

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

S.F. No. 4014

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/14/2022	5319	Introduction and first reading Referred to Health and Human Services Finance and Policy

1.1 A bill for an act

1.2 relating to state government; appropriating money for the Department of Health

1.3 and the Board of Dietetics and Nutrition Practice; amending certain health

1.4 provisions for health care spending, health plan companies, balanced billing, rural

1.5 health care, health care providers, suicide prevention, AIDS prevention, community

1.6 health workers, health disparities, and long-term care facilities; establishing certain

1.7 fees and surcharges, health professional education and loan forgiveness, and

1.8 prescription drugs; requiring compliance with federal No Surprises Act; establishing

1.9 Advisory Council on Water Supply Systems and Wastewater Treatment Facilities,

1.10 Sentinel Event Review Committee, Law-Enforcement-Involved Deadly Force

1.11 Encounter Community Advisory Committee, Long COVID Surveillance System,

1.12 Mercury Surveillance System, and Healthy Beginnings, Healthy Families Act;

1.13 establishing grants for health professions training sites, primary rural residency

1.14 training, clinical health care training, drug overdose and substance abuse prevention,

1.15 climate resiliency, healthy child development, lead remediation, community healing,

1.16 chronic disease prevention and health disparities, public health education, public

1.17 health Americorps, Minnesota School Health Initiative, and skin-lightening products

1.18 public awareness and education; requiring reports; amending Minnesota Statutes

1.19 2020, sections 62J.84, subdivisions 2, 7, 8, by adding subdivisions; 62Q.021, by

1.20 adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56, subdivision 2;

1.21 62Q.73, subdivision 7; 144.122; 144.1501, as amended; 144.1505, subdivision 2;

1.22 144.383; 144.554; 145.56, by adding subdivisions; 145.924; 403.161, subdivisions

1.23 1, 3, 5, 6; Minnesota Statutes 2021 Supplement, sections 62J.84, subdivisions 6,

1.24 9; 403.11, subdivision 1; Laws 2021, First Special Session chapter 7, article 3,

1.25 section 44; proposing coding for new law in Minnesota Statutes, chapters 62J;

1.26 115; 144; 145.

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

2.2 **ARTICLE 1**

2.3 **HEALTH POLICY**

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

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

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

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

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

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

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

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

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

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

2.19 (8) one member appointed by medical care systems;

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

2.21 (10) one member appointed by health plan companies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.32 (1) establishing a statement of purpose;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.6 (5) complete reports as outlined in subdivision 10.

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

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

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

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

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

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

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

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

5.29 (3) providing analytical support, including:

5.30 (i) conducting background research or environmental scans;

5.31 (ii) evaluating the suitability of available data;

5.32 (iii) performing needed analysis and data modeling;

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

6.2 (v) researching drivers of spending growth trends;

6.3 (4) synthesizing and reporting to the commission;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 8.1 (1) two members representing patients and health care consumers, at least one of whom
 8.2 must have experience working with communities experiencing health disparities;
- 8.3 (2) the commissioner of health or a designee;
- 8.4 (3) the commissioner of commerce or a designee;
- 8.5 (4) the commissioner of human services or a designee;
- 8.6 (5) the commissioner of management and budget or a designee;
- 8.7 (6) one member who is a health services researcher at the University of Minnesota;
- 8.8 (7) two members who represent nonprofit group purchasers;
- 8.9 (8) one member who represents for-profit group purchasers;
- 8.10 (9) two members who represent medical care systems;
- 8.11 (10) one member who represents independent health care providers; and
- 8.12 (11) two members who represent employee benefit plans.

8.13 Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September
 8.14 30, 2022. The initial appointed council members shall serve terms until September 30, 2026.

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

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

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

- 8.19 (1) provide technical advice to the commission relating to identifying metrics for health
 8.20 care spending growth targets;
- 8.21 (2) provide technical input on data sources for measuring health care spending; and
- 8.22 (3) advise the commission on how to measure the impact on communities most impacted
 8.23 by health disparities, the providers who primarily serve communities most impacted by
 8.24 health disparities, individuals with disabilities, individuals with health coverage through
 8.25 medical assistance or MinnesotaCare, and individuals who reside in rural areas.

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

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

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

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

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

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

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

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

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

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

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

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

10.8 (2) if, after taking the action in clause (1) compliance has not been achieved, the
10.9 commissioner of health shall notify the provider or facility that the provider or facility is in
10.10 violation of this section and that the commissioner is imposing a civil monetary penalty. If
10.11 the commissioner determines that more than one health care provider or facility was
10.12 responsible for a violation, the commissioner may impose a civil money penalty against
10.13 each health care provider or facility. The amount of a civil money penalty shall be up to
10.14 \$100 for each violation, but shall not exceed \$25,000 for identical violations during a
10.15 calendar year; and

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

10.20 (h) A health care provider or facility may contest whether the finding of facts constitute
10.21 a violation of this section according to the contested case proceeding in sections 14.57 to
10.22 14.62, subject to appeal according to sections 14.63 to 14.68.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.1 (d) The commissioners shall not post to the directory's website or portal any information
 12.2 described in this section if the information is not public data under section 13.02, subdivision
 12.3 8a.

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

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

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

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

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

12.14 (1) an original, new drug application approved under United States Code, title 21, section
 12.15 355(c), except for a generic drug as defined under Code of Federal Regulations, title 42,
 12.16 section 447.502; or

12.17 (2) a biologics license application approved under United States Code, title 45, section
 12.18 262(a)(c).

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

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

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

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

12.25 (2) an authorized generic as defined under Code of Federal Regulations, title 45, section
 12.26 447.502; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.8 (c) The commissioner shall not post to the department's website or a private entity
14.9 contracting with the commissioner shall not post any information described in this section
14.10 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
14.11 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
14.12 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
14.13 1836, as amended. If a manufacturer believes information should be withheld from public
14.14 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
14.15 that information and describe the legal basis in writing when the manufacturer submits the
14.16 information under this section. If the commissioner disagrees with the manufacturer's request
14.17 to withhold information from public disclosure, the commissioner shall provide the
14.18 manufacturer written notice that the information will be publicly posted 30 days after the
14.19 date of the notice.

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

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

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

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

15.1 of the information reported under this section; in posting information pursuant to subdivision
15.2 6; and in taking any other action for the purpose of implementing this section.

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

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

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

15.10 (1) failing to register under subdivision 15;

15.11 ~~(2)~~ (2) failing to submit timely reports or notices as required by this section;

15.12 ~~(2)~~ (3) failing to provide information required under this section; or

15.13 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17.3 (2) which the manufacturer manufactures or repackages;

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

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

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

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

17.11 (i) National Drug Code;

17.12 (ii) product name;

17.13 (iii) dosage form;

17.14 (iv) strength; and

17.15 (v) package size;

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

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

17.18 (ii) the introduced to market date; or

17.19 (iii) the acquisition date;

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

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

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

17.26 (i) to manufacture the prescription drug;

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

17.28 (iii) to distribute the prescription drug;

- 18.1 (6) the number of units of the prescription drug sold during the 12-month period prior
18.2 to the date of the notification to report;
- 18.3 (7) the total sales revenue for the prescription drug during the 12-month period prior to
18.4 the date of the notification to report;
- 18.5 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
18.6 period prior to the date of the notification to report;
- 18.7 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
18.8 period prior to the date of the notification to report;
- 18.9 (10) the total amount of financial assistance the manufacturer has provided through
18.10 patient prescription assistance programs during the 12-month period prior to the date of the
18.11 notification to report, if applicable;
- 18.12 (11) any agreement between a manufacturer and another entity contingent upon any
18.13 delay in offering to market a generic version of the prescription drug;
- 18.14 (12) the patent expiration date of the prescription drug if it is under patent;
- 18.15 (13) the name and location of the company that manufactured the drug;
- 18.16 (14) if a brand name prescription drug, the ten countries other than the United States
18.17 that paid the highest prices for the prescription drug during the previous calendar year and
18.18 their prices; and
- 18.19 (15) if the prescription drug was acquired by the manufacturer within the 12-month
18.20 period prior to the date of the notification to report, all of the following information:
- 18.21 (i) price at acquisition;
- 18.22 (ii) price in the calendar year prior to acquisition;
- 18.23 (iii) name of the company from which the drug was acquired;
- 18.24 (iv) date of acquisition; and
- 18.25 (v) acquisition price.
- 18.26 (c) The manufacturer may submit any documentation necessary to support the information
18.27 reported under this subdivision.

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

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

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

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

19.11 (i) National Drug Code;

19.12 (ii) product name;

19.13 (iii) dosage form;

19.14 (iv) strength; and

19.15 (v) package size;

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

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

19.20 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the
19.21 12-month period prior to the date of the notification to report;

19.22 (5) the number of pricing units of the drug dispensed by the pharmacy during the
19.23 12-month period prior to the date of the notification to report;

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

19.27 (7) the total rebate payable amount accrued by the pharmacy for the drug during the
19.28 12-month period prior to the date of the notification to report; and

19.29 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed
19.30 where no claim was submitted to a health care service plan or health insurer during the
19.31 12-month period prior to the date of the notification to report.

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

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

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

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

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

20.14 (i) National Drug Code;

20.15 (ii) product name;

20.16 (iii) dosage form;

20.17 (iv) strength; and

20.18 (v) package size;

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

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

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

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

20.29 (6) the total rebate payable amount accrued by the PBM for the drug product during the
20.30 12-month period prior to the date of the notification to report.

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

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

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

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

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

21.13 (i) National Drug Code;

21.14 (ii) product name;

21.15 (iii) dosage form;

21.16 (iv) strength; and

21.17 (v) package size;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23.2 **62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER**
 23.3 **PROTECTIONS AGAINST BALANCE BILLING.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.27 (i) an acute condition;

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

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

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

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

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

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

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

26.13 (1) is receiving culturally appropriate services and the health plan company does not
26.14 have a provider in its preferred provider network with special expertise in the delivery of
26.15 those culturally appropriate services within the time and distance requirements of section
26.16 62D.124, subdivision 1; or

26.17 (2) does not speak English and the health plan company does not have a provider in its
26.18 preferred provider network who can communicate with the enrollee, either directly or through
26.19 an interpreter, within the time and distance requirements of section 62D.124, subdivision
26.20 1.

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

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

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

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

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

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

27.3 (c) For an external review of any issue in an adverse determination by a health plan
27.4 company, other than a health plan company licensed under chapter 62D, that requires a
27.5 medical necessity determination, the external review must determine whether the adverse
27.6 determination was consistent with the definition of medically necessary care in section
27.7 62Q.53, subdivision 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29.23 (1) Bureau of Criminal Apprehension;

29.24 (2) Board of Peace Officer Standards and Training;

29.25 (3) Department of Health;

29.26 (4) Department of Human Rights;

29.27 (5) Department of Corrections;

29.28 (6) Department of Human Services;

29.29 (7) a Minnesota medical examiner or coroner; and

29.30 (8) two appointed members at large.

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

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

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

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

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

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

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

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

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

31.8 (b) The review team has access to the following not public data, as defined in section
31.9 13.02, subdivision 8a, relating to a case being reviewed by the SERC relating to the victim
31.10 or a family or household member of the victim: (1) inactive law enforcement investigative
31.11 data under section 13.82; (2) autopsy records and coroner or medical examiner investigative
31.12 data under section 13.83; (3) hospital, public health, or other medical records of the victim
31.13 under section 13.384; and (4) records under section 13.46, created by social service agencies
31.14 that provided services to the victim, the alleged perpetrator, or another victim who
31.15 experienced use of force or was threatened by the peace officer. Access to medical records
31.16 under this paragraph also includes records governed by sections 144.291 to 144.298. The
31.17 SERC has access to corrections and detention data as provided in section 13.85.

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

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

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

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

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

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

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

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

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

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

32.33 (ii) the LGBTQ+ community;

- 33.1 (iii) the disability community;
- 33.2 (iv) people affected by mental illness; and
- 33.3 (v) families and loved ones of persons who have died in law-enforcement-involved
- 33.4 deadly force encounter incidents;
- 33.5 (2) at least one academic partner with experience studying racial equity in health;
- 33.6 (3) a representative from the Department of Human Rights
- 33.7 (4) a representative from the Department of Public Safety;
- 33.8 (5) a representative from the Department of Human Services; and
- 33.9 (6) a representative from the Department of Health's Center for Health Equity.
- 33.10 (b) The advisory committee may also invite other relevant persons to serve on an ad hoc
- 33.11 basis and participate as full members of the review team for a particular review. These
- 33.12 persons may include but are not limited to:
- 33.13 (1) individuals with expertise that would be helpful to the review panel; or
- 33.14 (2) representatives of organizations or agencies that had contact with or provided services
- 33.15 to the decedent.
- 33.16 Subd. 3. **Duties.** The advisory committee shall:
- 33.17 (1) advise the commissioner and other state agencies on:
- 33.18 (i) health outcomes related to law-enforcement-involved deadly force encounter and
- 33.19 priorities for data collection and public health research;
- 33.20 (ii) specific communities and geographic areas on which to focus prevention efforts;
- 33.21 and
- 33.22 (iii) opportunities for community partnerships and sources of additional funding;
- 33.23 (2) develop goals and expectations for the Sentinel Event Review Committee (SERC)
- 33.24 that can be used in future evaluations;
- 33.25 (3) review and approve of reports and recommendations drafted by SERC; and
- 33.26 (4) review applications for community-based grants as described in section 144.0551,
- 33.27 subdivision 9, and make recommendations to the department about which should be funded.

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

34.2 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

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

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

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

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

34.30	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
34.31	Healthcare Organizations (JCAHO) and	
34.32	American Osteopathic Association (AOA)	
34.33	hospitals	
34.34	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
34.35	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
34.36		\$183 plus \$100 per bed between July 1, 2018,

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

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

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

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

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

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

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

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

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

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

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

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

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

36.25 **144.1501 HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS**
36.26 **PROGRAM.**

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

36.29 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
36.30 under section 150A.06, and who is certified as an advanced dental therapist under section
36.31 150A.106.

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

- 37.1 (d) "Dental therapist" means an individual who is licensed as a dental therapist under
37.2 section 150A.06.
- 37.3 (e) "Dentist" means an individual who is licensed to practice dentistry.
- 37.4 (f) "Designated rural area" means a statutory and home rule charter city or township that
37.5 is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,
37.6 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.
- 37.7 (g) "Emergency circumstances" means those conditions that make it impossible for the
37.8 participant to fulfill the service commitment, including death, total and permanent disability,
37.9 or temporary disability lasting more than two years.
- 37.10 (h) "Mental health professional" means an individual providing clinical services in the
37.11 treatment of mental illness who is qualified in at least one of the ways specified in section
37.12 245.462, subdivision 18.
- 37.13 (i) "Medical resident" means an individual participating in a medical residency in family
37.14 practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.
- 37.15 (j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist,
37.16 advanced clinical nurse specialist, or physician assistant.
- 37.17 (k) "Nurse" means an individual who has completed training and received all licensing
37.18 or certification necessary to perform duties as a licensed practical nurse or registered nurse.
- 37.19 (l) "Nurse-midwife" means a registered nurse who has graduated from a program of
37.20 study designed to prepare registered nurses for advanced practice as nurse-midwives.
- 37.21 (m) "Nurse practitioner" means a registered nurse who has graduated from a program
37.22 of study designed to prepare registered nurses for advanced practice as nurse practitioners.
- 37.23 (n) "Pharmacist" means an individual with a valid license issued under chapter 151.
- 37.24 (o) "Physician" means an individual who is licensed to practice medicine in the areas
37.25 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.
- 37.26 (p) "Physician assistant" means a person licensed under chapter 147A.
- 37.27 (q) "Public health employee" means an individual working in a local, Tribal, or state
37.28 public health department.
- 37.29 ~~(q)~~ (r) "Public health nurse" means a registered nurse licensed in Minnesota who has
37.30 obtained a registration certificate as a public health nurse from the Board of Nursing in
37.31 accordance with Minnesota Rules, chapter 6316.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40.1 area, facility type, teaching area, patient group, or specialty type specified in subdivision
40.2 2, except for funds for public health employees which will be distributed according to areas
40.3 of high need as determined by the commissioner. The commissioner shall allocate funds
40.4 for physician loan forgiveness so that 75 percent of the funds available are used for rural
40.5 physician loan forgiveness and 25 percent of the funds available are used for underserved
40.6 urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not
40.7 receive enough qualified applicants each year to use the entire allocation of funds for any
40.8 eligible profession, the remaining funds may be allocated proportionally among the other
40.9 eligible professions according to the vacancy rate for each profession in the required
40.10 geographic area, patient group, or facility type specified in subdivision 2. Applicants are
40.11 responsible for securing their own qualified educational loans. The commissioner shall
40.12 select participants based on their suitability for practice serving the required geographic
40.13 area or facility type specified in subdivision 2, as indicated by experience or training. The
40.14 commissioner shall give preference to applicants closest to completing their training. For
40.15 each year that a participant meets the service obligation required under subdivision 3, up
40.16 to a maximum of four years, the commissioner shall make annual disbursements directly
40.17 to the participant equivalent to 15 percent of the average educational debt for indebted
40.18 graduates in their profession in the year closest to the applicant's selection for which
40.19 information is available, not to exceed the balance of the participant's qualifying educational
40.20 loans. Before receiving loan repayment disbursements and as requested, the participant
40.21 must complete and return to the commissioner a confirmation of practice form provided by
40.22 the commissioner verifying that the participant is practicing as required under subdivisions
40.23 2 and 3. The participant must provide the commissioner with verification that the full amount
40.24 of loan repayment disbursement received by the participant has been applied toward the
40.25 designated loans. After each disbursement, verification must be received by the commissioner
40.26 and approved before the next loan repayment disbursement is made. Participants who move
40.27 their practice remain eligible for loan repayment as long as they practice as required under
40.28 subdivision 2.

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

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

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

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

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

41.11 (b) Funds may be used for:

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

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

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

41.18 (4) travel and lodging for students;

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

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

41.21 (7) evaluations;

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

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

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

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

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

42.1 (1) is located in Minnesota;

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

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

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

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

42.12 **Subd. 2. Rural residency training program.** (a) The commissioner of health shall
42.13 award rural residency training program grants to eligible programs to plan and implement
42.14 rural residency training programs. A rural residency training program grant shall not exceed
42.15 \$250,000 per resident per year for the first year of planning and development, and \$225,000
42.16 for each of the following years.

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

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

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

42.21 (3) establishing new rural residency training programs;

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

42.23 (5) travel and lodging for new residents;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46.2 **144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.**

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

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

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

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

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

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

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

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

46.25 **144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND**
46.26 **FEES.**

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

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

47.4	Construction project total estimated cost	Fee
47.5	\$0 - \$10,000	\$30 <u>\$45</u>
47.6	\$10,001 - \$50,000	\$150 <u>\$225</u>
47.7	\$50,001 - \$100,000	\$300 <u>\$450</u>
47.8	\$100,001 - \$150,000	\$450 <u>\$675</u>
47.9	\$150,001 - \$200,000	\$600 <u>\$900</u>
47.10	\$200,001 - \$250,000	\$750 <u>\$1,125</u>
47.11	\$250,001 - \$300,000	\$900 <u>\$1,350</u>
47.12	\$300,001 - \$350,000	\$1,050 <u>\$1,575</u>
47.13	\$350,001 - \$400,000	\$1,200 <u>\$1,800</u>
47.14	\$400,001 - \$450,000	\$1,350 <u>\$2,025</u>
47.15	\$450,001 - \$500,000	\$1,500 <u>\$2,250</u>
47.16	\$500,001 - \$550,000	\$1,650 <u>\$2,475</u>
47.17	\$550,001 - \$600,000	\$1,800 <u>\$2,700</u>
47.18	\$600,001 - \$650,000	\$1,950 <u>\$2,925</u>
47.19	\$650,001 - \$700,000	\$2,100 <u>\$3,150</u>
47.20	\$700,001 - \$750,000	\$2,250 <u>\$3,375</u>
47.21	\$750,001 - \$800,000	\$2,400 <u>\$3,600</u>
47.22	\$800,001 - \$850,000	\$2,550 <u>\$3,825</u>
47.23	\$850,001 - \$900,000	\$2,700 <u>\$4,050</u>
47.24	\$900,001 - \$950,000	\$2,850 <u>\$4,275</u>
47.25	\$950,001 - \$1,000,000	\$3,000 <u>\$4,500</u>
47.26	\$1,000,001 - \$1,050,000	\$3,150 <u>\$4,725</u>
47.27	\$1,050,001 - \$1,100,000	\$3,300 <u>\$4,950</u>
47.28	\$1,100,001 - \$1,150,000	\$3,450 <u>\$5,175</u>
47.29	\$1,150,001 - \$1,200,000	\$3,600 <u>\$5,400</u>
47.30	\$1,200,001 - \$1,250,000	\$3,750 <u>\$5,625</u>
47.31	\$1,250,001 - \$1,300,000	\$3,900 <u>\$5,850</u>
47.32	\$1,300,001 - \$1,350,000	\$4,050 <u>\$6,075</u>
47.33	\$1,350,001 - \$1,400,000	\$4,200 <u>\$6,300</u>
47.34	\$1,400,001 - \$1,450,000	\$4,350 <u>\$6,525</u>
47.35	\$1,450,001 - \$1,500,000	\$4,500 <u>\$6,750</u>
47.36	\$1,500,001 and over	\$4,800 <u>\$7,200</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

49.14 (1) increase awareness of climate change;

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

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

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

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

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

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

- 50.1 (2) a description of the pathway between the plan or project and its impacts on health;
 50.2 (3) a description of the objectives, a work plan, and a timeline for implementation; and
 50.3 (4) the community or group the grant proposes to focus on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

52.9 (2) the urine creatinine level, if performed;

52.10 (3) the date the sample was collected;

52.11 (4) the results of the analysis;

52.12 (5) the date the sample was analyzed;

52.13 (6) the method of analysis used;

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

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

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

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

52.21 (1) date of first symptoms;

52.22 (2) primary signs and symptoms;

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

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

52.26 (5) other information pertinent to the case.

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

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

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

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

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

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

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

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

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

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

53.31 (2) the signs and symptoms of mercury poisoning;

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

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

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

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

54.7 (b) The grant application must include:

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

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

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

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

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

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

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

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

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

55.1 (c) "988 Hotline" or "Lifeline Center" means a state identified center that is a member
55.2 of the National Suicide Prevention Lifeline network that responds to statewide or regional
55.3 988 contacts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

56.10 (b) The account shall consist of:

56.11 (1) 988 telecommunications service surcharge imposed under subdivision 10;

56.12 (2) appropriations made by the state legislature;

56.13 (3) grants and gifts intended for deposit;

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

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

56.16 (c) Money in the account:

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

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

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

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

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

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

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

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

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

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

57.14 **145.924 AIDS PREVENTION GRANTS.**

57.15 (a) The commissioner may award grants to community health boards as defined in section
57.16 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
57.17 evaluation and counseling services to populations at risk for acquiring human
57.18 immunodeficiency virus infection, including, but not limited to, minorities, adolescents,
57.19 intravenous drug users, and homosexual men.

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

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

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

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

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

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

58.18 (2) reduce racial disparities in children's health and development from prenatal to grade
58.19 3; and

58.20 (3) promote racial and geographic equity.

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

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

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

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

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

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

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

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

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

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

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

59.14 (2) two members representing the Latino community;

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

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

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

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

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

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

59.25 (c) The community solutions advisory council shall:

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

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

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

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

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

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

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

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

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

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

60.15 Subd. 5. **Strategic consideration and priority of proposals; eligible populations;**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62.7 (3) promote racial and geographic equity.

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

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

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

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

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

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

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

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

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

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

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

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

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

63.4 **Subd. 4. Strategic consideration and priority of proposals; eligible populations;**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

67.13 (b) Grantee activities shall:

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

67.15 (2) be based on community input;

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

67.17 and

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

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

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

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

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

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

68.6 (1) partnership development and capacity building;

68.7 (2) Tribal support;

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

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

68.10 (5) health equity.

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

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

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

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

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

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

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

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

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

69.15 (b) The commissioner shall:

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

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

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

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

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

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

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

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

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

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

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

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

70.20 (1) parenting classes or groups;

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

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

70.23 (4) correctional staff training;

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

70.25 (6) family-focused reentry planning.

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

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

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

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

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

71.7 (2) partnership building and community engagement;

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

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

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

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

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

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

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

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

71.31 (1) health care providers;

72.1 (2) community clinics;

72.2 (3) hospitals;

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

72.4 (5) health care foundations or nonprofit organizations;

72.5 (6) higher education institutions; or

72.6 (7) local health departments.

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

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

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

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

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

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

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

72.24 (1) preventative health care;

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

72.26 (3) mental health care and crisis management;

72.27 (4) acute care for illness and injury;

72.28 (5) oral health care;

72.29 (6) vision care;

72.30 (7) nutritional counseling;

73.1 (8) substance abuse counseling;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

74.11 (4) promote and establish lifelong healthy behaviors.

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

74.14 Subd. 8. **Technical assistance and oversight.** (a) The commissioner shall provide
 74.15 content expertise, technical expertise, and training to grant recipients in subdivisions 6 and
 74.16 7.

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

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

74.22 (1) needs assessment;

74.23 (2) community engagement and capacity building;

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

74.25 (4) dental provider training in calibration;

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

74.27 (6) communications;

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

74.29 (8) health equity;

74.30 (9) data collection and analysis; and

75.1 (10) evaluation.

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

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

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

75.19 (c) The fee may not be more than 95 cents a month on or after July 1, 2010, for each
75.20 customer access line or other basic access service, including trunk equivalents as designated
75.21 by the Public Utilities Commission for access charge purposes and including wireless
75.22 telecommunications services. With the approval of the commissioner of management and
75.23 budget, the commissioner of public safety shall establish the amount of the fee within the
75.24 limits specified and inform the companies and carriers of the amount to be collected. When
75.25 the revenue bonds authorized under section 403.27, subdivision 1, have been fully paid or
75.26 defeased, the commissioner shall reduce the fee to reflect that debt service on the bonds is
75.27 no longer needed. The commissioner shall provide companies and carriers a minimum of
75.28 45 days' notice of each fee change. The fee must be the same for all customers, except that
75.29 the fee imposed under this subdivision does not apply to prepaid wireless telecommunications
75.30 service, which is instead subject to the fee imposed under section 403.161, subdivision 1,
75.31 paragraph (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

79.9 (b) "Eligible facility" means:

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

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

79.12 (3) a board and care facility that is not federally certified and is licensed under chapter
79.13 144; and

79.14 (4) a nursing home that is not federally certified and is licensed under chapter 144A.

79.15 (c) "Eligible project" means a modernization project to update, remodel or replace
79.16 outdated equipment, systems, technology, or physical spaces.

79.17 Subd. 3. Program. (a) The commissioner of health shall award improvement grants to
79.18 an eligible facility. An improvement grant shall not exceed \$1,250,000.

79.19 (b) Funds may be used to improve the safety, quality of care, and livability of aging
79.20 infrastructure in a Department of Health licensed eligible facility with an emphasis on
79.21 reducing the transmission risk of COVID-19 and other infections. Projects include but are
79.22 not limited to:

79.23 (1) heating, ventilation, and air-conditioning systems improvements to reduce airborne
79.24 exposures;

79.25 (2) physical space changes for infection control; and

79.26 (3) technology improvements to reduce social isolation and improve resident or client
79.27 well-being.

79.28 (c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not
79.29 lapse until expended by the grantee.

79.30 Subd. 4. Applications. An eligible facility seeking a grant shall apply to the
79.31 commissioner. The application must include a description of the resident population

80.1 demographics, the problem the proposed project will address, a description of the project
 80.2 including construction and remodeling drawings or specifications, sources of funds for the
 80.3 project, including any in-kind resources, uses of funds for the project, the results expected,
 80.4 and a plan to maintain or operate any facility or equipment included in the project. The
 80.5 applicant must describe achievable objectives, a timetable, and roles and capabilities of
 80.6 responsible individuals and organization. An applicant must submit to the commissioner
 80.7 evidence that competitive bidding was used to select contractors for the project.

80.8 Subd. 5. **Consideration of applications.** The commissioner shall review each application
 80.9 to determine if the application is complete and if the facility and the project are eligible for
 80.10 a grant. In evaluating applications, the commissioner shall develop a standardized scoring
 80.11 system that assesses: (1) the applicant's understanding of the problem, description of the
 80.12 project and the likelihood of a successful outcome of the project; (2) the extent to which
 80.13 the project will reduce the transmission of COVID-19; (3) the extent to which the applicant
 80.14 has demonstrated that it has made adequate provisions to ensure proper and efficient operation
 80.15 of the facility once the project is completed; (4) and other relevant factors as determined
 80.16 by the commissioner. During application review, the commissioner may request additional
 80.17 information about a proposed project, including information on project cost. Failure to
 80.18 provide the information requested disqualifies an applicant.

80.19 Subd. 6. **Program oversight.** The commissioner shall determine the amount of a grant
 80.20 to be given to an eligible facility based on the relative score of each eligible facility's
 80.21 application, other relevant factors discussed during the review, and the funds available to
 80.22 the commissioner. During the grant period and within one year after completion of the grant
 80.23 period, the commissioner may collect from an eligible facility receiving a grant, any
 80.24 information necessary to evaluate the program.

80.25 Subd. 7. **Expiration.** This section expires June 30, 2025.

80.26 Sec. 61. **REVISOR INSTRUCTION.**

80.27 The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article
 80.28 3, section 44, as Minnesota Statutes, section 144.1504. The revisor of statutes may make
 80.29 any necessary cross-reference changes.

80.30 **ARTICLE 2**

80.31 **HEALTH APPROPRIATIONS**

80.32 Section 1. **HEALTH APPROPRIATIONS.**

82.1 14, section 3, subdivision 2, paragraph (c),
82.2 clause (4), is reduced by \$1,321,000 in fiscal
82.3 year 2024 and is reduced by \$1,321,000 in
82.4 fiscal year 2025.

82.5 **(b) Address Growing Health Care Costs.**
82.6 \$0 in fiscal year 2022 and \$3,375,000 in fiscal
82.7 year 2023 are from the general fund for
82.8 initiatives aimed at addressing growth in
82.9 health care spending while ensuring stability
82.10 in rural health care programs under Minnesota
82.11 Statutes, section 62J.0411. The general fund
82.12 base for this appropriation is \$4,175,000 in
82.13 fiscal year 2024, and \$4,175,000 in fiscal year
82.14 2025.

82.15 **(c) Community Healing Program. \$0 in**
82.16 fiscal year 2022 and \$2,019,000 in fiscal year
82.17 2023 are from the general fund for the
82.18 community healing grant program under
82.19 Minnesota Statutes, section 145.9281. Of the
82.20 total appropriation in fiscal year 2023,
82.21 \$313,000 is for administration and \$1,706,000
82.22 is for grants. The general fund base for this
82.23 appropriation is \$1,514,000 in fiscal year 2024
82.24 and \$1,514,000 in fiscal year 2025, of which
82.25 \$310,000 is for administration and \$1,204,000
82.26 in each fiscal year is for grants.

82.27 **(d) Community Health Workers. \$0 in fiscal**
82.28 year 2022 and \$1,462,000 in fiscal year 2023
82.29 are from the general fund for a public health
82.30 approach to developing community health
82.31 workers across Minnesota, under Minnesota
82.32 Statutes, section 145.9282. Of the fiscal year
82.33 2023 appropriation, \$462,000 is for
82.34 administration and \$1,000,000 is for grants.
82.35 The general fund base for this appropriation

83.1 is \$1,097,000 in fiscal year 2024, of which
 83.2 \$337,000 is for administration and \$760,000
 83.3 is for grants, and \$1,098,000 in fiscal year
 83.4 2025, of which \$338,000 is for administration
 83.5 and \$760,000 is for grants.

83.6 **(e) Community Solutions for Healthy Child**
 83.7 **Development.** \$0 in fiscal year 2022 and
 83.8 \$10,000,000 in fiscal year 2023 are from the
 83.9 general fund for the community solutions for
 83.10 healthy child development grant program
 83.11 under Minnesota Statutes, section 145.9271.
 83.12 Of the fiscal year 2023 appropriation,
 83.13 \$1,250,000 is for administration and
 83.14 \$8,750,000 is for grants. The general fund base
 83.15 appropriation is \$10,000,000 in fiscal year
 83.16 2024 and \$10,000,000 in fiscal year 2025, of
 83.17 which \$1,250,000 is for administration and
 83.18 \$8,750,000 is for grants in each fiscal year.

83.19 **(f) Disability as a Health Equity Issue.** \$0
 83.20 is fiscal year 2022 and \$1,575,000 in fiscal
 83.21 year 2023 are from the general fund to reduce
 83.22 disability-related health disparities through
 83.23 collaboration and coordination between state
 83.24 and community partners under Minnesota
 83.25 Statutes, section 145.9283. Of the fiscal year
 83.26 2023 appropriation, \$1,130,000 is for
 83.27 administration and \$445,000 is for grants. The
 83.28 general fund base for this appropriation is
 83.29 \$1,585,000 in fiscal year 2024 and \$1,585,000
 83.30 in fiscal year 2025, of which \$1,140,000 is for
 83.31 administration and \$445,000 is for grants.

83.32 **(g) Drug Overdose and Substance Abuse**
 83.33 **Prevention.** \$0 in fiscal year 2022 and
 83.34 \$5,042,000 in fiscal year 2023 are from the
 83.35 general fund for a public health prevention

84.1 approach to drug overdose and substance use
84.2 disorder in Minnesota Statutes, section
84.3 144.8611. Of the total appropriation in fiscal
84.4 year 2023, \$921,000 is for administration and
84.5 \$4,121,000 is for grants.

84.6 (h) **Health Care Provider Directory.** \$0 in
84.7 fiscal year 2022 and \$1,000,000 in fiscal year
84.8 2023 are from the general fund for
84.9 development of a statewide health care
84.10 provider directory under Minnesota Statutes,
84.11 section 62J.821. The general fund base for this
84.12 appropriation is \$2,000,000 in fiscal year 2024
84.13 and \$7,000,000 in fiscal year 2025.

84.14 (i) **Healthy Beginnings, Healthy Families.**
84.15 \$0 in fiscal year 2022 and \$11,700,000 in
84.16 fiscal year 2023 are from the general fund for
84.17 Healthy Beginnings, Healthy Families services
84.18 under Minnesota Statutes, section 145.987.
84.19 The general fund base for this appropriation
84.20 is \$11,818,000 in fiscal year 2024 and
84.21 \$11,763,000 in fiscal year 2025. Of this total
84.22 appropriation:

84.23 (1) \$0 in fiscal year 2022 and \$7,510,000 in
84.24 fiscal year 2023 are from the general fund for
84.25 Minnesota Collaborative to Prevent Infant
84.26 Mortality under Minnesota Statutes, section
84.27 145.987, subdivisions 2, 3, and 4. Of the fiscal
84.28 year 2023 appropriation, \$1,535,000 is for
84.29 administration and \$5,975,000 is for grants.
84.30 The general fund base for this appropriation
84.31 is \$7,501,000 in fiscal year 2024, of which
84.32 \$1,526,000 is for administration and
84.33 \$5,975,000 is for grants, and \$7,501,000 in
84.34 fiscal year 2025, of which \$1,526,000 is for
84.35 administration and \$5,975,000 is for grants.

85.1 (2) \$0 in fiscal year 2022 and \$340,000 in
85.2 fiscal year 2023 are from the general fund for
85.3 Help Me Connect under Minnesota Statutes,
85.4 section 145.987, subdivisions 5 and 6. The
85.5 general fund base for this appropriation is
85.6 \$663,000 in fiscal year 2024 and \$663,000 in
85.7 fiscal year 2025.

85.8 (3) \$0 in fiscal year 2022 and \$1,940,000 in
85.9 fiscal year 2023 are from the general fund for
85.10 voluntary developmental and social-emotional
85.11 screening and follow-up under Minnesota
85.12 Statutes, section 145.987, subdivisions 7 and
85.13 8. Of the fiscal year 2023 appropriation,
85.14 \$1,190,000 is for administration and \$750,000
85.15 is for grants. The general fund base for this
85.16 appropriation is \$1,764,000 in fiscal year
85.17 2024, of which \$1,014,000 is for
85.18 administration and \$750,000 is for grants, and
85.19 \$1,764,000 in fiscal year 2025 of which
85.20 \$1,014,000 is for administration and \$750,000
85.21 is for grants.

85.22 (4) \$0 in fiscal year 2022 and \$1,910,000 in
85.23 fiscal year 2023 are from the general fund for
85.24 model jail practices for incarcerated parents
85.25 under Minnesota Statutes, section 145.987,
85.26 subdivisions 9, 10, and 11. Of the fiscal year
85.27 2023 appropriation, \$485,000 is for
85.28 administration and \$1,425,000 is for grants.
85.29 The general fund base for this appropriation
85.30 is \$1,890,000 in fiscal year 2024, of which
85.31 \$465,000 is for administration and \$1,425,000
85.32 is for grants, and \$1,835,000 in fiscal year
85.33 2025, of which \$410,000 is for administration
85.34 and \$1,425,000 is for grants.

86.1 (j) Home Visiting. \$0 in fiscal year 2022 and
86.2 \$126,700,000 in fiscal year 2023 are from the
86.3 general fund for statewide home visiting
86.4 services under Minnesota Statutes, section
86.5 145.87. The general fund base for this
86.6 appropriation is \$210,501,000 in fiscal year
86.7 2024 and \$313,599,000 in fiscal year 2025.
86.8 Of the total appropriation, ten percent is for
86.9 administration and 90 percent is for
86.10 implementation grants of home visiting
86.11 services to families.

86.12 (k) Long COVID. \$0 in fiscal year 2022 and
86.13 \$2,669,000 in fiscal year 2023 are from the
86.14 general fund for a public health approach to
86.15 supporting long COVID survivors under
86.16 Minnesota Statutes, section 145.361. Of the
86.17 fiscal year 2023 appropriation, \$2,119,000 is
86.18 for administration and \$550,000 is for grants.
86.19 The base for this appropriation is \$3,706,000
86.20 in fiscal year 2024 and \$3,706,000 in fiscal
86.21 year 2025, of which \$3,156,000 is for
86.22 administration and \$550,000 is for grants in
86.23 each fiscal year.

86.24 (l) Medical Education Research Cost
86.25 (MERC). Of the amount previously
86.26 appropriated in the general fund by Laws
86.27 2015, chapter 71, article 3, section 2, for the
86.28 MERC program, \$150,000 in fiscal year 2023
86.29 and each year thereafter is for the
86.30 administration of grants under Minnesota
86.31 Statutes, section 62J.692.

86.32 (m) No Surprises Act Enforcement. \$0 in
86.33 fiscal year 2022 and \$964,000 in fiscal year
86.34 2023 are from the general fund for
86.35 implementation of the federal No Surprises

87.1 Act portion of the Consolidated
87.2 Appropriations Act, 2021, under Minnesota
87.3 Statutes, section 62Q.021, subdivision 3. The
87.4 general fund base for this appropriation is
87.5 \$763,000 in fiscal year 2024 and \$757,000 in
87.6 fiscal year 2025.

87.7 (n) **Public Health Workforce.** \$0 in fiscal
87.8 year 2022 and \$2,185,000 in fiscal year 2023
87.9 are from the general fund for a public health
87.10 workforce retention and expansion. The
87.11 general fund base for this appropriation is
87.12 \$1,436,000 in fiscal year 2024 and \$1,437,000
87.13 in fiscal year 2025. Of this total appropriation:

87.14 (1) \$0 in fiscal year 2022 and \$800,000 in
87.15 fiscal year 2023 are from the general fund for
87.16 loan forgiveness for individuals working in
87.17 local, Tribal, or state public health departments
87.18 in Minnesota under Minnesota Statutes,
87.19 section 144.1501, which may be added to the
87.20 account annually under section 144.1501,
87.21 subdivision 2. The base for this appropriation
87.22 is \$400,000 in fiscal year 2024 and \$400,000
87.23 in fiscal year 2025.

87.24 (2) \$0 in fiscal year 2022 and \$1,000,000 in
87.25 fiscal year 2023 are from the general fund for
87.26 a public health AmeriCorps grant under
87.27 Minnesota Statutes, section 145.9292. The
87.28 base for this appropriation is \$750,000 in fiscal
87.29 year 2024 and \$750,000 in fiscal year 2025.

87.30 (3) \$0 in fiscal year 2022 and \$70,000 in fiscal
87.31 year 2023 are from the general fund for public
87.32 health education stipend grants under
87.33 Minnesota Statutes, section 145.9291. The
87.34 base for this appropriation is \$38,000 in fiscal
87.35 year 2024 and \$38,000 in fiscal year 2025.

88.1 (4) \$0 in fiscal year 2022 and \$315,000 in
88.2 fiscal year 2023 are from the general fund for
88.3 administration of the public health workforce
88.4 retention and expansion program. The base
88.5 for this appropriation is \$248,000 in fiscal year
88.6 2024 and \$249,000 in fiscal year 2025.

88.7 **(o) Revitalize Health Care Workforce. \$0**
88.8 **in fiscal year 2022 and \$22,000,000 in fiscal**
88.9 **year 2023 are from the health care access fund**
88.10 **to address challenges of Minnesota's health**
88.11 **care workforce. Of the total appropriation:**

88.12 (1) \$0 in fiscal year 2022 and \$2,073,000 in
88.13 fiscal year 2023 are from the health care
88.14 access fund for the health professionals
88.15 clinical training expansion and rural and
88.16 underserved clinical rotations grant program
88.17 under Minnesota Statutes, section 144.1505.

88.18 Of the total appropriation in fiscal year 2023,
88.19 \$423,000 is for administration and \$1,650,000
88.20 is for grants. Grant appropriations are available
88.21 until expended under Minnesota Statutes,
88.22 section 144.1505, subdivision 2.

88.23 (2) \$0 in fiscal year 2022 and \$4,507,000 in
88.24 fiscal year 2023 are from the health care
88.25 access fund for the primary care rural
88.26 residency training grant program under
88.27 Minnesota Statutes, section 144.1507. Of the
88.28 total appropriation in fiscal year 2023,
88.29 \$207,000 is for administration and \$4,300,000
88.30 is for grants. Grant appropriations are available
88.31 until expended under Minnesota Statutes,
88.32 section 144.1507, subdivision 2.

88.33 (3) \$0 in fiscal year 2022 and \$425,000 in
88.34 fiscal year 2023 are from the health care
88.35 access fund for workforce research that

89.1 provides needed information on status and
89.2 causes of workforce shortages, maldistribution
89.3 of health care providers in Minnesota, and
89.4 determinants of practicing in rural areas, under
89.5 Minnesota Statutes, section 144.051.

89.6 (4) \$0 in fiscal year 2022 and \$430,000 in
89.7 fiscal year 2023 are from the health care
89.8 access fund to the international medical
89.9 graduates assistance program under Minnesota
89.10 Statutes, section 144.1911, for international
89.11 immigrant medical graduates to fill a gap in
89.12 their preparedness for medical residencies or
89.13 transition to a new career making use of their
89.14 medical degrees. Of the total appropriation in
89.15 fiscal year 2023, \$55,000 is for administration
89.16 and \$375,000 is for grants.

89.17 (5) \$0 in fiscal year 2022 and \$12,565,000 in
89.18 fiscal year 2023 are from the health care
89.19 access fund for a grant program to health care
89.20 systems, hospitals, clinics, and other providers
89.21 to ensure the availability of clinical training
89.22 for students, residents, and graduate students
89.23 to meet health professions educational
89.24 requirements, under Minnesota Statutes,
89.25 section 144.1508. Of the total appropriation
89.26 in fiscal year 2023, \$565,000 is for
89.27 administration and \$12,000,000 is for grants.

89.28 (6) \$0 in fiscal year 2022 and \$2,000,000 in
89.29 fiscal year 2023 are from the health care
89.30 access fund for the mental health cultural
89.31 community continuing education grant
89.32 program, under Minnesota Statutes, section
89.33 144.1504. Of the total appropriation in fiscal
89.34 year 2023, \$460,000 is for administration and
89.35 \$1,540,000 is for grants.

90.1 (p) **School Health.** \$0 in fiscal year 2022 and
90.2 \$837,000 in fiscal year 2023 are from the
90.3 general fund for the School Health Initiative
90.4 under Minnesota Statutes, section 145.988.
90.5 The general fund base for this appropriation
90.6 is \$3,462,000 in fiscal year 2024, of which
90.7 \$1,212,000 is for administration and
90.8 \$2,250,000 is for grants and \$3,287,000 in
90.9 fiscal year 2025, of which \$1,037,000 is for
90.10 administration and \$2,250,000 is for grants.

90.11 (q) **Sentinel Event Reviews for**
90.12 **Police-Involved Deadly Force Encounters.**
90.13 \$0 in fiscal year 2022 and \$494,000 in fiscal
90.14 year 2023 are from the general fund for a
90.15 public health response to law
90.16 enforcement-involved deadly force encounters
90.17 under Minnesota Statutes, section 144.0551.
90.18 Of the fiscal year 2023 appropriation,
90.19 \$444,000 is for administration of the sentinel
90.20 event reviews and \$50,000 is for a grant.

90.21 (r) **Trauma System.** \$0 in fiscal year 2022
90.22 and \$61,000 in fiscal year 2023 are from the
90.23 general fund to administer the trauma care
90.24 system throughout the state under Minnesota
90.25 Statutes, sections 144.602, 144.603, 144.604,
90.26 144.606, and 144.608. \$0 in fiscal year 2022
90.27 and \$430,000 in fiscal year 2023 are from the
90.28 state government special revenue fund for
90.29 trauma designations per Minnesota Statutes,
90.30 sections 144.122, paragraph (g), 144.605, and
90.31 144.6071.

90.32 (s) **Base Level Adjustments.** The general
90.33 fund base is increased by \$259,800,000 in
90.34 fiscal year 2024 and \$367,664,000 in fiscal
90.35 year 2025. The health care access fund base

91.1 is increased by \$22,000,000 in fiscal year 2024
 91.2 and \$22,000,000 in fiscal year 2025. The state
 91.3 government special revenue fund base is
 91.4 increased by \$430,000 in fiscal year 2024 and
 91.5 \$430,000 in fiscal year 2025.

91.6 **Subd. 3. Health Protection**

91.7 Appropriations by Fund

91.8	<u>General</u>	<u>14,989,000</u>
91.9	<u>State Government</u>		
91.10	<u>Special Revenue</u>	<u>4,167,000</u>

91.11 (a) Climate Resiliency. \$0 in fiscal year 2022
 91.12 and \$1,977,000 in fiscal year 2023 are from
 91.13 the general fund for climate resiliency actions
 91.14 under Minnesota Statutes, section 144.9981.
 91.15 Of the fiscal year 2023 appropriation,
 91.16 \$977,000 is for administration and \$1,000,000
 91.17 is for grants. The general fund base for this
 91.18 appropriation is \$988,000 in fiscal year 2024,
 91.19 of which \$888,000 is for administration and
 91.20 \$100,000 is for grants, and \$989,000 in fiscal
 91.21 year 2025, of which \$889,000 is for
 91.22 administration and \$100,000 is for grants.

91.23 **(b) Lead Remediation in Schools and Child**

91.24 **Care Settings. \$0 in fiscal year 2022 and**
 91.25 **\$2,054,000 in fiscal year 2023 are from the**
 91.26 **general fund for a lead in drinking water**
 91.27 **remediation in schools and child care settings**
 91.28 **grant program under Minnesota Statutes,**
 91.29 **section 145.9272. Of the total fiscal year 2023**
 91.30 **appropriation, \$454,000 is for administration**
 91.31 **and \$1,600,000 is for grants. The general fund**
 91.32 **base for this appropriation is \$1,540,000 in**
 91.33 **fiscal year 2024, of which \$370,000 is for**
 91.34 **administration and \$1,170,000 is for grants,**
 91.35 **and \$1,541,000 in fiscal year 2025, of which**

92.1 \$371,000 is for administration and \$1,170,000
92.2 is for grants.

92.3 **(c) Lead Service Line Inventory.** \$0 in fiscal
92.4 year 2022 and \$4,029,000 in fiscal year 2023
92.5 are from the general fund for grants to public
92.6 water suppliers to complete a lead service line
92.7 inventory of their distribution systems under
92.8 Minnesota Statutes, section 144.383, clause
92.9 (6). Of the total fiscal year 2023 appropriation,
92.10 \$279,000 is for administration and \$3,750,000
92.11 is for grants. The general fund base for this
92.12 appropriation is \$4,029,000 in fiscal year
92.13 2024, of which \$279,000 is for administration
92.14 and \$3,750,000 is for grants, and \$140,000 in
92.15 fiscal year 2025, which is for administration.

92.16 **(d) Mercury in Skin-Lightening Products**
92.17 **Grants.** \$0 in fiscal year 2022 and \$300,000
92.18 in fiscal year 2023 are from the general fund
92.19 for a skin-lightening products public
92.20 awareness and education grant program under
92.21 Minnesota Statutes, section 145.372. Of the
92.22 fiscal year 2023 appropriation, \$150,000 is
92.23 for administration and \$150,000 is for grants.

92.24 **(e) HIV Prevention for People Experiencing**
92.25 **Homelessness.** \$0 in fiscal year 2022 and
92.26 \$1,129,000 in fiscal year 2023 from the
92.27 general fund for expanding access to harm
92.28 reduction services and improving linkages to
92.29 care to prevent HIV/AIDS, hepatitis, and other
92.30 infectious diseases for those experiencing
92.31 homelessness or housing instability under
92.32 Minnesota Statutes, section 145.924,
92.33 paragraph (d). Of the total fiscal year 2023
92.34 appropriation, \$169,000 is for administration
92.35 and \$960,000 is for grants.

93.1 **(f) Safety Improvements for State-Licensed**
 93.2 **Long-Term Care Facilities.** \$0 in fiscal year
 93.3 2022 and \$5,500,000 in fiscal year 2023 are
 93.4 from the general fund for a temporary grant
 93.5 program. Of the total appropriation in fiscal
 93.6 year 2023, \$500,000 is for administration and
 93.7 \$5,000,000 is for grants. The general fund base
 93.8 for this appropriation is \$8,200,000 in fiscal
 93.9 year 2024 and \$0 in fiscal year 2025. Of the
 93.10 total appropriation in fiscal year 2024,
 93.11 \$700,000 is for administration and \$7,500,000
 93.12 is for grants. Amounts appropriated in this
 93.13 paragraph are available until June 30, 2025.

93.14 **(g) Base Level Adjustments.** The general
 93.15 fund base is increased by \$16,186,000 in fiscal
 93.16 year 2024 and \$4,099,000 in fiscal year 2025.
 93.17 The state government special revenue fund
 93.18 base is increased by \$4,167,000 in fiscal year
 93.19 2024 and \$4,167,000 in fiscal year 2025.

93.20 **Sec. 3. HEALTH-RELATED BOARDS**

93.21	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>-0-</u>	<u>\$</u>	<u>25,000</u>
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93.22 Appropriations by Fund

93.23	<u>State Government</u>				
93.24	<u>Special Revenue</u>	<u>-0-</u>		<u>25,000</u>	

93.25 This appropriation is from the state
 93.26 government special revenue fund unless
 93.27 specified otherwise. The amounts that may be
 93.28 spent for each purpose are specified in the
 93.29 following subdivisions.

93.30	<u>Subd. 2. Board of Dietetics and Nutrition</u>				
93.31	<u>Practice</u>		<u>-0-</u>		<u>25,000</u>