SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 981

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
02/15/2021	386	Introduction and first reading Referred to Health and Human Services Finance and Policy See HF2128, Art. 3, Sec. 1-4, 11-15, 44-47, 49 See First Special Session 2021, HF33, Art. 3, Sec. 1-4, 20

A bill for an act

relating to health; appropriating money for the Department of Health, health operations, and health-related boards, councils, and ombudsman; making health policy changes to electronic health records, health care information exchange, radiation hazard application fees, tests for infants for medical conditions, maternal morbidity and death studies, fetal and infant death studies, and asbestos abatement; amending Minnesota Statutes 2020, sections 62J.495, subdivisions 1, 2, 3, 4; 62J.498; 62J.4981; 62J.4982; 144.1205, subdivisions 2, 4, 8, 9, by adding a subdivision; 144.125, subdivision 1; 145.901; 326.71, subdivision 4; 326.75, subdivisions 1, 2, 3; Laws 2019, First Special Session chapter 9, article 14, section 3, as amended; proposing coding for new law in Minnesota Statutes, chapter 145.

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

ARTICLE 1

HEALTH AND HEALTH-BOARD APPROPRIATIONS

Section 1. **APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2022" and "2023" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2022, or June 30, 2023, respectively. "The first year" is fiscal year 2022. "The second year" is fiscal year 2023. "The biennium" is fiscal years 2022 and 2023.

APPROPRIATIONS

Available for the Year

		Ending June 30	
		2022	**2023**
Sec. 2. **COMMISSIONER OF HEALTH**			
Subdivision 1. **Total Appropriation**	**$**	**250,023,000**	**$** **249,704,000**

Appropriations by Fund

	2022	2023
General	132,347,000	132,324,000
State Government Special Revenue	68,451,000	68,835,000
Health Care Access	37,512,000	36,832,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	95,690,000	95,877,000
State Government Special Revenue	9,140,000	9,140,000
Health Care Access	37,512,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2022 and $3,579,000 in fiscal year 2023 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2022 and $2,000,000 in fiscal year 2023 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under

Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2022 and $4,978,000 in fiscal year 2023 are from the TANF fund for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2022 and $1,156,000 in fiscal year 2023 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Fetal and Infant Mortality Review.** $311,000 in fiscal year 2022 and $311,000 in fiscal year 2023 are appropriated from the general fund to the commissioner of health to

be used to conduct fetal and infant mortality reviews under Minnesota Statutes, section 145.9011.

(d) **Maternal Morbidity and Death Studies.** $198,000 in fiscal year 2022 and $198,000 in fiscal year 2023 are appropriated from the general fund to the commissioner of health to be used to conduct maternal morbidity and death studies under Minnesota Statutes, section 145.901.

(e) **Transfer.** The $77,000 transfer each year from the state government special revenue fund to the general fund as required by Laws 2008, chapter 364, section 17, paragraph (b), is canceled effective June 30, 2021.

(f) **MERC Program.** The general fund appropriation for distribution via the Medical Education and Research Cost formula under Minnesota Statutes, section 62J.692, subdivision 4, is $0 in fiscal years 2022 and 2023.

(g) **Base Level Adjustments.** The general fund base is $94,877,000 in fiscal year 2024 and $94,877,000 in fiscal year 2025. The state government special revenue fund base is $9,140,000 in fiscal year 2024 and $9,140,000 in fiscal year 2025. The health care access fund base is $37,432,000 in fiscal year 2024 and $36,832,000 in fiscal year 2025.

Subd. 3. **Health Protection**

	Appropriations by Fund	
General	25,087,000	24,868,000
State Government Special Revenue	59,311,000	59,695,000

Base Level Adjustments. The general fund base is $24,868,000 in fiscal year 2024 and $24,868,000 in fiscal year 2025. The state government special revenue fund base is $59,695,000 in fiscal year 2024 and $59,695,000 in fiscal year 2025.

Subd. 4. **Health Operations** 11,570,000 11,579,000

Sec. 3. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation** **$ 27,507,000 $ 26,943,000**

Appropriations by Fund

State Government Special Revenue	27,431,000	26,867,000
Health Care Access	76,000	76,000

This appropriation is from the state government special revenue fund unless specified otherwise. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners** 666,000 666,000

Subd. 3. **Board of Dentistry** 4,228,000 3,753,000

(a) **Administrative Services Unit - Operating Costs.** Of this appropriation, $2,738,000 in fiscal year 2022 and $2,263,000 in fiscal year 2023 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative Services Unit - Volunteer Health Care Provider Program.** Of this appropriation, $150,000 in fiscal year 2022 and $150,000 in fiscal year 2023 are to pay for medical professional liability coverage

required under Minnesota Statutes, section 214.40.

(c) **Administrative Services Unit - Retirement Costs.** Of this appropriation, $475,000 in fiscal year 2022 is a onetime appropriation to the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. These funds are available either year of the biennium.

(d) **Administrative Services Unit - Contested Cases and Other Legal Proceedings.** Of this appropriation, $200,000 in fiscal year 2022 and $200,000 in fiscal year 2023 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this

paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 4. **Board of Dietetics and Nutrition Practice**	164,000	164,000
Subd. 5. **Board of Marriage and Family Therapy**	406,000	406,000
Subd. 6. **Board of Medical Practice**	5,912,000	5,868,000

Health Professional Services Program. This appropriation includes $1,002,000 in fiscal year 2022 and $1,002,000 in fiscal year 2023 for the health professional services program.

Subd. 7. **Board of Nursing**	5,345,000	5,355,000
Subd. 8. **Board of Executives for Long Term Services and Supports**	693,000	635,000
Subd. 9. **Board of Optometry**	238,000	238,000
Subd. 10. **Board of Pharmacy**	4,479,000	4,479,000

Appropriations by Fund

State Government Special Revenue	4,403,000	4,403,000
Health Care Access	76,000	76,000

The base for this appropriation in the health care access fund is $76,000 in fiscal year 2024, $38,000 in fiscal year 2025, and $0 in fiscal year 2026.

Subd. 11. **Board of Physical Therapy**	564,000	564,000
Subd. 12. **Board of Podiatric Medicine**	214,000	214,000
Subd. 13. **Board of Psychology**	1,355,000	1,355,000
Subd. 14. **Board of Social Work**	1,556,000	1,559,000
Subd. 15. **Board of Veterinary Medicine**	363,000	363,000
Subd. 16. **Board of Behavioral Health and Therapy**	868,000	868,000

Subd. 17. **Board of Occupational Therapy Practice** 456,000 456,000

Sec. 4. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 3,803,000 $ 3,829,000**

(a) **Cooper/Sams Volunteer Ambulance Program.** $950,000 in fiscal year 2022 and $950,000 in fiscal year 2023 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(1) Of this amount, $861,000 in fiscal year 2022 and $861,000 in fiscal year 2023 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(2) Of this amount, $89,000 in fiscal year 2022 and $89,000 in fiscal year 2023 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) **EMSRB Operations.** $1,880,000 in fiscal year 2022 and $1,880,000 in fiscal year 2023 are for board operations.

(c) **Regional Grants.** $585,000 in fiscal year 2022 and $585,000 in fiscal year 2023 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions under Minnesota Statutes, section 144E.52.

(d) **Ambulance Training Grant.** $361,000 in fiscal year 2022 and $361,000 in fiscal year 2023 are for training grants under Minnesota Statutes, section 144E.35.

Sec. 5. **COUNCIL ON DISABILITY** **$ 1,022,000 $ 1,038,000**

Sec. 6. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 2,487,000 $ 2,536,000**

Department of Psychiatry Monitoring.

$100,000 in fiscal year 2022 and $100,000 in fiscal year 2023 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 7. **OMBUDSPERSONS FOR FAMILIES** **$ 733,000 $ 744,000**

Sec. 8. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by Laws 2019, First Special Session chapter 12, section 6, is amended to read:

Sec. 3. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation** **$ 231,829,000 $ ~~236,188,000~~ 233,979,000**

Appropriations by Fund

	2020	2021
General	124,381,000	126,276,000
State Government		~~61,367,000~~
Special Revenue	58,450,000	59,158,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

Appropriations by Fund

General	94,980,000	96,117,000
State Government		~~7,558,000~~
Special Revenue	7,614,000	6,924,000
Health Care Access	37,285,000	36,832,000
Federal TANF	11,713,000	11,713,000

(a) **TANF Appropriations.** (1) $3,579,000 in fiscal year 2020 and $3,579,000 in fiscal year 2021 are from the TANF fund for home visiting and nutritional services under

Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2020 and $2,000,000 in fiscal year 2021 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2020 and $4,978,000 in fiscal year 2021 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. $4,000,000 of the funding in each fiscal year must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding in each fiscal year must be distributed to tribal governments according to Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2020 and $1,156,000 in fiscal year 2021 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(5) The commissioner may use up to 6.23 percent of the amounts appropriated from the TANF fund each year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

(b) **TANF Carryforward.** Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

(c) **Comprehensive Suicide Prevention.** $2,730,000 in fiscal year 2020 and $2,730,000 in fiscal year 2021 are from the general fund for a comprehensive, community-based suicide prevention strategy. The funds are allocated as follows:

(1) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are for community-based suicide prevention grants authorized in Minnesota Statutes, section 145.56, subdivision 2. Specific emphasis must be placed on those communities with the greatest disparities. The base for this appropriation is $1,291,000 in fiscal year 2022 and $1,291,000 in fiscal year 2023;

(2) $683,000 in fiscal year 2020 and $683,000 in fiscal year 2021 are to support evidence-based training for educators and school staff and purchase suicide prevention curriculum for student use statewide, as authorized in Minnesota Statutes, section 145.56, subdivision 2. The base for this appropriation is $913,000 in fiscal year 2022 and $913,000 in fiscal year 2023;

(3) $137,000 in fiscal year 2020 and $137,000 in fiscal year 2021 are to implement the Zero Suicide framework with up to 20 behavioral and health care organizations each year to treat individuals at risk for suicide and support those individuals across systems of care upon discharge. The base for this appropriation is

$205,000 in fiscal year 2022 and $205,000 in fiscal year 2023;

(4) $955,000 in fiscal year 2020 and $955,000 in fiscal year 2021 are to develop and fund a Minnesota-based network of National Suicide Prevention Lifeline, providing statewide coverage. The base for this appropriation is $1,321,000 in fiscal year 2022 and $1,321,000 in fiscal year 2023; and

(5) the commissioner may retain up to 18.23 percent of the appropriation under this paragraph to administer the comprehensive suicide prevention strategy.

(d) **Statewide Tobacco Cessation.** $1,598,000 in fiscal year 2020 and $2,748,000 in fiscal year 2021 are from the general fund for statewide tobacco cessation services under Minnesota Statutes, section 144.397. The base for this appropriation is $2,878,000 in fiscal year 2022 and $2,878,000 in fiscal year 2023.

(e) **Health Care Access Survey.** $225,000 in fiscal year 2020 and $225,000 in fiscal year 2021 are from the health care access fund to continue and improve the Minnesota Health Care Access Survey. These appropriations may be used in either year of the biennium.

(f) **Community Solutions for Healthy Child Development Grant Program.** $1,000,000 in fiscal year 2020 and $1,000,000 in fiscal year 2021 are for the community solutions for healthy child development grant program to promote health and racial equity for young children and their families under article 11, section 107. The commissioner may use up to

23.5 percent of the total appropriation for administration. The base for this appropriation is $1,000,000 in fiscal year 2022, $1,000,000 in fiscal year 2023, and $0 in fiscal year 2024.

(g) **Domestic Violence and Sexual Assault Prevention Program.** $375,000 in fiscal year 2020 and $375,000 in fiscal year 2021 are from the general fund for the domestic violence and sexual assault prevention program under article 11, section 108. This is a onetime appropriation.

(h) **Skin Lightening Products Public Awareness Grant Program.** $100,000 in fiscal year 2020 and $100,000 in fiscal year 2021 are from the general fund for a skin lightening products public awareness and education grant program. This is a onetime appropriation.

(i) **Cannabinoid Products Workgroup.** $8,000 in fiscal year 2020 is from the state government special revenue fund for the cannabinoid products workgroup. This is a onetime appropriation.

(j) **Base Level Adjustments.** The general fund base is $96,742,000 in fiscal year 2022 and $96,742,000 in fiscal year 2023. The health care access fund base is $37,432,000 in fiscal year 2022 and $36,832,000 in fiscal year 2023.

Subd. 3. **Health Protection**

Appropriations by Fund		
General	18,803,000	19,774,000
State Government Special Revenue	50,836,000	~~53,809,000~~ 52,234,000

(a) **Public Health Laboratory Equipment.** $840,000 in fiscal year 2020 and $655,000 in fiscal year 2021 are from the general fund for equipment for the public health laboratory. This is a onetime appropriation and is available until June 30, 2023.

(b) **Base Level Adjustment.** The general fund base is $19,119,000 in fiscal year 2022 and $19,119,000 in fiscal year 2023. The state government special revenue fund base is $53,782,000 in fiscal year 2022 and $53,782,000 in fiscal year 2023.

Subd. 4. **Health Operations**	10,598,000	10,385,000

Base Level Adjustment. The general fund base is $10,912,000 in fiscal year 2022 and $10,912,000 in fiscal year 2023.

EFFECTIVE DATE. This section is effective the day following final enactment and the reductions in subdivisions 1 to 3 are onetime reductions.

Sec. 9. **TRANSFERS; HEALTH.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner considers necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 10. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 11. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2023, unless a different expiration date is explicit.

Sec. 12. **EFFECTIVE DATE.**

This article is effective July 1, 2021, unless a different effective date is specified.

ARTICLE 2
HEALTH POLICY

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

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

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

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

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

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

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

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

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

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

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

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

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

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

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

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

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

62J.498 HEALTH INFORMATION EXCHANGE.

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

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

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

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

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

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers

(HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

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

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

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

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

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

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

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

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

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

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and~~

~~Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

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

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

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

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

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic, a medical group, a home health care agency, an urgent care center, and an emergent care center;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified

as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

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

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

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

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

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

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

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

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

~~(1) hold reciprocal agreements with at least one state-certified health information organization to access patient data, and for the transmission and receipt of clinical~~

~~transactions. Reciprocal agreements must meet the requirements established in subdivision 5; and~~

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

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

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

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

(1) the entity is a legally established organization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

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

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

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

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

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

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

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

(7) whether the violation was intentional;

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

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

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

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

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

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

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

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~

organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

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

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

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

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

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

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

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

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

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

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative

rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

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

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

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may, by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

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

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

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

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

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

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

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

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

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

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

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

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

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

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

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

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

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

Sec. 8. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

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

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

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075
Academic broad scope - type A, B, or C (9 or more locations)	$36,254
	~~19,920~~
Medical broad scope - type A	$25,896
Medical broad scope- type A (4-8 locations)	$31,075
Medical broad scope- type A (9 or more locations)	$36,254
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~
~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~
~~Eye applicators~~	~~3,680~~
~~Nuclear medical vans~~	~~3,680~~
~~High dose rate afterloader~~	~~3,680~~
~~Mobile high dose rate afterloader~~	~~3,680~~
~~Medical therapy - other emerging technology~~	~~3,680~~
	~~8,960~~
Teletherapy	$11,648
	~~8,960~~
Gamma knife	$11,648
Veterinary medicine	~~2,000~~ $2,600
In vitro testing lab	~~2,000~~ $2,600
	~~8,800~~
Nuclear pharmacy	$11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992

Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
X-ray fluorescent analyzer	~~1,520~~ $1,976
~~Measuring systems - gas chromatograph~~	~~2,000~~
~~Measuring systems - other~~	~~2,000~~
~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075
Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032
Manufacturing and distribution - other	~~5,280~~ $6,864
Manufacturing and distribution - other (4-8 locations)	$8,236
Manufacturing and distribution - other (9 or more locations)	$9,609
Nuclear laundry	~~18,640~~ $24,232
Decontamination services	~~4,960~~ $6,448
Leak test services only	~~2,000~~ $2,600
Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448

Waste disposal service, prepackaged only	~~6,000~~ $7,800
	~~8,320~~
Waste disposal	$10,816
Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
	~~9,840~~
Industrial radiography - fixed or temporary location	$12,792
~~Industrial radiography - temporary job sites~~	~~9,840~~
Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~
	~~9,520~~
Research and development - type A, B, or C broad scope	$12,376
~~Research and development - type B broad scope~~	~~9,520~~
~~Research and development - type C broad scope~~	~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)	$14,851
Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
Research and development - other	~~4,480~~ $5,824
Storage - no operations	~~2,000~~ $2,600
Source material - shielding	~~584~~ $759
Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
Accelerator-produced radioactive material	~~3,840~~ $4,992
Nonprofit educational institutions	~~300~~ $500
~~General license registration~~	~~150~~

Sec. 9. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

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

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~

~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104
Nuclear pharmacy	~~4,880~~ $5,612
Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612
Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612
Well logging - sealed sources	~~1,600~~ $1,840
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104
~~Measuring systems - portable gauge~~	~~960~~
X-ray fluorescent analyzer	~~584~~ $671
~~Measuring systems - gas chromatograph~~	~~960~~
~~Measuring systems - other~~	~~960~~
~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
Manufacturing and distribution - other	~~2,320~~ $2,668
	~~10,080~~
Nuclear laundry	$11,592
Decontamination services	~~2,640~~ $3,036

Leak test services only	~~960~~ $1,104
Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
~~Instrument calibration service only, 100 curies or more~~	~~960~~
Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
Waste disposal service, prepackaged only	~~2,240~~ $2,576
Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104
Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 10. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; and

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 12. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 13. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 14. Minnesota Statutes 2020, section 145.901, is amended to read:

145.901 MATERNAL MORBIDITY AND DEATH STUDIES.

Subdivision 1. **Purpose.** The commissioner of health may conduct maternal morbidity and death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable adverse maternal outcomes and deaths in Minnesota.

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), without the consent of the subject of the data, and without the consent of the parent, spouse, other guardian, or legal representative of the subject of the data, when the subject of the data is a woman who died or experienced morbidities during a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a pregnancy.

The commissioner has access only to medical data and health records related to maternal morbidity and deaths that occur on or after July 1, 2000, including the names of the providers; clinics; or other health services, such as family home visiting, WIC, prescription drug monitoring programs, and behavioral health services, where care was received before, during, or relating to the pregnancy or death. The commissioner has access to records maintained by the medical examiner, coroner, or hospitals or hospital discharge data for the purpose of providing the name and location of any pre-pregnancy, prenatal, or other care up to one year after the end of the pregnancy received by the subject of the data.

The subject of the data or the subject's parent, spouse, other guardian, or legal representative may voluntarily participate in an informant interview with staff on behalf of the commissioner related to the maternal experience. If the subject of the data or the subject's parent, spouse, other guardian, or legal representative agrees to an interview, the commissioner may compensate the interviewee for time and other expenses related to the interview.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the subject of the data, or the subject's parent, spouse, other guardian, or legal representative ~~of the subject~~

~~of the data~~ before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the subject of the data, or the subject's parent, spouse, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from a coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, and other health services to the subject of the data.

(f) The commissioner may access Department of Human Services data to identify sources of care and services to assist with the evaluation of welfare systems, including housing and Healthy Start, to reduce preventable maternal deaths.

(g) The commissioner may request and receive law enforcement reports or incident reports related to the subject of the data.

Subd. 3. **Management of records.** After the commissioner has collected all data about a subject of a morbidity or maternal death study needed to perform the study, the data from source records obtained under subdivision 2, other than data identifying the subject, must be transferred to separate records to be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their children, and data derived by the commissioner under subdivision 3 for the purpose of carrying out maternal morbidity and death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out maternal morbidity and death studies.

(c) Summary data on maternal morbidity and death studies created by the commissioner, which does not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retains the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Sec. 15. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

Subdivision 1. **Purpose.** The commissioner of health may conduct fetal and infant death studies to assist the planning, implementation, and evaluation of medical, health, and welfare service systems and to reduce the numbers of preventable fetal and infant deaths in Minnesota.

Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined in section 13.83, subdivision 1, and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), without the consent of the subject of the data, and without the consent of the parent, other guardian, or legal representative of the subject of the data, when the subject of the data is:

(1) a live-born infant that died within the first year of life;

(2) a fetal death which meets the criteria required for reporting as defined in section 144.222; or

(3) the biological mother of a fetus or infant as described in clause (1) or (2).

The commissioner has access only to medical data and health records related to fetal or infant deaths that occur on or after July 1, 2000, including the names of the providers and clinics where care was received before, during, or relating to the pregnancy or fetal death or death of the infant. The commissioner has access to records maintained by the medical examiner, coroner, or hospitals for the purpose of providing the name and location of any pre-pregnancy, prenatal, postpartum, or pediatric care received by the subject of the data and biological mother.

(b) The provider or responsible authority that creates, maintains, or stores the data shall furnish the data upon the request of the commissioner. The provider or responsible authority may charge a fee for providing the data, not to exceed the actual cost of retrieving and duplicating the data.

(c) The commissioner shall make a good faith reasonable effort to notify the parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last-known address of the parent, guardian, or legal representative informing the recipient of the data collection and offering a public health nurse support visit if desired.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner may request and receive from the coroner or medical examiner the name of the health care provider that provided prenatal, postpartum, pediatric, and other health services to the subject of the data and biological mother.

(f) The commissioner shall have access to Department of Human Services data to identify sources of care and services to assist with evaluation of welfare systems to reduce preventable fetal and infant deaths.

Subd. 3. **Management of records.** After the commissioner has collected all data on a subject of a fetal or infant death study that is needed to perform the study, the data from source records obtained under subdivision 2, other than data identifying the subject, must be transferred to separate records to be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 possessed by the commissioner must be destroyed.

Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, data subjects, or their family, and data derived by the commissioner under subdivision 3 for the purpose of carrying out fetal or infant death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3; and 13.10, subdivision 1, paragraph (a).

(b) Information classified under paragraph (a) shall not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source shall not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out fetal or infant death studies.

(c) Summary data on fetal and infant death studies created by the commissioner, which do not identify individual data subjects or individual providers, shall be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services to the commissioner of health under this section retains the same classification the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Subd. 5. **Fetal and infant mortality reviews.** The commissioner of health shall convene case review committees to conduct death study reviews, make recommendations, and publicly share summary information, especially for racial and ethnic groups, including American Indians and African Americans, that experience significantly disparate rates of fetal and infant mortality. The case review committees may include but are not limited to medical examiners or coroners, health care institutions that provide care to pregnant people and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency women and infant program representatives, and individuals from the communities with disparate rates and other subject matter experts as appropriate. The case review committees shall review data from source records obtained under subdivision 2, other than data identifying the subject or the provider. Every three years beginning December 1, 2022, the case review committees shall provide findings and recommendations to the Maternal and Child Health Advisory Task Force and the commissioner from review of fetal and infant deaths and provide specific recommendations designed to reduce disparities in fetal and infant deaths.

Subd. 6. **Community action committees.** (a) The commissioner shall convene community action committees to implement the priority recommendations from the case review committees.

(b) Members of the community action committees may include but are not limited to local, tribal, and state government representatives; local hospital or health care administration; local public health; nonprofit organizations serving the community's mothers, infants, and fathers; state maternal and child health consultants; case review committee members; representatives of communities disproportionately affected by fetal and infant death; Minnesotans with lived experiences; and others based on recommendations.

Sec. 16. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or

off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos containing~~ material applies separately for every project.

Sec. 17. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 18. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 19. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material

on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.