.043.

125.20 (c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14),

125.21 are reduced under section 256.043, \$5,000 of the reduced fee shall be deposited in the opiate

125.22 epidemic response fund in section 256.043.

125.23 Sec. 7. Minnesota Statutes 2020, section 151.066, subdivision 3, is amended to read:

125.24 Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall

125.25 annually assess an opiate product registration fee on any manufacturer of an opiate that

125.26 annually sells, delivers, or distributes an opiate within or into the state 2,000,000 or more

125.27 units as reported to the board under subdivision 2.

125.28 (b) For purposes of assessing the annual registration fee under this section and

125.29 determining the number of opiate units a manufacturer sold, delivered, or distributed within

125.30 or into the state, the board shall not consider any opiate that is used for medication-assisted

126.1 therapy for substance use disorders. If there is money deposited into the separate account
126.2 as described in section 16A.151, subdivision 2, paragraph (g), the board shall submit to the
126.3 commissioner of management and budget an estimate of the difference in the annual fee
126.4 revenue collected under this section due to this exception.

126.5 (c) The annual registration fee for each manufacturer meeting the requirement under
126.6 paragraph (a) is \$250,000.

126.7 ~~(e)~~ (d) In conjunction with the data reported under this section, and notwithstanding
126.8 section 152.126, subdivision 6, the board may use the data reported under section 152.126,
126.9 subdivision 4, to determine which manufacturers meet the requirement under paragraph (a)
126.10 and are required to pay the registration fees under this subdivision.

126.11 ~~(d)~~ (e) By April 1 of each year, beginning April 1, 2020, the board shall notify a
126.12 manufacturer that the manufacturer meets the requirement in paragraph (a) and is required
126.13 to pay the annual registration fee in accordance with section 151.252, subdivision 1,
126.14 paragraph (b).

126.15 ~~(e)~~ (f) A manufacturer may dispute the board's determination that the manufacturer must
126.16 pay the registration fee no later than 30 days after the date of notification. However, the
126.17 manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph
126.18 (b). The dispute must be filed with the board in the manner and using the forms specified
126.19 by the board. A manufacturer must submit, with the required forms, data satisfactory to the
126.20 board that demonstrates that the assessment of the registration fee was incorrect. The board
126.21 must make a decision concerning a dispute no later than 60 days after receiving the required
126.22 dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated
126.23 that the fee was incorrectly assessed, the board must refund the amount paid in error.

126.24 ~~(f)~~ (g) For purposes of this subdivision, a unit means the individual dosage form of the
126.25 particular drug product that is prescribed to the patient. One unit equals one tablet, capsule,
126.26 patch, syringe, milliliter, or gram.

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

126.28 Sec. 8. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

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

126.31 (b) "Central repository" means a wholesale distributor that meets the requirements under
126.32 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
126.33 section.

- 127.1 (c) "Distribute" means to deliver, other than by administering or dispensing.
- 127.2 (d) "Donor" means:
- 127.3 (1) a health care facility as defined in this subdivision;
- 127.4 (2) a skilled nursing facility licensed under chapter 144A;
- 127.5 (3) an assisted living facility registered under chapter 144D where there is centralized
- 127.6 storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;
- 127.7 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
- 127.8 the state;
- 127.9 (5) a drug wholesaler licensed under section 151.47;
- 127.10 (6) a drug manufacturer licensed under section 151.252; or
- 127.11 (7) an individual at least 18 years of age, provided that the drug or medical supply that
- 127.12 is donated was obtained legally and meets the requirements of this section for donation.
- 127.13 (e) "Drug" means any prescription drug that has been approved for medical use in the
- 127.14 United States, is listed in the United States Pharmacopoeia or National Formulary, and
- 127.15 meets the criteria established under this section for donation; or any over-the-counter
- 127.16 medication that meets the criteria established under this section for donation. This definition
- 127.17 includes cancer drugs and antirejection drugs, but does not include controlled substances,
- 127.18 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
- 127.19 to a patient registered with the drug's manufacturer in accordance with federal Food and
- 127.20 Drug Administration requirements.
- 127.21 (f) "Health care facility" means:
- 127.22 (1) a physician's office or health care clinic where licensed practitioners provide health
- 127.23 care to patients;
- 127.24 (2) a hospital licensed under section 144.50;
- 127.25 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or
- 127.26 (4) a nonprofit community clinic, including a federally qualified health center; a rural
- 127.27 health clinic; public health clinic; or other community clinic that provides health care utilizing
- 127.28 a sliding fee scale to patients who are low-income, uninsured, or underinsured.
- 127.29 (g) "Local repository" means a health care facility that elects to accept donated drugs
- 127.30 and medical supplies and meets the requirements of subdivision 4.

128.1 (h) "Medical supplies" or "supplies" means any prescription and nonprescription medical
128.2 supplies needed to administer a prescription drug.

128.3 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
128.4 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
128.5 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
128.6 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
128.7 part 6800.3750.

128.8 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
128.9 it does not include a veterinarian.

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

128.11 Sec. 9. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

128.12 Subd. 7. **Standards and procedures for inspecting and storing donated prescription**
128.13 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
128.14 under contract with the central repository or a local repository shall inspect all donated
128.15 prescription drugs and supplies before the drug or supply is dispensed to determine, to the
128.16 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
128.17 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
128.18 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
128.19 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
128.20 inspection record stating that the requirements for donation have been met. If a local
128.21 repository receives drugs and supplies from the central repository, the local repository does
128.22 not need to reinspect the drugs and supplies.

128.23 (b) The central repository and local repositories shall store donated drugs and supplies
128.24 in a secure storage area under environmental conditions appropriate for the drug or supply
128.25 being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If~~
128.26 ~~donated drugs or supplies are not inspected immediately upon receipt, a repository must~~
128.27 ~~quarantine the donated drugs or supplies separately from all dispensing stock until the~~
128.28 ~~donated drugs or supplies have been inspected and (1) approved for dispensing under the~~
128.29 ~~program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to~~
128.30 ~~paragraph (d).~~

128.31 (c) The central repository and local repositories shall dispose of all prescription drugs
128.32 and medical supplies that are not suitable for donation in compliance with applicable federal
128.33 and state statutes, regulations, and rules concerning hazardous waste.

129.1 (d) In the event that controlled substances or prescription drugs that can only be dispensed
129.2 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
129.3 local repository for donation, the shipment delivery must be documented by the repository
129.4 and returned immediately to the donor or the donor's representative that provided the drugs.

129.5 (e) Each repository must develop drug and medical supply recall policies and procedures.
129.6 If a repository receives a recall notification, the repository shall destroy all of the drug or
129.7 medical supply in its inventory that is the subject of the recall and complete a record of
129.8 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
129.9 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
129.10 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
129.11 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
129.12 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

129.13 (f) A record of destruction of donated drugs and supplies that are not dispensed under
129.14 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
129.15 shall be maintained by the repository for at least ~~five~~ two years. For each drug or supply
129.16 destroyed, the record shall include the following information:

129.17 (1) the date of destruction;

129.18 (2) the name, strength, and quantity of the drug destroyed; and

129.19 (3) the name of the person or firm that destroyed the drug.

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

129.21 Sec. 10. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

129.22 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
129.23 for the administration of this program shall be utilized by the participants of the program
129.24 and shall be available on the board's website:

129.25 (1) intake application form described under subdivision 5;

129.26 (2) local repository participation form described under subdivision 4;

129.27 (3) local repository withdrawal form described under subdivision 4;

129.28 (4) drug repository donor form described under subdivision 6;

129.29 (5) record of destruction form described under subdivision 7; and

129.30 (6) drug repository recipient form described under subdivision 8.

130.1 (b) All records, including drug inventory, inspection, and disposal of donated prescription
130.2 drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two
130.3 years. Records required as part of this program must be maintained pursuant to all applicable
130.4 practice acts.

130.5 (c) Data collected by the drug repository program from all local repositories shall be
130.6 submitted quarterly or upon request to the central repository. Data collected may consist of
130.7 the information, records, and forms required to be collected under this section.

130.8 (d) The central repository shall submit reports to the board as required by the contract
130.9 or upon request of the board.

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

130.11 Sec. 11. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision
130.12 to read:

130.13 **Subd. 14. Cooperation.** The central repository, as approved by the Board of Pharmacy,
130.14 may enter into an agreement with another state that has an established drug repository or
130.15 drug donation program if the other state's program includes regulations to ensure the purity,
130.16 integrity, and safety of the drugs and supplies donated, to permit the central repository to
130.17 offer to another state program inventory that is not needed by a Minnesota resident and to
130.18 accept inventory from another state program to be distributed to local repositories and
130.19 dispensed to Minnesota residents in accordance with this program.

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

130.21 Sec. 12. **OPIATE REGISTRATION FEE REDUCTION.**

130.22 (a) For purposes of assessing the opiate registration fee under Minnesota Statutes, section
130.23 151.066, subdivision 3, that is required to be paid on June 1, 2021, in accordance with
130.24 Minnesota Statutes, section 151.252, subdivision 1, paragraph (b), the Board of Pharmacy
130.25 shall not consider any injectable opiate product distributed to a hospital or hospital pharmacy.
130.26 If there is money deposited into the separate account as described in Minnesota Statutes,
130.27 section 16A.151, subdivision 2, paragraph (g), the board shall submit to the commissioner
130.28 of management and budget an estimate of the difference in the annual opiate registration
130.29 fee revenue collected under Minnesota Statutes, section 151.066, due to the exception
130.30 described in this paragraph.

131.1 (b) Any estimated loss to the opiate registration fee revenue attributable to paragraph
 131.2 (a) must be included in any transfer that occurs under Minnesota Statutes, section 16A.151,
 131.3 subdivision 2, paragraph (g), in calendar year 2021.

131.4 (c) If a manufacturer has already paid the opiate registration fee due on June 1, 2021,
 131.5 the Board of Pharmacy shall return the amount of the fee to the manufacturer if the
 131.6 manufacturer would not have been required to pay the fee after the calculations described
 131.7 in paragraph (a) were made.

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

131.9 **ARTICLE 5**

131.10 **HEALTH COVERAGE AND TRANSPARENCY**

131.11 Section 1. Minnesota Statutes 2020, section 62J.701, is amended to read:

131.12 **62J.701 GOVERNMENTAL PROGRAMS.**

131.13 ~~(a) Beginning January 1, 1999, the provisions in paragraphs (b) to (e) apply.~~

131.14 ~~(b)~~ (a) For purposes of sections 62J.695 to 62J.80, the requirements and other provisions
 131.15 that apply to health plan companies also apply to governmental programs.

131.16 ~~(e)~~ (b) For purposes of this section, "governmental programs" means the medical
 131.17 assistance program, the MinnesotaCare program, the state employee group insurance
 131.18 program, the public employees insurance program under section 43A.316, and coverage
 131.19 provided by political subdivisions under section 471.617.

131.20 ~~(d)~~ (c) Notwithstanding paragraph ~~(b)~~ (a), section 62J.72 does not apply to the
 131.21 fee-for-service programs under medical assistance and MinnesotaCare and section 62J.72,
 131.22 subdivision 3, paragraph (b), does not apply to the prepaid medical assistance program or
 131.23 MinnesotaCare.

131.24 ~~(e)~~ (d) If a state commissioner or local unit of government contracts with a health plan
 131.25 company or a third-party administrator, the contract may assign any obligations under
 131.26 paragraph ~~(b)~~ (a) to the health plan company or third-party administrator. Nothing in this
 131.27 paragraph shall be construed to remove or diminish any enforcement responsibilities of the
 131.28 commissioners of health or commerce provided in sections 62J.695 to 62J.80.

131.29 Sec. 2. Minnesota Statutes 2020, section 62J.72, subdivision 3, is amended to read:

131.30 Subd. 3. **Information on patients' medical bills.** (a) A health plan company and health
 131.31 care provider shall provide patients and enrollees with a copy of an explicit and intelligible

132.1 bill ~~whenever the patient or enrollee is sent a bill and is responsible for paying any portion~~
 132.2 ~~of that bill.~~ The ~~bills~~ bill must contain descriptive language sufficient to be understood by
 132.3 the average patient or enrollee. This subdivision does not apply to a flat co-pay paid by the
 132.4 patient or enrollee at the time the service is required.

132.5 (b) In addition to the requirements in paragraph (a), when a health care provider transmits
 132.6 a bill to a patient, the bill must specify the following for the health care services provided:

132.7 (1) the Medicare-allowable fee-for-service payment rate if the service is covered by
 132.8 Medicare; and

132.9 (2) the provider's Medicare percent, as defined in section 62J.825, subdivision 1.

132.10 Sec. 3. [62J.825] HEALTH CARE PRICE TRANSPARENCY; NOTICE AND
 132.11 DISCLOSURE OF MEDICARE PERCENT.

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

132.14 (b) "Health plan" has the meaning given in section 62A.011, subdivision 3, and does
 132.15 not include coverage provided under medical assistance, MinnesotaCare, or Medicare Part
 132.16 A, Part B, or Part C.

132.17 (c) "Medicare percent" means the percentage of the Medicare allowable payment rate
 132.18 that a health care provider accepts as payment in full for health care services provided by
 132.19 the provider that are covered by Medicare, and for services not covered by Medicare, a
 132.20 dollar amount the provider is willing to accept as payment in full.

132.21 Subd. 2. Required notice. (a) A health care provider must establish a Medicare percent
 132.22 that the provider will accept as payment in full for health care services provided by that
 132.23 provider. For services that are not covered by a patient's health plan or for patients who are
 132.24 not insured, a provider must provide notice to patients and the public of the provider's
 132.25 Medicare percent by:

132.26 (1) posting information describing the Medicare percent and specifying the provider's
 132.27 Medicare percent in a prominent, clearly visible location at or near the provider's reception
 132.28 desk, registration desk, or patient check-in area;

132.29 (2) posting information describing the Medicare percent and specifying the provider's
 132.30 Medicare percent on the provider's public website; and

133.1 (3) including information describing the Medicare percent and specifying the provider's
133.2 Medicare percent on any document related to provider payments that the provider requires
133.3 a patient or patient's representative to sign.

133.4 (b) The notices required in paragraph (a) must include the following statement: "The
133.5 Medicare percent means the reimbursement that this provider will accept as payment in full
133.6 for services provided to patients. The Medicare percent can be used by a patient to compare
133.7 the cost of care between providers."

133.8 **Sec. 4. [62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

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

133.10 (b) "Clean application for provider credentialing" or "clean application" means an
133.11 application for provider credentialing submitted by a health care provider to a health plan
133.12 company that is complete, is in the format required by the health plan company, and includes
133.13 all information and substantiation required by the health plan company and does not require
133.14 evaluation of any identified potential quality or safety concern.

133.15 (c) "Provider credentialing" means the process undertaken by a health plan company to
133.16 evaluate and approve a health care provider's education, training, residency, licenses,
133.17 certifications, and history of significant quality or safety concerns in order to approve the
133.18 health care provider to provide health care services to patients at a clinic or facility.

133.19 Subd. 2. Time limit for credentialing determination. A health plan company that
133.20 receives an application for provider credentialing must:

133.21 (1) if the application is determined to be a clean application for provider credentialing
133.22 and if the health care provider submitting the application or the clinic or facility at which
133.23 the health care provider provides services requests the information, affirm that the health
133.24 care provider's application is a clean application and notify the health care provider or clinic
133.25 or facility of the date by which the health plan company will make a determination on the
133.26 health care provider's application;

133.27 (2) if the application is determined not to be a clean application, inform the health care
133.28 provider of the application's deficiencies or missing information or substantiation within
133.29 three business days after the health plan company determines the application is not a clean
133.30 application; and

133.31 (3) make a determination on the health care provider's clean application within 45 days
133.32 after receiving the clean application unless the health plan company identifies a substantive
133.33 quality or safety concern in the course of provider credentialing that requires further

134.1 investigation. Upon notice to the health care provider, clinic, or facility, the health plan
 134.2 company is allowed 30 additional days to investigate any quality or safety concerns.

134.3 **EFFECTIVE DATE.** This section applies to applications for provider credentialing
 134.4 submitted to a health plan company on or after January 1, 2022.

134.5 Sec. 5. **[62Q.524] DISCLOSURE OF APPLICATION OF FUNDS FROM A PATIENT**
 134.6 **ASSISTANCE PROGRAM TO A DEDUCTIBLE.**

134.7 A health plan company must include in the summary of benefits and coverage a statement
 134.8 indicating whether funds from a patient assistance program, as defined in section 62J.84,
 134.9 subdivision 2, paragraph (h), are applied by the health plan company to an enrollee's
 134.10 deductible.

134.11 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to health
 134.12 plans offered, issued, or renewed on or after that date.

134.13 Sec. 6. Minnesota Statutes 2020, section 62W.13, is amended to read:

134.14 **62W.13 RETROACTIVE ADJUSTMENTS.**

134.15 No pharmacy benefit manager shall directly or indirectly retroactively adjust deny or
 134.16 reduce a claim or aggregate of claims for reimbursement submitted by a pharmacy for a
 134.17 prescription drug, more than 30 days after the original claim was submitted, unless the
 134.18 adjustment is a result of a:

134.19 ~~(1)~~ pharmacy audit conducted in accordance with section 62W.09 and it was determined
 134.20 that:

134.21 (1) the original claim was submitted fraudulently; or

134.22 (2) the original claim payment was incorrect because the pharmacy was already paid
 134.23 for the prescription drug or service; ~~or,~~

134.24 ~~(2) technical billing error.~~

134.25

ARTICLE 6

134.26

BACKGROUND STUDIES

134.27 Section 1. Minnesota Statutes 2020, section 144.057, subdivision 1, is amended to read:

134.28 Subdivision 1. **Background studies required.** (a) Except as specified in paragraph (b),
 134.29 the commissioner of health shall contract with the commissioner of human services to
 134.30 conduct background studies of:

135.1 (1) individuals providing services that have direct contact, as defined under section
135.2 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
135.3 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
135.4 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
135.5 facilities with dementia care licensed under chapter 144G; and board and lodging
135.6 establishments that are registered to provide supportive or health supervision services under
135.7 section 157.17;

135.8 (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact
135.9 services in a nursing home or a home care agency licensed under chapter 144A; an assisted
135.10 living facility or assisted living facility with dementia care licensed under chapter 144G;
135.11 or a boarding care home licensed under sections 144.50 to 144.58. If the individual under
135.12 study resides outside Minnesota, the study must include a check for substantiated findings
135.13 of maltreatment of adults and children in the individual's state of residence when the
135.14 information is made available by that state, and must include a check of the National Crime
135.15 Information Center database;

135.16 (3) all other employees in assisted living facilities or assisted living facilities with
135.17 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
135.18 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
135.19 an individual in this section shall disqualify the individual from positions allowing direct
135.20 contact or access to patients or residents receiving services. "Access" means physical access
135.21 to a client or the client's personal property without continuous, direct supervision as defined
135.22 in section 245C.02, subdivision 8, when the employee's employment responsibilities do not
135.23 include providing direct contact services;

135.24 (4) individuals employed by a supplemental nursing services agency, as defined under
135.25 section 144A.70, who are providing services in health care facilities; and

135.26 (5) controlling persons of a supplemental nursing services agency, as defined under
135.27 section 144A.70.

135.28 (b) The commissioner of human services is not required to conduct a background study
135.29 on any individual identified in paragraph (a) if the individual has a valid license issued by
135.30 a health-related licensing board as defined in section 214.01, subdivision 2, and has completed
135.31 the criminal background check as required in section 214.075.

135.32 (c) If a facility or program is licensed by the Department of Human Services and subject
135.33 to the background study provisions of chapter 245C and is also licensed by the Department

136.1 of Health, the Department of Human Services is solely responsible for the background
136.2 studies of individuals in the jointly licensed programs.

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

136.4 Sec. 2. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

136.5 Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection
136.6 vendor" means a one of up to three qualified organization organizations under a written
136.7 contract with the commissioner to provide services in accordance with section 245C.05,
136.8 subdivision 5, paragraph (b).

136.9 Sec. 3. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

136.10 Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each
136.11 background study, the entity initiating the study must provide the commissioner's privacy
136.12 notice to the background study subject required under section 13.04, subdivision 2. The
136.13 notice must be available through the commissioner's electronic NETStudy and NETStudy
136.14 2.0 systems and shall include the information in paragraphs (b) and (c).

136.15 (b) The background study subject shall be informed that any previous background studies
136.16 that received a set-aside will be reviewed, and without further contact with the background
136.17 study subject, the commissioner may notify the agency that initiated the subsequent
136.18 background study:

136.19 (1) that the individual has a disqualification that has been set aside for the program or
136.20 agency that initiated the study;

136.21 (2) the reason for the disqualification; and

136.22 (3) that information about the decision to set aside the disqualification will be available
136.23 to the license holder upon request without the consent of the background study subject.

136.24 (c) The background study subject must also be informed that:

136.25 (1) the subject's fingerprints collected for purposes of completing the background study
136.26 under this chapter must not be retained by the Department of Public Safety, Bureau of
136.27 Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will
136.28 only retain fingerprints of subjects with a criminal history;

136.29 (2) effective upon implementation of NETStudy 2.0, the subject's photographic image
136.30 will be retained by the commissioner, and if the subject has provided the subject's Social
136.31 Security number for purposes of the background study, the photographic image will be

137.1 available to prospective employers and agencies initiating background studies under this
137.2 chapter to verify the identity of the subject of the background study;

137.3 (3) ~~the commissioner's~~ an authorized fingerprint collection vendor shall, for purposes
137.4 of verifying the identity of the background study subject, be able to view the identifying
137.5 information entered into NETStudy 2.0 by the entity that initiated the background study,
137.6 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
137.7 2.0. ~~The~~ An authorized fingerprint collection vendor shall retain no more than the subject's
137.8 name and the date and time the subject's fingerprints were recorded and sent, only as
137.9 necessary for auditing and billing activities;

137.10 (4) the commissioner shall provide the subject notice, as required in section 245C.17,
137.11 subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

137.12 (5) the subject may request in writing a report listing the entities that initiated a
137.13 background study on the individual as provided in section 245C.17, subdivision 1, paragraph
137.14 (b);

137.15 (6) the subject may request in writing that information used to complete the individual's
137.16 background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051,
137.17 paragraph (a), are met; and

137.18 (7) notwithstanding clause (6), the commissioner shall destroy:

137.19 (i) the subject's photograph after a period of two years when the requirements of section
137.20 245C.051, paragraph (c), are met; and

137.21 (ii) any data collected on a subject under this chapter after a period of two years following
137.22 the individual's death as provided in section 245C.051, paragraph (d).

137.23 Sec. 4. Minnesota Statutes 2020, section 245C.05, subdivision 5, is amended to read:

137.24 Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for
137.25 background studies conducted by the commissioner for child foster care, children's residential
137.26 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the
137.27 subject of the background study, who is 18 years of age or older, shall provide the
137.28 commissioner with a set of classifiable fingerprints obtained from an authorized agency for
137.29 a national criminal history record check.

137.30 (b) For background studies initiated on or after the implementation of NETStudy 2.0,
137.31 except as provided under subdivision 5a, every subject of a background study must provide
137.32 the commissioner with a set of the background study subject's classifiable fingerprints and

138.1 photograph. The photograph and fingerprints must be recorded at the same time by ~~the~~
138.2 ~~commissioner's~~ an authorized fingerprint collection vendor and sent to the commissioner
138.3 through the commissioner's secure data system described in section 245C.32, subdivision
138.4 1a, paragraph (b).

138.5 (c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
138.6 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
138.7 Investigation for a national criminal history record check.

138.8 (d) The fingerprints must not be retained by the Department of Public Safety, Bureau
138.9 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
138.10 not retain background study subjects' fingerprints.

138.11 (e) ~~The commissioner's~~ An authorized fingerprint collection vendor shall, for purposes
138.12 of verifying the identity of the background study subject, be able to view the identifying
138.13 information entered into NETStudy 2.0 by the entity that initiated the background study,
138.14 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
138.15 2.0. ~~The~~ An authorized fingerprint collection vendor shall retain no more than the name
138.16 and date and time the subject's fingerprints were recorded and sent, only as necessary for
138.17 auditing and billing activities.

138.18 (f) For any background study conducted under this chapter, the subject shall provide the
138.19 commissioner with a set of classifiable fingerprints when the commissioner has reasonable
138.20 cause to require a national criminal history record check as defined in section 245C.02,
138.21 subdivision 15a.

138.22 Sec. 5. Minnesota Statutes 2020, section 245C.08, subdivision 1, is amended to read:

138.23 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
138.24 For a background study conducted by the Department of Human Services, the commissioner
138.25 shall review:

138.26 (1) information related to names of substantiated perpetrators of maltreatment of
138.27 vulnerable adults that has been received by the commissioner as required under section
138.28 626.557, subdivision 9c, paragraph (j);

138.29 (2) the commissioner's records relating to the maltreatment of minors in licensed
138.30 programs, and from findings of maltreatment of minors as indicated through the social
138.31 service information system;

138.32 (3) information from juvenile courts as required in subdivision 4 for individuals listed
138.33 in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

139.1 (4) information from the Bureau of Criminal Apprehension, including information
139.2 regarding a background study subject's registration in Minnesota as a predatory offender
139.3 under section 243.166;

139.4 (5) except as provided in clause (6), information received as a result of submission of
139.5 fingerprints for a national criminal history record check, as defined in section 245C.02,
139.6 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
139.7 record check as defined under section 245C.02, subdivision 15a, or as required under section
139.8 144.057, subdivision 1, paragraph (a), clause (2);

139.9 (6) for a background study related to a child foster family setting application for licensure,
139.10 foster residence settings, children's residential facilities, a transfer of permanent legal and
139.11 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a
139.12 background study required for family child care, certified license-exempt child care, child
139.13 care centers, and legal nonlicensed child care authorized under chapter 119B, the
139.14 commissioner shall also review:

139.15 (i) information from the child abuse and neglect registry for any state in which the
139.16 background study subject has resided for the past five years;

139.17 (ii) when the background study subject is 18 years of age or older, or a minor under
139.18 section 245C.05, subdivision 5a, paragraph (c), information received following submission
139.19 of fingerprints for a national criminal history record check; and

139.20 (iii) when the background study subject is 18 years of age or older or a minor under
139.21 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
139.22 license-exempt child care, licensed child care centers, and legal nonlicensed child care
139.23 authorized under chapter 119B, information obtained using non-fingerprint-based data
139.24 including information from the criminal and sex offender registries for any state in which
139.25 the background study subject resided for the past five years and information from the national
139.26 crime information database and the national sex offender registry; and

139.27 (7) for a background study required for family child care, certified license-exempt child
139.28 care centers, licensed child care centers, and legal nonlicensed child care authorized under
139.29 chapter 119B, the background study shall also include, to the extent practicable, a name
139.30 and date-of-birth search of the National Sex Offender Public website.

139.31 (b) Notwithstanding expungement by a court, the commissioner may consider information
139.32 obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice
139.33 of the petition for expungement and the court order for expungement is directed specifically
139.34 to the commissioner.

140.1 (c) The commissioner shall also review criminal case information received according
140.2 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
140.3 to individuals who have already been studied under this chapter and who remain affiliated
140.4 with the agency that initiated the background study.

140.5 (d) When the commissioner has reasonable cause to believe that the identity of a
140.6 background study subject is uncertain, the commissioner may require the subject to provide
140.7 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
140.8 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph
140.9 shall not be saved by the commissioner after they have been used to verify the identity of
140.10 the background study subject against the particular criminal record in question.

140.11 (e) The commissioner may inform the entity that initiated a background study under
140.12 NETStudy 2.0 of the status of processing of the subject's fingerprints.

140.13 Sec. 6. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

140.14 Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test
140.15 the NETStudy 2.0 system and implement it no later than September 1, 2015.

140.16 (b) The NETStudy 2.0 system developed and implemented by the commissioner shall
140.17 incorporate and meet all applicable data security standards and policies required by the
140.18 Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal
140.19 Apprehension, and the Office of MN.IT Services. The system shall meet all required
140.20 standards for encryption of data at the database level as well as encryption of data that
140.21 travels electronically among agencies initiating background studies, ~~the commissioner's~~
140.22 authorized fingerprint collection ~~vendor~~ vendors, the commissioner, the Bureau of Criminal
140.23 Apprehension, and in cases involving national criminal record checks, the FBI.

140.24 (c) The data system developed and implemented by the commissioner shall incorporate
140.25 a system of data security that allows the commissioner to control access to the data field
140.26 level by the commissioner's employees. The commissioner shall establish that employees
140.27 have access to the minimum amount of private data on any individual as is necessary to
140.28 perform their duties under this chapter.

140.29 (d) The commissioner shall oversee regular quality and compliance audits of ~~the~~
140.30 authorized fingerprint collection ~~vendor~~ vendors.

141.1 **Sec. 7. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ON-SITE**
 141.2 **BACKGROUND STUDY FINGERPRINTING.**

141.3 (a) The commissioner of human services shall contract with a qualified contractor to
 141.4 conduct on-site fingerprinting beginning August 1, 2021, at locations of employers with 50
 141.5 or more staff with outstanding background studies, including studies that have been delayed
 141.6 pursuant to the commissioner's modifications to background study requirements issued in
 141.7 response to the COVID-19 outbreak. The commissioner shall develop a list of employers
 141.8 with 50 or more staff who need fingerprints taken in order to complete a background study.
 141.9 The commissioner and the contractor shall coordinate to develop a plan to identify which
 141.10 employer locations the contractor shall serve and inform those employers and staff of the
 141.11 timing and nature of the contractor's services.

141.12 (b) The commissioner may contract with the qualified contractor to provide services
 141.13 under paragraph (a) up to the date of the expiration of the modification in CV23: modifying
 141.14 certain background study requirements, issued by the commissioner of human services
 141.15 pursuant to Executive Orders 20-11 and 20-12.

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

141.17 **ARTICLE 7**

141.18 **MISCELLANEOUS**

141.19 **Section 1. [62A.082] NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

141.20 Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have
 141.21 the meanings given unless the context clearly requires otherwise.

141.22 (b) "Disability" has the meaning given in section 363A.03, subdivision 12.

141.23 (c) "Enrollee" means a natural person covered by a health plan or group health plan and
 141.24 includes an insured, policy holder, subscriber, covered person, member, contract holder, or
 141.25 certificate holder.

141.26 (d) "Organ transplant" means the transplantation or transfusion of a part of a human
 141.27 body into the body of another for the purpose of treating or curing a medical condition.

141.28 Subd. 2. **Transplant discrimination prohibited.** A health plan or group health plan
 141.29 that provides coverage for anatomical gifts, organ transplants, or related treatment and
 141.30 services shall not:

141.31 (1) deny coverage to an enrollee based on the enrollee's disability;

142.1 (2) deny eligibility, or continued eligibility, to enroll or to renew coverage under the
 142.2 terms of the health plan or group health plan solely for the purpose of avoiding the
 142.3 requirements of this section;

142.4 (3) penalize or otherwise reduce or limit the reimbursement of a health care provider,
 142.5 or provide monetary or nonmonetary incentives to a health care provider, to induce the
 142.6 provider to provide care to a patient in a manner inconsistent with this section; or

142.7 (4) reduce or limit an enrollee's coverage benefits because of the enrollee's disability for
 142.8 medical services and other services related to organ transplantation performed pursuant to
 142.9 this section as determined in consultation with the enrollee's treating health care provider
 142.10 and the enrollee.

142.11 Subd. 3. **Collective bargaining.** In the case of a group health plan maintained pursuant
 142.12 to one or more collective bargaining agreements between employee representatives and one
 142.13 or more employers, any plan amendment made pursuant to a collective bargaining agreement
 142.14 relating to the plan which amends the plan solely to conform to any requirement imposed
 142.15 pursuant to this section shall not be treated as a termination of the collective bargaining
 142.16 agreement.

142.17 Subd. 4. **Coverage limitation.** Nothing in this section shall be deemed to require a health
 142.18 plan or group health plan to provide coverage for a medically inappropriate organ transplant.

142.19 Sec. 2. Minnesota Statutes 2020, section 260E.31, subdivision 1, is amended to read:

142.20 Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person
 142.21 mandated to report under this chapter shall immediately report to the local welfare agency
 142.22 if the person knows or has reason to believe that a woman is pregnant and has used a
 142.23 controlled substance for a nonmedical purpose during the pregnancy, including but not
 142.24 limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy
 142.25 in any way that is habitual or excessive.

142.26 (b) A health care professional or a social service professional who is mandated to report
 142.27 under this chapter is exempt from reporting under paragraph (a) ~~a woman's use or~~
 142.28 ~~consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy~~ if the
 142.29 professional is providing or collaborating with other professionals to provide the woman
 142.30 with prenatal care, postpartum care, or other health care services, including care of the
 142.31 woman's infant. If the woman does not continue to receive regular prenatal or postpartum
 142.32 care, after the woman's health care professional has made attempts to contact the woman,
 142.33 then the professional is required to report under paragraph (a).

143.1 (c) Any person may make a voluntary report if the person knows or has reason to believe
 143.2 that a woman is pregnant and has used a controlled substance for a nonmedical purpose
 143.3 during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed
 143.4 alcoholic beverages during the pregnancy in any way that is habitual or excessive.

143.5 (d) An oral report shall be made immediately by telephone or otherwise. An oral report
 143.6 made by a person required to report shall be followed within 72 hours, exclusive of weekends
 143.7 and holidays, by a report in writing to the local welfare agency. Any report shall be of
 143.8 sufficient content to identify the pregnant woman, the nature and extent of the use, if known,
 143.9 and the name and address of the reporter. The local welfare agency shall accept a report
 143.10 made under paragraph (c) notwithstanding refusal by a voluntary reporter to provide the
 143.11 reporter's name or address as long as the report is otherwise sufficient.

143.12 (e) For purposes of this section, "prenatal care" means the comprehensive package of
 143.13 medical and psychological support provided throughout the pregnancy.

143.14 **Sec. 3. [363A.50] NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

143.15 **Subdivision 1. Definitions.** (a) For purposes of this section, the following terms have
 143.16 the meanings given unless the context clearly requires otherwise.

143.17 (b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

143.18 (c) "Auxiliary aids and services" include, but are not limited to:

143.19 (1) qualified interpreters or other effective methods of making aurally delivered materials
 143.20 available to individuals with hearing impairments;

143.21 (2) qualified readers, taped texts, texts in accessible electronic format, or other effective
 143.22 methods of making visually delivered materials available to individuals with visual
 143.23 impairments;

143.24 (3) the provision of information in a format that is accessible for individuals with
 143.25 cognitive, neurological, developmental, intellectual, or physical disabilities;

143.26 (4) the provision of supported decision-making services; and

143.27 (5) the acquisition or modification of equipment or devices.

143.28 (d) "Covered entity" means:

143.29 (1) any licensed provider of health care services, including licensed health care
 143.30 practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric

144.1 residential treatment facilities, institutions for individuals with intellectual or developmental
 144.2 disabilities, and prison health centers; or

144.3 (2) any entity responsible for matching anatomical gift donors to potential recipients.

144.4 (e) "Disability" has the meaning given in section 363A.03, subdivision 12.

144.5 (f) "Organ transplant" means the transplantation or infusion of a part of a human body
 144.6 into the body of another for the purpose of treating or curing a medical condition.

144.7 (g) "Qualified individual" means an individual who, with or without available support
 144.8 networks, the provision of auxiliary aids and services, or reasonable modifications to policies
 144.9 or practices, meets the essential eligibility requirements for the receipt of an anatomical
 144.10 gift.

144.11 (h) "Reasonable modifications" include, but are not limited to:

144.12 (1) communication with individuals responsible for supporting an individual with
 144.13 postsurgical and post-transplantation care, including medication; and

144.14 (2) consideration of support networks available to the individual, including family,
 144.15 friends, and home and community-based services, including home and community-based
 144.16 services funded through Medicaid, Medicare, another health plan in which the individual
 144.17 is enrolled, or any program or source of funding available to the individual, in determining
 144.18 whether the individual is able to comply with post-transplant medical requirements.

144.19 (i) "Supported decision making" has the meaning given in section 524.5-102, subdivision
 144.20 16a.

144.21 Subd. 2. **Prohibition of discrimination.** (a) A covered entity may not on the basis of a
 144.22 qualified individual's mental or physical disability:

144.23 (1) deem an individual ineligible to receive an anatomical gift or organ transplant;

144.24 (2) deny medical or related organ transplantation services, including evaluation, surgery,
 144.25 counseling, and postoperative treatment and care;

144.26 (3) refuse to refer the individual to a transplant center or other related specialist for the
 144.27 purpose of evaluation or receipt of an anatomical gift or organ transplant;

144.28 (4) refuse to place an individual on an organ transplant waiting list or place the individual
 144.29 at a lower-priority position on the list than the position at which the individual would have
 144.30 been placed if not for the individual's disability; or

145.1 (5) decline insurance coverage for any procedure associated with the receipt of the
145.2 anatomical gift or organ transplant, including post-transplantation and postinfusion care.

145.3 (b) Notwithstanding paragraph (a), a covered entity may take an individual's disability
145.4 into account when making treatment or coverage recommendations or decisions, solely to
145.5 the extent that the physical or mental disability has been found by a physician, following
145.6 an individualized evaluation of the potential recipient to be medically significant to the
145.7 provision of the anatomical gift or organ transplant. The provisions of this section may not
145.8 be deemed to require referrals or recommendations for, or the performance of, medically
145.9 inappropriate organ transplants.

145.10 (c) If an individual has the necessary support system to assist the individual in complying
145.11 with post-transplant medical requirements, an individual's inability to independently comply
145.12 with those requirements may not be deemed to be medically significant for the purposes of
145.13 paragraph (b).

145.14 (d) A covered entity must make reasonable modifications to policies, practices, or
145.15 procedures, when such modifications are necessary to make services such as
145.16 transplantation-related counseling, information, coverage, or treatment available to qualified
145.17 individuals with disabilities, unless the entity can demonstrate that making such modifications
145.18 would fundamentally alter the nature of such services.

145.19 (e) A covered entity must take such steps as may be necessary to ensure that no qualified
145.20 individual with a disability is denied services such as transplantation-related counseling,
145.21 information, coverage, or treatment because of the absence of auxiliary aids and services,
145.22 unless the entity can demonstrate that taking such steps would fundamentally alter the nature
145.23 of the services being offered or result in an undue burden.

145.24 (f) A covered entity must otherwise comply with the requirements of Titles II and III of
145.25 the Americans with Disabilities Act of 1990, the Americans with Disabilities Act
145.26 Amendments Act of 2008, and the Minnesota Human Rights Act.

145.27 (g) The provisions of this section apply to each part of the organ transplant process.

145.28 Subd. 3. Remedies. In addition to all other remedies available under this chapter, any
145.29 individual who has been subjected to discrimination in violation of this section may initiate
145.30 a civil action in a court of competent jurisdiction to enjoin violations of this section.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet the rate increase required under section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

144E.27 EDUCATION PROGRAMS; BOARD APPROVAL.

Subdivision 1. **Education program instructor.** An education program instructor must be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.

Subd. 1a. **Approval required.** (a) All education programs for an emergency medical responder must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

(iii) admission criteria for students; and

(iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to Emergency Medical Responder registration education;

(3) have a program medical director and a program coordinator;

(4) have at least one instructor for every ten students at the practical skill stations;

(5) retain documentation of program approval by the board, course outline, and student information; and

(6) submit the appropriate fee as required under section 144E.29.

(c) The National EMS Education Standards by the NHTSA, United States Department of Transportation contains the minimal entry level of knowledge and skills for emergency medical responders. Medical directors of emergency medical responder groups may expand the knowledge and skill set.

151.19 REGISTRATION; FEES.

Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not licensed as a pharmacy or a practitioner must not engage in the retail sale or dispensing of federally restricted medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration must be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board. It is unlawful for a person to sell or dispense federally restricted medical gases unless a certificate has been issued to that person by the board.

(b) Application for a medical gas dispenser registration under this section must be made in a manner specified by the board.

(c) A registration must not be issued or renewed for a medical gas dispenser located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. A license must not be issued for a medical gas dispenser

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located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when dispensing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) A registration must not be issued or renewed for a medical gas dispenser that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may, by rule, establish standards for the registration of a medical gas dispenser that is not required to be licensed or registered by the state in which it is physically located.

(e) The board must require a separate registration for each medical gas dispenser located within the state and for each facility located outside of the state from which medical gases are dispensed to residents of this state.

(f) Prior to the issuance of an initial or renewed registration for a medical gas dispenser, the board may require the medical gas dispenser to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas dispenser located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.