SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 2452

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
03/14/2019	921	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/11/2019	2753a	Comm report: To pass as amended and re-refer to Finance
04/29/2019		Comm report: To pass as amended Second reading

A bill for an act

relating to health; establishing the health and human services budget; modifying provisions governing health care, health insurance, Department of Human Services operations, Department of Health, and MNsure; requiring care coordination; modifying medical cannabis requirements; permitting licensed hemp growers to sell hemp to medical cannabis manufacturers; permitting electronic monitoring in health care facilities; requiring hospital charges disclosure; modifying public interest review; authorizing statewide tobacco cessation services; modifying requirements for PPEC centers; modifying benefits for MnCare and MA for adults; requiring physicians to allow the opportunity to view ultrasound imaging prior to an abortion; prohibiting abortions after 20 weeks post fertilization; requiring health care facilities to post the women's right to know information on their website; modifying the positive alternatives grant eligibility; modifying the SHIP program; requiring coverage of 3D mammograms as a preventive service; exempting certain seasonal food stands from licensure; adjusting license fees for social workers and optometrists; requiring reports; making technical changes; appropriating money; amending Minnesota Statutes 2018, sections 16A.055, subdivision 1a; 18K.03; 62A.30, by adding a subdivision; 62J.495, subdivisions 1, 3; 62V.05, subdivisions 2, 5, 10; 62V.08; 144.1506, subdivision 2; 144.3831, subdivision 1; 144.552; 144.586, by adding a subdivision; 144.966, subdivision 2; 144H.01, subdivision 5; 144H.04, subdivision 1, by adding a subdivision; 144H.06; 144H.07, subdivisions 1, 2; 144H.08, subdivision 2; 144H.11, subdivisions 2, 3, 4; 145.4131, subdivision 1; 145.4235, subdivision 2; 145.4242; 145.4244; 145.928, subdivisions 1, 7; 145.986, subdivisions 1, 1a, 4, 5, 6; 148.59; 148E.180; 152.126, subdivision 6; 152.22, subdivision 6, by adding a subdivision; 152.25, subdivision 4; 152.28, subdivision 1; 152.29, subdivisions 1, 2, 3, 3a; 152.31; 157.22; 256B.04, subdivision 14; 256B.056, subdivisions 1, 3, 7a; 256B.0625, subdivision 56a, by adding a subdivision; 256B.69, subdivisions 4, 31; 256L.03, subdivision 5, by adding a subdivision; 525A.11; Laws 2015, chapter 71, article 12, section 8; proposing coding for new law in Minnesota Statutes, chapters 8; 144; 145; 254A; 256B; proposing coding for new law as Minnesota Statutes, chapter 245I; repealing Minnesota Statutes 2018, sections 16A.724, subdivision 2; 144.1464; 144.1911; 256B.0625, subdivision 31c.

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

ARTICLE 1
DEPARTMENT OF HEALTH

Section 1. **[8.40] LITIGATION DEFENSE FUND.**

(a) There is created in the special revenue fund an account entitled the Pain-Capable Unborn Child Protection Act litigation account for the purpose of providing funds to pay for any costs and expenses incurred by the state attorney general in relation to actions surrounding defense of sections 145.4141 to 145.4147.

(b) The account shall be maintained by the commissioner of management and budget.

(c) The litigation account shall consist of:

(1) appropriations made to the account by the legislature; and

(2) any donations, gifts, or grants made to the account by private citizens or entities.

(d) The litigation account shall retain the interest income derived from the money credited to the account.

(e) Any funds in the litigation account are appropriated to the attorney general for the purposes described in paragraph (a).

Sec. 2. Minnesota Statutes 2018, section 18K.03, is amended to read:

18K.03 AGRICULTURAL CROP; POSSESSION AUTHORIZED.

Subdivision 1. **Industrial hemp.** Industrial hemp is an agricultural crop in this state. A person may possess, transport, process, sell, or buy industrial hemp that is grown pursuant to this chapter.

Subd. 2. **Sale to medical cannabis manufacturers.** A licensee under this chapter may sell hemp products derived from industrial hemp grown in this state to medical cannabis manufacturers as authorized under sections 152.22 to 152.37.

Sec. 3. Minnesota Statutes 2018, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** ~~By January 1, 2015, all hospitals and health care providers, as defined in section 62J.03, subdivision 8, must have in place an interoperable electronic health records system within their hospital system or clinical practice setting.~~ The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop ~~a statewide plan to meet this goal, including~~ 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.

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

Sec. 4. Minnesota Statutes 2018, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) ~~To meet the requirements of subdivision 1,~~ 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.

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

Sec. 5. Minnesota Statutes 2018, section 144.1506, subdivision 2, is amended to read:

Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award primary care residency expansion grants to eligible primary care residency programs to plan and implement new residency slots. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 per new residency slot for the first year, $100,000 for the second year, and $50,000 for the third year of the new residency slot. For eligible residency programs longer than three years, training grants may be awarded for the duration of the residency, not exceeding an average of $100,000 per residency slot per year.

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

(1) planning related to establishing an accredited primary care residency program;

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

(3) establishing new residency programs or new resident training slots;

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

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new residency slots;

(7) training site improvements, fees, equipment, and supplies required for new primary care resident training slots; and

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

Sec. 6. Minnesota Statutes 2018, section 144.3831, subdivision 1, is amended to read:

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of ~~$6.36~~ $9.72 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

EFFECTIVE DATE. This section is effective January 1, 2020.

Sec. 7. **[144.397] STATEWIDE TOBACCO CESSATION SERVICES.**

(a) The commissioner of health shall administer, or contract for the administration of, statewide tobacco cessation services to assist Minnesotans who are seeking advice or services to help them quit using tobacco products. The commissioner shall establish statewide public

awareness activities to inform the public of the availability of the services and encourage the public to utilize the services because of the dangers and harm of tobacco use and dependence.

(b) Services to be provided may include, but are not limited to:

(1) telephone-based coaching and counseling;

(2) referrals;

(3) written materials mailed upon request;

(4) web-based texting or e-mail services; and

(5) free Food and Drug Administration-approved tobacco cessation medications.

(c) Services provided must be consistent with evidence-based best practices in tobacco cessation services. Services provided must be coordinated with health plan company tobacco prevention and cessation services that may be available to individuals depending on their health coverage.

Sec. 8. Minnesota Statutes 2018, section 144.552, is amended to read:

144.552 PUBLIC INTEREST REVIEW.

(a) The following entities must submit a plan to the commissioner:

(1) a hospital seeking to increase its number of licensed beds; or

(2) an organization seeking to obtain a hospital license and notified by the commissioner under section 144.553, subdivision 1, paragraph (c), that it is subject to this section.

The plan must include information that includes an explanation of how the expansion will meet the public's interest. When submitting a plan to the commissioner, an applicant shall pay the commissioner for the commissioner's cost of reviewing and monitoring the plan, as determined by the commissioner and notwithstanding section 16A.1283. Money received by the commissioner under this section is appropriated to the commissioner for the purpose of administering this section. If the commissioner does not issue a finding within the time limit specified in paragraph (c), the commissioner must return to the applicant the entire amount the applicant paid to the commissioner. For a hospital that is seeking an exception to the moratorium under section 144.551, the plan must be submitted to the commissioner no later than August 1 of the calendar year prior to the year when the exception will be considered by the legislature.

(b) Plans submitted under this section shall include detailed information necessary for the commissioner to review the plan and reach a finding. The commissioner may request additional information from the hospital submitting a plan under this section and from others affected by the plan that the commissioner deems necessary to review the plan and make a finding. If the commissioner determines that additional information is required from the hospital submitting a plan under this section, the commissioner shall notify the hospital of the additional information required no more than 30 days after the initial submission of the plan. A hospital submitting a plan from whom the commissioner has requested additional information shall submit the requested additional information within 14 calendar days of the commissioner's request.

(c) The commissioner shall review the plan and, within ~~90~~ 150 calendar days~~, but no more than six months if extenuating circumstances apply~~ of the initial submission of the plan, issue a finding on whether the plan is in the public interest. In making the recommendation, the commissioner shall consider issues including but not limited to:

(1) whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services given the number of available beds. For the purposes of this clause, "available beds" means the number of licensed acute care beds that are immediately available for use or could be brought online within 48 hours without significant facility modifications;

(2) the financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;

(3) how the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;

(4) the extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and

(5) the views of affected parties.

(d) If the plan is being submitted by an existing hospital seeking authority to construct a new hospital, the commissioner shall also consider:

(1) the ability of the applicant to maintain the applicant's current level of community benefit as defined in section 144.699, subdivision 5, at the existing facility; and

(2) the impact on the workforce at the existing facility including the applicant's plan for:

(i) transitioning current workers to the new facility;

(ii) retraining and employment security for current workers; and

(iii) addressing the impact of layoffs at the existing facility on affected workers.

(e) Prior to making a recommendation, the commissioner shall conduct a public hearing in the affected hospital service area to take testimony from interested persons.

(f) Upon making a recommendation under paragraph (c), the commissioner shall provide a copy of the recommendation to the chairs of the house of representatives and senate committees having jurisdiction over health and human services policy and finance.

(g) If an exception to the moratorium is approved under section 144.551 after a review under this section, the commissioner shall monitor the implementation of the exception up to completion of the construction project. Thirty days after completion of the construction project, the hospital shall submit to the commissioner a report on how the construction has met the provisions of the plan originally submitted under the public interest review process or a plan submitted pursuant to section 144.551, subdivision 1, paragraph (b), clause (20).

Sec. 9. Minnesota Statutes 2018, section 144.586, is amended by adding a subdivision to read:

Subd. 3. **Care coordination implementation.** (a) This subdivision applies to hospital discharges involving a child with a high-cost medical or chronic condition who needs post-hospital continuing aftercare, including but not limited to home health care services, post-hospital extended care services, or outpatient services for follow-up or ancillary care, or is at risk of recurrent hospitalization or emergency room services due to a medical or chronic condition.

(b) In addition to complying with the discharge planning requirements in subdivision 2, the hospital must ensure that the following conditions are met and arrangements made before discharging any patient described in paragraph (a):

(1) the patient's primary care provider and either the health carrier or, if the patient is enrolled in medical assistance, the managed care organization are notified of the patient's date of anticipated discharge and provided a description of the patient's aftercare needs and a copy of the patient's discharge plan, including any necessary medical information release forms;

(2) the appropriate arrangements for home health care or post-hospital extended care services are made and the initial services as indicated on the discharge plan are scheduled; and

(3) if the patient is eligible for care coordination services through a health plan or health certified medical home, the appropriate care coordinator has connected with the patient's family.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 10. **[144.591] DISCLOSURE OF HOSPITAL CHARGES.**

(a) Each hospital, including hospitals designated as critical access hospitals, shall provide to each discharged patient within 30 calendar days of discharge an itemized description of billed charges for medical services and goods the patient received during the hospital stay. The itemized description of billed charges may include technical terms to describe the medical services and goods if the technical terms are defined on the itemized description with limited medical nomenclature. The itemized description of billed charges must not describe a billed charge using only a medical billing code, "miscellaneous charges," or "supply charges."

(b) A hospital may not bill or otherwise charge a patient for the itemized description of billed charges.

(c) A hospital must provide an itemized description by secure e-mail, via a secure online portal, or, upon request, by mail.

(d) This section does not apply to patients enrolled in Medicare, medical assistance, the MinnesotaCare program, or who receive health care coverage through an employer self-insured health plan.

EFFECTIVE DATE. This section is effective August 1, 2020.

Sec. 11. **[144.6502] ELECTRONIC MONITORING IN CERTAIN HEALTH CARE FACILITIES.**

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

(b) "Electronic monitoring" means the placement and use of an electronic monitoring device by a resident in the resident's room or private living unit in accordance with this section.

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

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

(e) "Electronic monitoring device" means a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living unit.

(f) "Facility" means a nursing home licensed under chapter 144A, a boarding care home licensed under sections 144.50 to 144.56, or a housing with services establishment registered under chapter 144D that is either subject to chapter 144G or has a disclosed special unit under section 325F.72.

(g) "Resident" means a person 18 years of age or older residing in a facility.

(h) "Resident representative" means one of the following in the order of priority listed, to the extent the person may reasonably be identified and located:

(1) a court-appointed guardian;

(2) a health care agent under section 145C.01, subdivision 2; or

(3) a person who is not an agent of a facility or of a home care provider designated in writing by the resident and maintained in the resident's records on file with the facility or with the resident's executed housing with services contract.

Subd. 2. **Electronic monitoring.** (a) A resident or a resident representative may conduct electronic monitoring of the resident's room or private living unit through the use of electronic monitoring devices placed in the resident's room or private living unit as provided in this section.

(b) Nothing in this section precludes the use of electronic monitoring of health care allowed under other law.

(c) Electronic monitoring authorized under this section is not a covered service under home and community-based waivers under sections 256B.0913, 256B.0915, 256B.092, and 256B.49.

(d) This section does not apply to monitoring technology authorized as a home and community-based service under section 256B.0913, 256B.0915, 256B.092, or 256B.49.

Subd. 3. **Consent to electronic monitoring.** (a) Except as otherwise provided in this subdivision, a resident must consent to electronic monitoring in the resident's room or private living unit in writing on a notification and consent form. If the resident has not affirmatively objected to electronic monitoring and the resident's medical professional determines that the resident currently lacks the ability to understand and appreciate the nature and consequences of electronic monitoring, the resident representative may consent on behalf

of the resident. For purposes of this subdivision, a resident affirmatively objects when the resident orally, visually, or through the use of auxiliary aids or services declines electronic monitoring. The resident's response must be documented on the notification and consent form.

(b) Prior to a resident representative consenting on behalf of a resident, the resident must be asked if the resident wants electronic monitoring to be conducted. The resident representative must explain to the resident:

(1) the type of electronic monitoring device to be used;

(2) the standard conditions that may be placed on the electronic monitoring device's use, including those listed in subdivision 6;

(3) with whom the recording may be shared under subdivision 10 or 11; and

(4) the resident's ability to decline all recording.

(c) A resident, or resident representative when consenting on behalf of the resident, may consent to electronic monitoring with any conditions of the resident's or resident representative's choosing, including the list of standard conditions provided in subdivision 6. A resident, or resident representative when consenting on behalf of the resident, may request that the electronic monitoring device be turned off or the visual or audio recording component of the electronic monitoring device be blocked at any time.

(d) Prior to implementing electronic monitoring, a resident, or resident representative when acting on behalf of the resident, must obtain the written consent on the notification and consent form of any other resident residing in the shared room or shared private living unit. A roommate's or roommate's resident representative's written consent must comply with the requirements of paragraphs (a) to (c). Consent by a roommate or a roommate's resident representative under this paragraph authorizes the resident's use of any recording obtained under this section, as provided under subdivision 10 or 11.

(e) Any resident conducting electronic monitoring must immediately remove or disable an electronic monitoring device prior to a new roommate moving into a shared room or shared private living unit, unless the resident obtains the roommate's or roommate's resident representative's written consent as provided under paragraph (d) prior to the roommate moving into the shared room or shared private living unit. Upon obtaining the new roommate's signed notification and consent form and submitting the form to the facility as required under subdivision 5, the resident may resume electronic monitoring.

(f) The resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, may withdraw consent at any time and the withdrawal of consent must be documented on the original consent form as provided under subdivision 5, paragraph (c).

Subd. 4. **Refusal of roommate to consent.** If a resident of a facility who is residing in a shared room or shared living unit, or the resident representative of such a resident when acting on behalf of the resident, wants to conduct electronic monitoring and another resident living in or moving into the same shared room or shared living unit refuses to consent to the use of an electronic monitoring device, the facility shall make a reasonable attempt to accommodate the resident who wants to conduct electronic monitoring. A facility has met the requirement to make a reasonable attempt to accommodate a resident or resident representative who wants to conduct electronic monitoring when, upon notification that a roommate has not consented to the use of an electronic monitoring device in the resident's room, the facility offers to move the resident to another shared room or shared living unit that is available at the time of the request. If a resident chooses to reside in a private room or private living unit in a facility in order to accommodate the use of an electronic monitoring device, the resident must pay either the private room rate in a nursing home setting, or the applicable rent in a housing with services establishment. If a facility is unable to accommodate a resident due to lack of space, the facility must reevaluate the request every two weeks until the request is fulfilled. A facility is not required to provide a private room, a single-bed room, or a private living unit to a resident who is unable to pay.

Subd. 5. **Notice to facility.** (a) Electronic monitoring may begin only after the resident or resident representative who intends to place an electronic monitoring device and any roommate or roommate's resident representative completes the notification and consent form and submits the form to the facility.

(b) Upon receipt of any completed notification and consent form, the facility must place the original form in the resident's file or file the original form with the resident's housing with services contract. The facility must provide a copy to the resident and the resident's roommate, if applicable.

(c) In the event that a resident or roommate, or the resident representative or roommate's resident representative if the representative is consenting on behalf of the resident or roommate, chooses to alter the conditions under which consent to electronic monitoring is given or chooses to withdraw consent to electronic monitoring, the facility must make available the original notification and consent form so that it may be updated. Upon receipt of the updated form, the facility must place the updated form in the resident's file or file the

original form with the resident's signed housing with services contract. The facility must provide a copy of the updated form to the resident and the resident's roommate, if applicable.

(d) If a new roommate, or the new roommate's resident representative when consenting on behalf of the new roommate, does not submit to the facility a completed notification and consent form and the resident conducting the electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(e) If a roommate, or the roommate's resident representative when withdrawing consent on behalf of the roommate, submits an updated notification and consent form withdrawing consent and the resident conducting electronic monitoring does not remove or disable the electronic monitoring device, the facility must remove the electronic monitoring device.

(f) Notwithstanding paragraph (a), the resident or resident representative who intends to place an electronic monitoring device may do so without submitting a notification and consent form to the facility, provided that:

(1) the resident or resident representative reasonably fears retaliation by the facility;

(2) the resident does not have a roommate;

(3) the resident or resident representative submits the completed notification and consent form to the Office of the Ombudsman for Long-Term Care;

(4) the resident or resident representative submits the notification and consent form to the facility within 14 calendar days of placing the electronic monitoring device; and

(5) the resident or resident representative immediately submits a Minnesota Adult Abuse Reporting Center report or police report upon evidence from the electronic monitoring device that suspected maltreatment has occurred between the time the electronic monitoring device is placed under this paragraph and the time the resident or resident representative submits the completed notification and consent form to the facility.

Subd. 6. **Form requirements.** (a) The notification and consent form completed by the resident must include, at a minimum, the following information:

(1) the resident's signed consent to electronic monitoring or the signature of the resident representative, if applicable. If a person other than the resident signs the consent form, the form must document the following:

(i) the date the resident was asked if the resident wants electronic monitoring to be conducted;

(ii) who was present when the resident was asked;

(iii) an acknowledgment that the resident did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf;

(2) the resident's roommate's signed consent or the signature of the roommate's resident representative, if applicable. If a roommate's resident representative signs the consent form, the form must document the following:

(i) the date the roommate was asked if the roommate wants electronic monitoring to be conducted;

(ii) who was present when the roommate was asked;

(iii) an acknowledgment that the roommate did not affirmatively object; and

(iv) the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf;

(3) the type of electronic monitoring device to be used;

(4) a list of standard conditions or restrictions that the resident or a roommate may elect to place on the use of the electronic monitoring device, including but not limited to:

(i) prohibiting audio recording;

(ii) prohibiting video recording;

(iii) prohibiting broadcasting of audio or video;

(iv) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional;

(v) turning off the electronic monitoring device or blocking the visual recording component of the electronic monitoring device while dressing or bathing is performed; and

(vi) turning off the electronic monitoring device for the duration of a visit with a spiritual adviser, ombudsman, attorney, financial planner, intimate partner, or other visitor;

(5) any other condition or restriction elected by the resident or roommate on the use of an electronic monitoring device;

(6) a statement of the circumstances under which a recording may be disseminated under subdivision 10;

(7) a signature box for documenting that the resident or roommate has withdrawn consent; and

(8) an acknowledgment that the resident, in accordance with subdivision 3, consents, authorizes, and allows the Office of Ombudsman for Long-Term Care and representatives of its office to disclose information about the form limited to:

(i) the fact that the form was received from the resident or resident representative;

(ii) if signed by a resident representative, the name of the resident representative and the source of authority allowing the resident representative to sign the notification and consent form on the resident's behalf; and

(iii) the type of electronic monitoring device placed.

(b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit.

(c) Notification and consent forms received by the Office of Ombudsman for Long-Term Care are data protected under section 256.9744.

Subd. 7. **Cost and installation.** (a) A resident choosing to conduct electronic monitoring must do so at the resident's own expense, including paying purchase, installation, maintenance, and removal costs.

(b) If a resident chooses to place an electronic monitoring device that uses Internet technology for visual or audio monitoring, the resident may be responsible for contracting with an Internet service provider.

(c) The facility shall make a reasonable attempt to accommodate the resident's installation needs, including allowing access to the facility's public-use Internet or Wi-Fi systems when available for other public uses.

(d) All electronic monitoring device installations and supporting services must be UL-listed.

Subd. 8. **Notice to visitors.** (a) A facility shall post a sign at each facility entrance accessible to visitors that states "Security cameras and audio devices may be present to record persons and activities."

(b) The facility is responsible for installing and maintaining the signage required in this subdivision.

Subd. 9. **Obstruction of electronic monitoring devices.** (a) A person must not knowingly hamper, obstruct, tamper with, or destroy an electronic monitoring device placed in a resident's room or private living unit without the permission of the resident or resident representative.

(b) It is not a violation of paragraph (a) if a person turns off the electronic monitoring device or blocks the visual recording component of the electronic monitoring device at the direction of the resident or resident representative, or if consent has been withdrawn.

Subd. 10. **Dissemination of recordings.** (a) No person may access any video or audio recording created through authorized electronic monitoring without the written consent of the resident or resident representative.

(b) Except as required under other law, a recording or copy of a recording made as provided in this section may only be disseminated for the purpose of addressing health, safety, or welfare concerns of a resident or residents.

(c) A person disseminating a recording or copy of a recording made as provided in this section in violation of paragraph (b) may be civilly or criminally liable.

Subd. 11. **Admissibility of evidence.** Subject to applicable rules of evidence and procedure, any video or audio recording created through electronic monitoring under this section may be admitted into evidence in a civil, criminal, or administrative proceeding.

Subd. 12. **Liability.** (a) For the purposes of state law, the mere presence of an electronic monitoring device in a resident's room or private living unit is not a violation of the resident's right to privacy under section 144.651 or 144A.44.

(b) For the purposes of state law, a facility or home care provider is not civilly or criminally liable for the mere disclosure by a resident or a resident representative of a recording.

Subd. 13. **Immunity from liability.** The Office of Ombudsman for Long-Term Care and representatives of the office are immune from liability as provided under section 256.9742, subdivision 2.

Subd. 14. **Resident protections.** (a) A facility must not:

(1) refuse to admit a potential resident or remove a resident because the facility disagrees with the potential resident's or the resident's decisions regarding electronic monitoring, including when the decision is made by a resident representative acting on behalf of the resident;

(2) retaliate or discriminate against any resident for consenting or refusing to consent to electronic monitoring; or

(3) prevent the placement or use of an electronic monitoring device by a resident who has provided the facility or the Office of the Ombudsman for Long-Term Care with notice and consent as required under this section.

(b) Any contractual provision prohibiting, limiting, or otherwise modifying the rights and obligations in this section is contrary to public policy and is void and unenforceable.

Subd. 15. **Employee discipline.** An employee of the facility or of a contractor providing services at the facility, including an arranged home care provider as defined in section 144D.01, subdivision 2a, who is the subject of proposed corrective or disciplinary action based upon evidence obtained by electronic monitoring must be given access to that evidence for purposes of defending against the proposed action. The recording or a copy of the recording must be treated confidentially by the employee and must not be further disseminated to any other person except as required under law. Any copy of the recording must be returned to the facility or resident who provided the copy when it is no longer needed for purposes of defending against a proposed action.

Subd. 16. **Penalties.** (a) The commissioner may issue a correction order as provided under section 144A.10, 144A.45, or 144A.474, upon a finding that the facility has failed to comply with subdivision 5, paragraphs (b) to (e); 6, paragraph (b); 7, paragraph (c); 8; 9; 10; or 14. For each violation of this section, the commissioner may impose a fine up to $500 upon a finding of noncompliance with a correction order issued according to this subdivision.

(b) The commissioner may exercise the commissioner's authority provided under section 144D.05 to compel a housing with services establishment to meet the requirements of this section.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to all agreements in effect, entered into, or renewed on or after that date.

Sec. 12. Minnesota Statutes 2018, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low-incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

(e) This subdivision expires June 30, ~~2019~~ 2025.

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

Sec. 13. Minnesota Statutes 2018, section 144H.01, subdivision 5, is amended to read:

Subd. 5. **Medically complex or technologically dependent child.** "Medically complex or technologically dependent child" means a child under ~~21~~ seven years of age who, because of a medical condition, requires continuous therapeutic interventions or skilled nursing supervision ~~which~~ that must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

Sec. 14. Minnesota Statutes 2018, section 144H.04, subdivision 1, is amended to read:

Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a completed application for licensure to the commissioner, in a form and manner determined by the commissioner. The applicant must also submit the application fee, in the amount specified in section 144H.05, subdivision 1. ~~Effective January 1, 2018,~~ Beginning July 1, 2020, the commissioner shall issue a license for a PPEC center if the commissioner determines that the applicant and center meet the requirements of this chapter and rules that apply to PPEC centers. A license issued under this subdivision is valid for two years.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2018.

Sec. 15. Minnesota Statutes 2018, section 144H.04, is amended by adding a subdivision to read:

Subd. 1a. **Licensure phase-in.** (a) The commissioner shall phase in licensure of PPEC centers by issuing prior to June 30, 2024, no more than two licenses to applicants the commissioner determines meet the requirements of this chapter. A license issued under this subdivision is valid until June 30, 2024.

(b) This subdivision expires July 1, 2024.

EFFECTIVE DATE. This section is effective upon the effective date of section 12.

Sec. 16. Minnesota Statutes 2018, section 144H.06, is amended to read:

144H.06 APPLICATION OF RULES FOR HOSPICE SERVICES AND RESIDENTIAL HOSPICE FACILITIES.

Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter, except that the following parts, subparts, and items~~, and subitems~~ do not apply:

(1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

(2) Minnesota Rules, part 4664.0008;

(3) Minnesota Rules, part 4664.0010, subparts 3; 4, ~~items A, subitem (6), and~~ item B; and 8;

(4) Minnesota Rules, part 4664.0020, subpart 13;

(5) Minnesota Rules, part 4664.0370, subpart 1;

(6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

(7) Minnesota Rules, part 4664.0420;

(8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

(9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

(10) Minnesota Rules, part 4664.0490; and

(11) Minnesota Rules, part 4664.0520.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 17. Minnesota Statutes 2018, section 144H.07, subdivision 1, is amended to read:

Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex or technologically dependent children, based on a protocol of care established for each child. A PPEC center may provide services up to ~~14~~ 12.5 hours a day and up to six days a week with hours of operation during normal waking hours.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 18. Minnesota Statutes 2018, section 144H.07, subdivision 2, is amended to read:

Subd. 2. **Limitations.** A PPEC center must comply with the following standards related to services:

(1) a child is prohibited from attending a PPEC center for more than ~~14~~ 12.5 hours within a 24-hour period;

(2) a PPEC center is prohibited from providing services other than those provided to medically complex or technologically dependent children; and

(3) the maximum capacity for medically complex or technologically dependent children at a center shall not exceed 45 children.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 19. Minnesota Statutes 2018, section 144H.08, subdivision 2, is amended to read:

Subd. 2. ~~**Duties of administrator**~~ **Administrators.** (a) The center administrator is responsible and accountable for overall management of the center. The administrator must:

(1) designate in writing a person to be responsible for the center when the administrator is absent from the center for more than 24 hours;

(2) maintain the following written records, in a place and form and using a system that allows for inspection of the records by the commissioner during normal business hours:

(i) a daily census record, which indicates the number of children currently receiving services at the center;

(ii) a record of all accidents or unusual incidents involving any child or staff member that caused, or had the potential to cause, injury or harm to a person at the center or to center property;

(iii) copies of all current agreements with providers of supportive services or contracted services;

(iv) copies of all current agreements with consultants employed by the center, documentation of each consultant's visits, and written, dated reports; and

(v) a personnel record for each employee, which must include an application for employment, references, employment history for the preceding five years, and copies of all performance evaluations;

(3) develop and maintain a current job description for each employee;

(4) provide necessary qualified personnel and ancillary services to ensure the health, safety, and proper care for each child; and

(5) develop and implement infection control policies that comply with rules adopted by the commissioner regarding infection control.

(b) In order to serve as an administrator of a PPEC center, an individual must have at least two years of experience in the past five years caring for or managing the care of medically complex or technologically dependent individuals.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 20. Minnesota Statutes 2018, section 144H.11, subdivision 2, is amended to read:

Subd. 2. **Registered nurses.** A registered nurse employed by a PPEC center must be a registered nurse licensed in Minnesota, and hold a current certification in cardiopulmonary resuscitation~~, and have experience in the previous 24 months in being responsible for the care of acutely ill or chronically ill children~~.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 21. Minnesota Statutes 2018, section 144H.11, subdivision 3, is amended to read:

Subd. 3. **Licensed practical nurses.** A licensed practical nurse employed by a PPEC center must be supervised by a registered nurse and must be a licensed practical nurse

licensed in Minnesota, ~~have at least two years of experience in pediatrics,~~ and hold a current certification in cardiopulmonary resuscitation.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 22. Minnesota Statutes 2018, section 144H.11, subdivision 4, is amended to read:

Subd. 4. **Other direct care personnel.** (a) Direct care personnel governed by this subdivision may include nursing assistants ~~and~~ or individuals with training and experience in the field of education, social services, or child care.

(b) All direct care personnel employed by a PPEC center must work under the supervision of a registered nurse and are responsible for providing direct care to children at the center. Direct care personnel must have extensive, documented education and skills training in providing care to infants and toddlers, provide employment references documenting skill in the care of infants and children, and hold a current certification in cardiopulmonary resuscitation.

EFFECTIVE DATE. This section is effective August 1, 2019.

Sec. 23. Minnesota Statutes 2018, section 145.4131, subdivision 1, is amended to read:

Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner.

(b) The form shall require the following information:

(1) the number of abortions performed by the physician in the previous calendar year, reported by month;

(2) the method used for each abortion;

(3) the approximate gestational age expressed in one of the following increments:

(i) less than nine weeks;

(ii) nine to ten weeks;

(iii) 11 to 12 weeks;

(iv) 13 to 15 weeks;

(v) 16 to 20 weeks;

(vi) 21 to 24 weeks;

(vii) 25 to 30 weeks;

(viii) 31 to 36 weeks; or

(ix) 37 weeks to term;

(4) the age of the woman at the time the abortion was performed;

(5) the specific reason for the abortion, including, but not limited to, the following:

(i) the pregnancy was a result of rape;

(ii) the pregnancy was a result of incest;

(iii) economic reasons;

(iv) the woman does not want children at this time;

(v) the woman's emotional health is at stake;

(vi) the woman's physical health is at stake;

(vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues;

(viii) the pregnancy resulted in fetal anomalies; or

(ix) unknown or the woman refused to answer;

(6) the number of prior induced abortions;

(7) the number of prior spontaneous abortions;

(8) whether the abortion was paid for by:

(i) private coverage;

(ii) public assistance health coverage; or

(iii) self-pay;

(9) whether coverage was under:

(i) a fee-for-service plan;

(ii) a capitated private plan; or

(iii) other;

(10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form;

(11) the medical specialty of the physician performing the abortion;

(12) if the abortion was performed via telemedicine, the facility code for the patient and the facility code for the physician; ~~and~~

(13) whether the abortion resulted in a born alive infant, as defined in section 145.423, subdivision 4, and:

(i) any medical actions taken to preserve the life of the born alive infant;

(ii) whether the born alive infant survived; and

(iii) the status of the born alive infant, should the infant survive, if known~~.~~;

(14) whether a determination of probable postfertilization age was made and the probable postfertilization age determined, including:

(i) the method used to make such a determination; or

(ii) if a determination was not made prior to performing an abortion, the basis of the determination that a medical emergency existed; and

(15) for abortions performed after a determination of postfertilization age of 20 or more weeks, the basis of the determination that the pregnant woman had a condition that so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.

Sec. 24. **[145.4141] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 145.4141 to 145.4147, the following terms have the meanings given them.

Subd. 2. **Abortion.** "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to terminate the pregnancy of a woman known to be pregnant, with an intention other than to increase the probability of a live birth; to preserve the life or health of the child after live birth; or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma, or a criminal assault on the pregnant woman or her unborn child; and which causes the premature termination of the pregnancy.

Subd. 3. **Attempt to perform or induce an abortion.** "Attempt to perform or induce an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of

conduct planned to culminate in the performance or induction of an abortion in this state in violation of sections 145.4141 to 145.4147.

Subd. 4. **Fertilization.** "Fertilization" means the fusion of a human spermatozoon with a human ovum.

Subd. 5. **Medical emergency.** "Medical emergency" means a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman that it necessitates the immediate abortion of her pregnancy without first determining postfertilization age to avert her death or for which the delay necessary to determine postfertilization age will create serious risk of substantial and irreversible physical impairment of a major bodily function not including psychological or emotional conditions. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Subd. 6. **Physician.** "Physician" means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in this state.

Subd. 7. **Postfertilization age.** "Postfertilization age" means the age of the unborn child as calculated from the fusion of a human spermatozoon with a human ovum.

Subd. 8. **Probable postfertilization age of the unborn child.** "Probable postfertilization age of the unborn child" means what, in reasonable medical judgment, will with reasonable probability be the postfertilization age of the unborn child at the time the abortion is planned to be performed or induced.

Subd. 9. **Reasonable medical judgment.** "Reasonable medical judgment" means a medical judgment that would be made by a reasonably prudent physician knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.

Subd. 10. **Unborn child or fetus.** "Unborn child" or "fetus" means an individual organism of the species homo sapiens from fertilization until live birth.

Subd. 11. **Woman.** "Woman" means a female human being whether or not she has reached the age of majority.

Sec. 25. **[145.4142] LEGISLATIVE FINDINGS.**

(a) The legislature makes the following findings.

(b) Pain receptors (nociceptors) are present throughout an unborn child's entire body and nerves link these receptors to the brain's thalamus and subcortical plate by 20 weeks.

(c) By eight weeks after fertilization, an unborn child reacts to touch. After 20 weeks an unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example by recoiling.

(d) In the unborn child, application of such painful stimuli is associated with significant increases in stress hormones known as the stress response.

(e) Subjection to such painful stimuli is associated with long-term harmful neurodevelopmental effects, such as altered pain sensitivity and, possibly, emotional, behavioral, and learning disabilities later in life.

(f) For the purposes of surgery on an unborn child, fetal anesthesia is routinely administered and is associated with a decrease in stress hormones compared to the level when painful stimuli is applied without anesthesia.

(g) The position, asserted by some medical experts, that an unborn child is incapable of experiencing pain until a point later in pregnancy than 20 weeks after fertilization predominately rests on the assumption that the ability to experience pain depends on the cerebral cortex and requires nerve connections between the thalamus and the cortex. However, recent medical research and analysis, especially since 2007, provides strong evidence for the conclusion that a functioning cortex is not necessary to experience pain.

(h) Substantial evidence indicates that children born missing the bulk of the cerebral cortex, those with hydranencephaly, nevertheless experience pain.

(i) In adults, stimulation or ablation of the cerebral cortex does not alter pain perception, while stimulation or ablation of the thalamus does.

(j) Substantial evidence indicates that structures used for pain processing in early development differ from those of adults, using different neural elements available at specific times during development, such as the subcortical plate, to fulfill the role of pain processing.

(k) The position asserted by some medical experts, that the unborn child remains in a coma-like sleep state that precludes the unborn child experiencing pain is inconsistent with the documented reaction of unborn children to painful stimuli and with the experience of fetal surgeons who have found it necessary to sedate the unborn child with anesthesia to prevent the unborn child from thrashing about in reaction to invasive surgery.

(l) Consequently, there is substantial medical evidence that an unborn child is capable of experiencing pain by 20 weeks after fertilization.

(m) It is the purpose of the state to assert a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain.

Sec. 26. **[145.4143] DETERMINATION OF POSTFERTILIZATION AGE.**

Subdivision 1. **Determination of postfertilization age.** Except in the case of a medical emergency, no abortion shall be performed or induced or be attempted to be performed or induced unless the physician performing or inducing it has first made a determination of the probable postfertilization age of the unborn child or relied upon such a determination made by another physician. In making such a determination, the physician shall make those inquiries of the woman and perform or cause to be performed those medical examinations and tests that a reasonably prudent physician, knowledgeable about the case and the medical conditions involved, would consider necessary to perform in making an accurate diagnosis with respect to postfertilization age.

Subd. 2. **Unprofessional conduct.** Failure by any physician to conform to any requirement of this section constitutes unprofessional conduct under section 147.091, subdivision 1, paragraph (k).

Sec. 27. **[145.4144] ABORTION OF UNBORN CHILD OF 20 OR MORE WEEKS POSTFERTILIZATION AGE PROHIBITED; CAPABLE OF FEELING PAIN.**

Subdivision 1. **Abortion prohibition; exemption.** No person shall perform or induce or attempt to perform or induce an abortion upon a woman when it has been determined, by the physician performing or inducing or attempting to perform or induce the abortion, or by another physician upon whose determination that physician relies, that the probable postfertilization age of the woman's unborn child is 20 or more weeks unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Subd. 2. **When abortion not prohibited.** When an abortion upon a woman whose unborn child has been determined to have a probable postfertilization age of 20 or more weeks is not prohibited by this section, the physician shall terminate the pregnancy in the

manner which, in reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in reasonable medical judgment, termination of the pregnancy in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the woman than would other available methods. No such greater risk shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function.

Sec. 28. **[145.4145] ENFORCEMENT.**

Subdivision 1. **Criminal penalties.** A person who intentionally or recklessly performs or induces or attempts to perform or induce an abortion in violation of sections 145.4141 to 145.4147 shall be guilty of a felony. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

Subd. 2. **Civil remedies.** (a) A woman upon whom an abortion has been performed or induced in violation of sections 145.4141 to 145.4147, or the father of the unborn child who was the subject of such an abortion, may maintain an action against the person who performed or induced the abortion in intentional or reckless violation of sections 145.4141 to 145.4147 for damages. A woman upon whom an abortion has been attempted in violation of sections 145.4141 to 145.4147 may maintain an action against the person who attempted to perform or induce the abortion in an intentional or reckless violation of sections 145.4141 to 145.4147 for damages.

(b) A cause of action for injunctive relief against a person who has intentionally violated sections 145.4141 to 145.4147 may be maintained by the woman upon whom an abortion was performed or induced or attempted to be performed or induced in violation of sections 145.4141 to 145.4147; by a person who is the father of the unborn child subject to an abortion, parent, sibling, or guardian of, or a current or former licensed health care provider of, the woman upon whom an abortion has been performed or induced or attempted to be performed or induced in violation of sections 145.4141 to 145.4147; by a county attorney with appropriate jurisdiction; or by the attorney general. The injunction shall prevent the abortion provider from performing or inducing or attempting to perform or induce further abortions in this state in violation of sections 145.4141 to 145.4147.

(c) If judgment is rendered in favor of the plaintiff in an action described in this section, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant.

(d) If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

(e) No damages or attorney fees may be assessed against the woman upon whom an abortion was performed or induced or attempted to be performed or induced except according to paragraph (d).

Sec. 29. **[145.4146] PROTECTION OF PRIVACY IN COURT PROCEEDINGS.**

In every civil or criminal proceeding or action brought under the Pain-Capable Unborn Child Protection Act, the court shall rule on whether the anonymity of a woman upon whom an abortion has been performed or induced or attempted to be performed or induced shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each such order shall be accompanied by specific written findings explaining why the anonymity of the woman should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the woman upon whom an abortion has been performed or induced or attempted to be performed or induced, anyone, other than a public official, who brings an action under section 145.4145, subdivision 2, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant or from attorneys for the defendant.

Sec. 30. **[145.4147] SEVERABILITY.**

If any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of sections 145.4141 to 145.4146, or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4141 to 145.4146 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4141 to 145.4146, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of sections 145.4141 to 145.4146, or the application of sections 145.4141 to 145.4146, would be declared unconstitutional.

Sec. 31. Minnesota Statutes 2018, section 145.4235, subdivision 2, is amended to read:

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence ~~for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011~~ for at least two years prior to the date the agency or organization submits an application to the commissioner for a grant under this section.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) The commissioner shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information is medically accurate.

Sec. 32. Minnesota Statutes 2018, section 145.4242, is amended to read:

145.4242 INFORMED CONSENT.

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed;

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored website, and what the website address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the website, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), item (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

(c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly incompatible with life must be informed of available perinatal hospice services and offered

this care as an alternative to abortion. If perinatal hospice services are declined, voluntary and informed consent by the female seeking an abortion is given if the female receives the information required in paragraphs (a), clause (1), and (b). The female must comply with the requirements in paragraph (a), clauses (3) and (4).

(d) If, at any time prior to the performance of an abortion, a female undergoes an ultrasound examination, or a physician determines that ultrasound imaging will be used during the course of a patient's abortion, the physician or the physician's agent shall orally inform the patient of the opportunity to view or decline to view an active ultrasound image of the unborn child.

Sec. 33. Minnesota Statutes 2018, section 145.4244, is amended to read:

145.4244 INTERNET WEBSITE.

(a) The commissioner of health shall develop and maintain a stable Internet website to provide the information described under section 145.4243. No information regarding who uses the website shall be collected or maintained. The commissioner of health shall monitor the website on a weekly basis to prevent and correct tampering.

(b) A health care facility performing abortions must provide the information described in section 145.4243 on the facility's website or provide a link to the Department of Health website where this information may be viewed.

Sec. 34. Minnesota Statutes 2018, section 145.928, subdivision 1, is amended to read:

Subdivision 1. **Goal; establishment.** It is the goal of the state~~, by 2010,~~ to decrease ~~by 50 percent~~ the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, access to and utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Sec. 35. Minnesota Statutes 2018, section 145.928, subdivision 7, is amended to read:

Subd. 7. **Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates.** (a) The commissioner shall award grants to eligible

applicants for local or regional projects and initiatives directed at reducing health disparities in one or ~~both~~ more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; ~~or~~

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

~~(2)~~ (3) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or ~~both~~ more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact ~~both~~ two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Sec. 36. Minnesota Statutes 2018, section 145.986, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the ~~top three~~ leading preventable causes of illness and death~~: tobacco use and exposure, poor diet, and lack of regular physical activity~~ as determined by the commissioner through the statewide health assessment;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Sec. 37. Minnesota Statutes 2018, section 145.986, subdivision 1a, is amended to read:

Subd. 1a. **Grants to local communities.** (a) ~~Beginning July 1, 2009,~~ The commissioner of health shall award competitive grants to community health boards and tribal governments to convene, coordinate, and implement ~~evidence-based~~ proven-effective strategies ~~targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco~~, and promising practices or activities that can be evaluated using experimental or quasi-experimental design. Grants shall be awarded to all community health boards and tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and other requirements of this section.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, work site, and health care settings;

(5) be focused on policy, systems, and environmental changes that support healthy behaviors; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

(f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

(g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) ~~Beginning November 1, 2015, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to implement health improvement strategies that improve the health status, delay the expression of dementia, or slow the progression of dementia, for a targeted population at risk for dementia and shall award at least two of the grants awarded on November 1, 2015, for these purposes. The grants must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services, the Minnesota Board on Aging, and community-based organizations with a focus on dementia. Each grant must include selected outcomes and evaluation measures related to the incidence or progression of dementia among the targeted population using the procedure described in subdivision 2.~~ For purposes of this subdivision, "proven-effective strategy" means a strategy or practice that offers a high level of research on effectiveness for at least one outcome of interest; and "promising practice or activity" means a practice or activity that is supported by research demonstrating effectiveness for at least one outcome of interest.

~~(i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of using a grant awarded under this subdivision to confront the opioid addiction and overdose epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for these purposes. The grants awarded under this paragraph must meet all other requirements of this section. The commissioner shall coordinate grant planning activities with the commissioner of human services. Each grant shall include selected outcomes and evaluation measures related to addressing the opioid epidemic.~~

Sec. 38. Minnesota Statutes 2018, section 145.986, subdivision 4, is amended to read:

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct a biennial evaluation of the statewide health improvement program grants funded under this section. The evaluation must use the most appropriate experimental or quasi-experimental design suitable for the grant activity or project. Grant recipients shall cooperate with the commissioner in the evaluation and provide the

commissioner with the information necessary to conduct the evaluation, including information on any impact on the health indicators listed in section 62U.10, subdivision 6, within the geographic area or among the population targeted.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems. The commissioner shall consult with the commissioner of management and budget to ensure that the evaluation process is using experimental or quasi-experimental design.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

(e) For purposes of this subdivision, "experimental design" means a method of evaluating the impact of a strategy that uses random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated; and "quasi-experimental design" means a method of evaluating the impact of a strategy that uses an approach other than random assignment to establish statistically similar groups, so that any difference in outcomes found at the end of the evaluation can be attributed to the strategy being evaluated.

Sec. 39. Minnesota Statutes 2018, section 145.986, subdivision 5, is amended to read:

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. The report must include information on each grant recipient, including the activities that were conducted by the grantee using grant funds, the grantee's progress toward achieving the measurable outcomes established under subdivision 2, and the data provided to the commissioner by the grantee to measure these outcomes for grant activities. The commissioner shall provide information on grants in which a corrective action plan was required under subdivision 1a, the types of plan action, and the progress that has been made toward meeting the measurable

outcomes. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. ~~In the report due on January 15, 2014,~~ In the reports due beginning January 15, 2020, the commissioner shall include a description of the contracts awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems that were designed and implemented under these contracts.

Sec. 40. Minnesota Statutes 2018, section 145.986, subdivision 6, is amended to read:

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs ~~that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~, or replace discontinued state or federal funds ~~previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco~~. Funds must not be used to supplant current state or local funding to community health boards or tribal governments ~~used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use~~.

Sec. 41. Minnesota Statutes 2018, section 152.22, is amended by adding a subdivision to read:

Subd. 5a. **Hemp.** "Hemp" means industrial hemp as defined in section 18K.02, subdivision 3.

Sec. 42. Minnesota Statutes 2018, section 152.22, subdivision 6, is amended to read:

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil but which does not require the use of dried leaves or plant form; or

(4) any other method, excluding smoking, approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22

to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp grower licensed under chapter 18K as permitted under section 152.29, subdivision 1, paragraph (b).

Sec. 43. Minnesota Statutes 2018, section 152.25, subdivision 4, is amended to read:

Subd. 4. **Reports.** (a) The commissioner shall provide regular updates to the task force on medical cannabis therapeutic research and to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, public safety, judiciary, and civil law regarding: (1) any changes in federal law or regulatory restrictions regarding the use of medical cannabis and hemp; and (2) the market demand and supply in this state for hemp products that can be used for medicinal purposes.

(b) The commissioner may submit medical research based on the data collected under sections 152.22 to 152.37 to any federal agency with regulatory or enforcement authority over medical cannabis to demonstrate the effectiveness of medical cannabis for treating a qualifying medical condition.

Sec. 44. Minnesota Statutes 2018, section 152.28, subdivision 1, is amended to read:

Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in the registry program, a health care practitioner shall:

(1) determine, in the health care practitioner's medical judgment, whether a patient suffers from a qualifying medical condition, and, if so determined, provide the patient with a certification of that diagnosis;

(2) determine whether a patient is developmentally or physically disabled and, as a result of that disability, the patient is unable to self-administer medication or acquire medical cannabis from a distribution facility, and, if so determined, include that determination on the patient's certification of diagnosis;

(3) advise patients, registered designated caregivers, and parents or legal guardians who are acting as caregivers of the existence of any nonprofit patient support groups or organizations;

(4) provide explanatory information from the commissioner to patients with qualifying medical conditions, including disclosure to all patients about the experimental nature of therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the

proposed treatment; the application and other materials from the commissioner; and provide patients with the Tennessen warning as required by section 13.04, subdivision 2; and

(5) agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner.

(b) Upon notification from the commissioner of the patient's enrollment in the registry program, the health care practitioner shall:

(1) participate in the patient registry reporting system under the guidance and supervision of the commissioner;

(2) report health records of the patient throughout the ongoing treatment of the patient to the commissioner in a manner determined by the commissioner and in accordance with subdivision 2;

(3) determine, on a yearly basis, if the patient continues to suffer from a qualifying medical condition and, if so, issue the patient a new certification of that diagnosis; and

(4) otherwise comply with all requirements developed by the commissioner.

(c) A health care practitioner may conduct a patient assessment to issue a recertification as required under paragraph (b), clause (3), via telemedicine as defined under section 62A.671, subdivision 9.

~~(c)~~ (d) Nothing in this section requires a health care practitioner to participate in the registry program.

Sec. 45. Minnesota Statutes 2018, section 152.29, subdivision 1, is amended to read:

Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer shall operate ~~four~~ eight distribution facilities, which may include the manufacturer's single location for cultivation, harvesting, manufacturing, packaging, and processing but is not required to include that location. ~~A manufacturer is required to begin distribution of medical cannabis from at least one distribution facility by July 1, 2015. All distribution facilities must be operational and begin distribution of medical cannabis by July 1, 2016. The distribution facilities shall be located~~ The commissioner shall designate the geographical service areas to be served by each manufacturer based on geographical need throughout the state to improve patient access. ~~A manufacturer shall disclose the proposed locations for the distribution facilities to the commissioner during the registration process.~~ A manufacturer shall not have more than two distribution facilities in each geographical service area assigned to the manufacturer by the commissioner. A manufacturer shall operate only one location

where all cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis shall be conducted. ~~Any~~ This location may be one of the manufacturer's distribution facility sites. The additional distribution facilities may dispense medical cannabis and medical cannabis products but may not contain any medical cannabis in a form other than those forms allowed under section 152.22, subdivision 6, and the manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or processing at ~~an additional~~ the other distribution facility ~~site~~ sites. Any distribution facility operated by the manufacturer is subject to all of the requirements applying to the manufacturer under sections 152.22 to 152.37, including, but not limited to, security and distribution requirements.

(b) A manufacturer may obtain hemp from a hemp grower licensed with the commissioner of agriculture under chapter 18K if the hemp was grown in this state. A manufacturer may use hemp for the purpose of making it available in a form allowable under section 152.22, subdivision 6. Any hemp acquired by a manufacturer under this paragraph is subject to the same quality control program, security and testing requirements, and any other requirement for medical cannabis under sections 152.22 to 152.37 and Minnesota Rules, chapter 4770.

~~(b)~~ (c) A medical cannabis manufacturer shall contract with a laboratory approved by the commissioner, subject to any additional requirements set by the commissioner, for purposes of testing medical cannabis manufactured or hemp acquired by the medical cannabis manufacturer as to content, contamination, and consistency to verify the medical cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory testing shall be paid by the manufacturer.

~~(c)~~ (d) The operating documents of a manufacturer must include:

(1) procedures for the oversight of the manufacturer and procedures to ensure accurate record keeping; ~~and~~

(2) procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabis and unauthorized entrance into areas containing medical cannabis~~.~~ ; and

(3) procedures for the delivery and transportation of hemp between hemp growers licensed under chapter 18K and manufacturers.

~~(d)~~ (e) A manufacturer shall implement security requirements, including requirements for the delivery and transportation of hemp, protection of each location by a fully operational security alarm system, facility access controls, perimeter intrusion detection systems, and a personnel identification system.

~~(e)~~ (f) A manufacturer shall not share office space with, refer patients to a health care practitioner, or have any financial relationship with a health care practitioner.

~~(f)~~ (g) A manufacturer shall not permit any person to consume medical cannabis on the property of the manufacturer.

~~(g)~~ (h) A manufacturer is subject to reasonable inspection by the commissioner.

~~(h)~~ (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

~~(i)~~ (j) A medical cannabis manufacturer may not employ any person who is under 21 years of age or who has been convicted of a disqualifying felony offense. An employee of a medical cannabis manufacturer must submit a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees for submission to the Bureau of Criminal Apprehension before an employee may begin working with the manufacturer. The bureau must conduct a Minnesota criminal history records check and the superintendent is authorized to exchange the fingerprints with the Federal Bureau of Investigation to obtain the applicant's national criminal history record information. The bureau shall return the results of the Minnesota and federal criminal history records checks to the commissioner.

~~(j)~~ (k) A manufacturer may not operate in any location, whether for distribution or cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a public or private school existing before the date of the manufacturer's registration with the commissioner.

~~(k)~~ (l) A manufacturer shall comply with reasonable restrictions set by the commissioner relating to signage, marketing, display, and advertising of medical cannabis.

(m) Before a manufacturer acquires hemp, the manufacturer must verify that the person from whom the manufacturer is acquiring hemp has a valid license issued by the commissioner of agriculture under chapter 18K.

Sec. 46. Minnesota Statutes 2018, section 152.29, subdivision 2, is amended to read:

Subd. 2. **Manufacturer; production.** (a) A manufacturer of medical cannabis shall provide a reliable and ongoing supply of all medical cannabis needed for the registry program.

(b) All cultivation, harvesting, manufacturing, packaging, and processing of medical cannabis or manufacturing, packaging, or processing of hemp acquired by the manufacturer

must take place in an enclosed, locked facility at a physical address provided to the commissioner during the registration process.

(c) A manufacturer must process and prepare any medical cannabis plant material into a form allowable under section 152.22, subdivision 6, prior to distribution of any medical cannabis.

Sec. 47. Minnesota Statutes 2018, section 152.29, subdivision 3, is amended to read:

Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval for the distribution of medical cannabis to a patient.

(b) A manufacturer may dispense medical cannabis products, whether or not the products have been manufactured by the manufacturer, but is not required to dispense medical cannabis products.

(c) Prior to distribution of any medical cannabis, the manufacturer shall:

(1) verify that the manufacturer has received the registry verification from the commissioner for that individual patient;

(2) verify that the person requesting the distribution of medical cannabis is the patient, the patient's registered designated caregiver, or the patient's parent or legal guardian listed in the registry verification using the procedures described in section 152.11, subdivision 2d;

(3) assign a tracking number to any medical cannabis distributed from the manufacturer;

(4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to chapter 151 has consulted with the patient to determine the proper dosage for the individual patient after reviewing the ranges of chemical compositions of the medical cannabis and the ranges of proper dosages reported by the commissioner. For purposes of this clause, a consultation may be conducted remotely using a videoconference, so long as the employee providing the consultation is able to confirm the identity of the patient, the consultation occurs while the patient is at a distribution facility, and the consultation adheres to patient privacy requirements that apply to health care services delivered through telemedicine;

(5) properly package medical cannabis in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients, and label distributed medical cannabis with a list of all active ingredients and individually identifying information, including:

(i) the patient's name and date of birth;

(ii) the name and date of birth of the patient's registered designated caregiver or, if listed on the registry verification, the name of the patient's parent or legal guardian, if applicable;

(iii) the patient's registry identification number;

(iv) the chemical composition of the medical cannabis; and

(v) the dosage; and

(6) ensure that the medical cannabis distributed contains a maximum of a ~~30-day~~ 90-day supply of the dosage determined for that patient.

(d) A manufacturer shall require any employee of the manufacturer who is transporting medical cannabis or medical cannabis products to a distribution facility to carry identification showing that the person is an employee of the manufacturer.

Sec. 48. Minnesota Statutes 2018, section 152.29, subdivision 3a, is amended to read:

Subd. 3a. **Transportation of medical cannabis; staffing.** (a) A medical cannabis manufacturer may staff a transport motor vehicle with only one employee if the medical cannabis manufacturer is transporting medical cannabis to either a certified laboratory for the purpose of testing or a facility for the purpose of disposal. If the medical cannabis manufacturer is transporting medical cannabis for any other purpose or destination, the transport motor vehicle must be staffed with a minimum of two employees as required by rules adopted by the commissioner.

(b) Notwithstanding paragraph (a), a medical cannabis manufacturer that is only transporting hemp for any purpose may staff the transport motor vehicle with only one employee.

Sec. 49. Minnesota Statutes 2018, section 152.31, is amended to read:

152.31 DATA PRACTICES.

(a) Government data in patient files maintained by the commissioner and the health care practitioner, and data submitted to or by a medical cannabis manufacturer, are private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13 and complying with a request from the legislative auditor or the state auditor in the performance of official duties. The provisions of section 13.05, subdivision 11, apply to a

registration agreement entered between the commissioner and a medical cannabis manufacturer under section 152.25.

(b) Not public data maintained by the commissioner may not be used for any purpose not provided for in sections 152.22 to 152.37, and may not be combined or linked in any manner with any other list, dataset, or database.

(c) The commissioner may execute data sharing arrangements with the commissioner of agriculture to verify licensing information, inspection, and compliance related to hemp growers under chapter 18K.

Sec. 50. Minnesota Statutes 2018, section 157.22, is amended to read:

157.22 EXEMPTIONS.

This chapter does not apply to:

(1) interstate carriers under the supervision of the United States Department of Health and Human Services;

(2) weddings, fellowship meals, or funerals conducted by a faith-based organization using any building constructed and primarily used for religious worship or education;

(3) any building owned, operated, and used by a college or university in accordance with health regulations promulgated by the college or university under chapter 14;

(4) any person, firm, or corporation whose principal mode of business is licensed under sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage establishment; provided that the holding of any license pursuant to sections 28A.04 and 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of this chapter or the rules of the state commissioner of health relating to food and beverage service establishments;

(5) family day care homes and group family day care homes governed by sections 245A.01 to 245A.16;

(6) nonprofit senior citizen centers for the sale of home-baked goods;

(7) fraternal, sportsman, or patriotic organizations that are tax exempt under section 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue Code of 1986, or organizations related to, affiliated with, or supported by such fraternal, sportsman, or patriotic organizations for events held in the building or on the grounds of the organization and at which home-prepared food is donated by organization members for sale at the events, provided:

(i) the event is not a circus, carnival, or fair;

(ii) the organization controls the admission of persons to the event, the event agenda, or both; and

(iii) the organization's licensed kitchen is not used in any manner for the event;

(8) food not prepared at an establishment and brought in by individuals attending a potluck event for consumption at the potluck event. An organization sponsoring a potluck event under this clause may advertise the potluck event to the public through any means. Individuals who are not members of an organization sponsoring a potluck event under this clause may attend the potluck event and consume the food at the event. Licensed food establishments other than schools cannot be sponsors of potluck events. A school may sponsor and hold potluck events in areas of the school other than the school's kitchen, provided that the school's kitchen is not used in any manner for the potluck event. For purposes of this clause, "school" means a public school as defined in section 120A.05, subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at which a child is provided with instruction in compliance with sections 120A.22 and 120A.24. Potluck event food shall not be brought into a licensed food establishment kitchen;

(9) a home school in which a child is provided instruction at home;

(10) school concession stands serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626;

(11) group residential facilities of ten or fewer beds licensed by the commissioner of human services under Minnesota Rules, chapter 2960, provided the facility employs or contracts with a certified food manager under Minnesota Rules, part 4626.2015;

(12) food served at fund-raisers or community events conducted in the building or on the grounds of a faith-based organization, provided that a certified food manager, or a volunteer trained in a food safety course, trains the food preparation workers in safe food handling practices. This exemption does not apply to faith-based organizations at the state agricultural society or county fairs or to faith-based organizations that choose to apply for a license;

(13) food service events conducted following a disaster for purposes of feeding disaster relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods, as defined in Minnesota Rules, chapter 4626; ~~and~~

(14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a community-based nonprofit organization, provided:

(i) the municipality where the event is located approves the event;

(ii) the sponsoring organization must develop food safety rules and ensure that participants follow these rules; and

(iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign or placard must be posted that states: "These products are homemade and not subject to state inspection."

Foods exempt under this clause must be labeled to accurately reflect the name and address of the person preparing the foods~~.~~; and

(15) a special event food stand or a seasonal temporary food stand provided:

(i) the stand is operated solely by a person or persons under the age of 14;

(ii) the stand is located on private property with the permission of the property owner;

(iii) the stand has gross receipts or contributions of $1,000 or less in a calendar year; and

(iv) the operator of the stand posts a sign or placard at the site that states "The products sold at this stand are not subject to state inspection or regulation.", if the stand offers for sale potentially hazardous food as defined in Minnesota Rules, part 4626.0020, subdivision 62.

Sec. 51. **DIRECTION TO THE COMMISSIONER OF HEALTH.**

The commissioner of health shall prescribe the notification and consent form described in Minnesota Statutes, section 144.6502, subdivision 6, no later than January 1, 2020. The commissioner shall make the form available on the department's website.

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

Sec. 52. **PERINATAL HOSPICE GRANTS.**

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

(b) "Eligible program entity" means a hospital, hospice, health care facility, or community-based organization. An eligible program entity must have a perinatal hospice program coordinator who is eligible to be certified in perinatal loss care.

(c) "Eligible training entity" means an eligible program entity that has experience providing perinatal hospice services, or a qualified individual who is eligible to be certified in perinatal loss care and has experience providing perinatal hospice services.

(d) "Eligible to be certified in perinatal loss care" means an individual who meets the criteria to sit for the perinatal loss care exam, or is already certified in perinatal loss care, by the Hospice and Palliative Credentialing Center.

(e) "Life-limiting prenatal diagnosis" means a fetal condition diagnosed before birth that will with reasonable certainty result in the death of the child within six months after birth.

(f) "Perinatal hospice" means comprehensive support to the pregnant woman and her family that includes family-centered multidisciplinary care to meet their medical, spiritual, and emotional needs from the time of a life-limiting prenatal diagnosis through the birth, life, and natural death of the child, and through the postpartum period. Supportive care may be provided by medical staff, counselors, clergy, mental health providers, social workers, geneticists, certified nurse midwives, hospice professionals, and others.

Subd. 2. **Perinatal hospice development grants.** Perinatal hospice development grants are available to eligible program entities and must be used for expenditures to:

(1) establish a new perinatal hospice program;

(2) expand an existing perinatal hospice program;

(3) recruit a perinatal hospice program coordinator; or

(4) fund perinatal hospice administrative and coordinator expenses for a period of not more than six months.

Subd. 3. **Perinatal hospice training grants.** Perinatal hospice training grants are available to eligible training entities and may be used for expenses to enable existing perinatal hospice programs to provide training for members of a multidisciplinary team providing perinatal hospice services. Funds must be used for:

(1) development and operation of a perinatal hospice training program. The curriculum must include but is not limited to training to provide the following services to families eligible for perinatal hospice:

(i) counseling at the time of a life-limiting prenatal diagnosis;

(ii) specialized birth planning;

(iii) specialized advance care planning;

(iv) services to address the emotional needs of the family through prenatal and postpartum counseling that:

(A) helps the family prepare for the death of their child;

(B) helps the family work within the health care delivery system to create a safe and professionally supported environment where parents can parent their child during their brief life in a way that is meaningful for that family and baby; and

(C) helps the family with the grief that begins at diagnosis and continues after the death of the child; and

(v) evidence-based perinatal bereavement care;

(2) trainer support, including travel expenses and reasonable living expenses during the period of training;

(3) trainee support, including tuition, books, travel expenses, program fees, and reasonable living expenses during the period of training; or

(4) materials used in the provision of training.

Subd. 4. **Perinatal hospice awareness grants.** Perinatal hospice awareness grants are available to eligible program entities and may be used for the creation and distribution of materials promoting awareness of perinatal hospice programs.

Subd. 5. **Report.** The commissioner of health shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by February 1, 2023, on how the grant funds have been used.

Sec. 53. **PLAN FOR A WORKING GROUP ON LINKS BETWEEN HEALTH DISPARITIES AND EDUCATIONAL ACHIEVEMENT FOR CHILDREN FROM AMERICAN INDIAN COMMUNITIES AND COMMUNITIES OF COLOR.**

(a) The commissioner of health, in consultation with the commissioner of education, shall develop a plan to convene one or more working groups to:

(1) examine the links between health disparities and disparities in educational achievement for children from American Indian communities and communities of color; and

(2) develop recommendations for programs, services, or funding to address health disparities and decrease disparities in educational achievement for children from American Indian communities and communities of color.

(b) The plan shall include the possible membership of the proposed working group and the duties for the proposed working group.

(c) The commissioner shall submit the plan for the working group, including proposed legislation establishing the working group, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and education by February 15, 2020.

Sec. 54. **SHORT TITLE.**

Minnesota Statutes, sections 145.4141 to 145.4147 may be cited as the "Pain-Capable Unborn Child Protection Act."

Sec. 55. **STUDY ON BREASTFEEDING DISPARITIES; STAKEHOLDER ENGAGEMENT.**

(a) The commissioner of health shall work with community stakeholders in Minnesota including but not limited to representatives from the Minnesota Breastfeeding Coalition; Academy of Lactation Policy and Practice; International Board of Lactation Consultant Examiners; DONA International; HealthConnect; Reaching Sisters Everywhere; the La Leche League; the women, infants, and children program; hospitals and clinics; local public health professionals and organizations; community-based organizations; and representatives of populations with low breastfeeding rates to carry out a study to identify barriers, challenges, and successes affecting the initiation, duration, and exclusivity of breastfeeding.

(b) The study must address policy, systemic, and environmental factors that both support and create barriers to breastfeeding. The study must also identify and make recommendations regarding culturally appropriate practices that have been shown to increase breastfeeding rates in populations that have the greatest breastfeeding disparity rates.

(c) The commissioner shall submit a report on the study with any recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on or before September 15, 2020.

Sec. 56. **TRANSITION TO AUTHORIZED ELECTRONIC MONITORING IN CERTAIN HEALTH CARE FACILITIES.**

Any resident, resident representative, or other person conducting electronic monitoring in a resident's room or private living unit prior to January 1, 2020, must comply with the requirements of Minnesota Statutes, section 144.6502, by January 1, 2020.

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

Sec. 57. **REPEALER.**

Minnesota Statutes 2018, sections 144.1464; and 144.1911, are repealed.

ARTICLE 2
DEPARTMENT OF HUMAN SERVICES; HEALTH CARE

Section 1. **[254A.21] FETAL ALCOHOL SPECTRUM DISORDERS PREVENTION GRANTS.**

(a) The commissioner of human services shall award a grant to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders. The grant recipient must make subgrants to eligible regional collaboratives in rural and urban areas of the state for the purposes specified in paragraph (c).

(b) "Eligible regional collaboratives" means a partnership between at least one local government and at least one community-based organization and, where available, a family home visiting program. For purposes of this paragraph, a local government includes a county or a multicounty organization, a tribal government, a county-based purchasing entity, or a community health board.

(c) Eligible regional collaboratives must use subgrant funds to reduce the incidence of fetal alcohol spectrum disorders and other prenatal drug-related effects in children in Minnesota by identifying and serving pregnant women suspected of or known to use or abuse alcohol or other drugs. Eligible regional collaboratives must provide intensive services to chemically dependent women to increase positive birth outcomes.

(d) An eligible regional collaborative that receives a subgrant under this section must report to the grant recipient by January 15 of each year on the services and programs funded by the subgrant. The report must include measurable outcomes for the previous year, including the number of pregnant women served and the number of toxic-free babies born. The grant recipient must compile the information in the subgrant reports and submit a summary report to the commissioner of human services by February 15 of each year.

Sec. 2. Minnesota Statutes 2018, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

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

Sec. 3. Minnesota Statutes 2018, section 256B.056, subdivision 1, is amended to read:

Subdivision 1. **Residency.** (a) To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota, in accordance with Code of Federal Regulations, title 42, section 435.403.

(b) The commissioner shall identify individuals who are enrolled in medical assistance and who are absent from the state for more than 30 consecutive days, but who continue to qualify for medical assistance in accordance with paragraph (a).

(c) If the individual is absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota in accordance with paragraph (a), any covered service provided to the individual must be paid through the fee-for-service system and not through the managed care capitated rate payment system under section 256B.69 or 256L.12.

Sec. 4. Minnesota Statutes 2018, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the Supplemental Security Income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the Supplemental Security Income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the Supplemental Security Income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses;

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before

the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) Upon initial enrollment, no asset limit shall apply to persons eligible under section 256B.055, subdivision 15. Upon renewal, a person eligible under section 256B.055, subdivision 15, must not own either individually or as a member of a household more than $1,000,000 in assets to continue to be eligible for medical assistance.

Sec. 5. Minnesota Statutes 2018, section 256B.056, subdivision 7a, is amended to read:

Subd. 7a. **Periodic renewal of eligibility.** (a) The commissioner shall make an annual redetermination of eligibility based on information contained in the enrollee's case file and other information available to the agency, including but not limited to information accessed through an electronic database, without requiring the enrollee to submit any information when sufficient data is available for the agency to renew eligibility.

(b) If the commissioner cannot renew eligibility in accordance with paragraph (a), the commissioner must provide the enrollee with a prepopulated renewal form containing eligibility information available to the agency and permit the enrollee to submit the form with any corrections or additional information to the agency and sign the renewal form via any of the modes of submission specified in section 256B.04, subdivision 18.

(c) An enrollee who is terminated for failure to complete the renewal process may subsequently submit the renewal form and required information within four months after the date of termination and have coverage reinstated without a lapse, if otherwise eligible under this chapter. The local agency may close the enrollee's case file if the required information is not submitted within four months of termination.

(d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be required to renew eligibility every six months.

Sec. 6. Minnesota Statutes 2018, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination.** (a) Medical assistance covers ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination for an individual who:

(1) has been identified as having a mental illness or substance use disorder using a screening tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination through a diversion contract in lieu of incarceration.

(b) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) ~~Post-arrest~~ Officer-involved community-based ~~service~~ care coordination must be provided by an individual who is an employee of a county or is under contract with a county to provide ~~post-arrest~~ officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a licensed mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6);

(2) a mental health practitioner as defined in section 245.462, subdivision 17, working under the clinical supervision of a mental health professional; or

(3) a certified peer specialist under section 256B.0615, working under the clinical supervision of a mental health professional.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure that services and payments provided under ~~post-arrest~~ officer-involved community-based ~~service~~ care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, 256B.0753, 256B.0755, or 256B.0757.

~~(f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for post-arrest community-based service coordination services shall be provided by the county providing the services, from sources other than federal funds or funds used to match other federal funds.~~

Sec. 7. Minnesota Statutes 2018, section 256B.0625, is amended by adding a subdivision to read:

Subd. 66. **Prescribed pediatric extended care (PPEC) center basic services.** Medical assistance covers PPEC center basic services as defined under section 144H.01, subdivision 2. PPEC basic services shall be reimbursed according to section 256B.86.

EFFECTIVE DATE. This section is effective July 1, 2020, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the commissioner of health and the revisor of statutes when federal approval is obtained.

Sec. 8. **[256B.0633] MINNESOTA EHB BENCHMARK PLAN.**

Notwithstanding section 256B.0625, 256B.69, or any other law to the contrary, the services covered for parents and caretakers and for a single adult without children who are eligible for medical assistance under section 256B.055, subdivisions 3a and 15, shall be the services covered under the Minnesota EHB Benchmark Plan for plan year 2016 or the actuarial equivalent.

Sec. 9. Minnesota Statutes 2018, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; ~~and~~

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15; and

(10) persons who are absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision 1, paragraph (b).

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program

for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

Sec. 10. Minnesota Statutes 2018, section 256B.69, subdivision 31, is amended to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning July 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 4.0 percent for MinnesotaCare adults without children.

(f) The commissioner may limit trend increases to less than the maximum. For calendar year 2014, the commissioner shall reduce the maximum aggregate trend increases by $47,000,000 in state and federal funds to account for the reductions in administrative expenses in subdivision 5i.

(g) Beginning July 1, 2019, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2020, 2021, 2023, and 2024:

(1) 4.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 4.0 percent for medical assistance special needs basic care;

(3) 3.0 percent for medical assistance families and children; and

(4) 3.0 percent for medical assistance adults without children.

Sec. 11. **[256B.86] PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTER SERVICES.**

Subdivision 1. **Reimbursement rates.** The daily per-child payment rates for PPEC basic services covered by medical assistance and provided at PPEC centers licensed under chapter 144H are:

(1) for intense complexity: $550 for four or more hours and $275 for less than four hours;

(2) for high complexity: $450 for four or more hours and $225 for less than four hours; and

(3) for moderate complexity: $400 for four or more hours and $200 for less than four hours.

Subd. 2. **Determination of complexity level.** Complexity level shall be determined based on the level of nursing intervention required for each child using an assessment tool approved by the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2020, or upon federal approval, whichever occurs later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 12. Minnesota Statutes 2018, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent for families or individuals with incomes equal to or below 150 percent of the federal poverty guidelines; and to 87 percent for families or individuals with incomes that are above 150 percent of the federal poverty guidelines and equal to or less than 200 percent of the federal poverty guidelines for the applicable family size. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

Sec. 13. Minnesota Statutes 2018, section 256L.03, is amended by adding a subdivision to read:

Subd. 7. **Minnesota EHB Benchmark Plan.** Notwithstanding subdivisions 1, 2, 3, 3a, and 3b, and section 256L.12, or any other law to the contrary, the services covered for parents, caretakers, foster parents, or legal guardians and single adults without children eligible for MinnesotaCare under section 256L.04 shall be the services covered under the Minnesota EHB Benchmark Plan for plan year 2016 or the actuarial equivalent.

Sec. 14. **CORRECTIVE PLAN TO ELIMINATE DUPLICATE PERSONAL IDENTIFICATION NUMBERS.**

(a) The commissioner of human services shall design and implement a corrective plan to address the issue of medical assistance enrollees being assigned more than one personal identification number. Any corrections or fixes that are necessary to address this issue are required to be completed by June 30, 2021.

(b) By February 15, 2020, the commissioner shall submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the progress of the corrective plan required in paragraph (a), including an update on meeting the June 30, 2021, deadline. The report must also include information on:

(1) the number of medical assistance enrollees who have been assigned two or more personal identification numbers;

(2) any possible financial effect of enrollees having duplicate personal identification numbers on health care providers and managed care organizations, including the effect on reimbursement rates, meeting withhold requirements, and capitated payments; and

(3) any effect on federal payments received by the state.

Sec. 15. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; QUALITY MEASURES FOR PRESCRIBED PEDIATRIC EXTENDED CARE (PPEC) CENTERS.**

(a) The commissioner of human services, in consultation with community stakeholders as defined by the commissioner and PPEC centers licensed prior to June 30, 2024, shall develop quality measures for PPEC centers, procedures for PPEC centers to report quality measures to the commissioner, and methods for the commissioner to make the results of the quality measures available to the public.

(b) The commissioner of human services shall submit by February 1, 2024, a report on the topics described in paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services.

EFFECTIVE DATE. This section is effective upon the effective date of section 13.

Sec. 16. **REPEALER.**

Minnesota Statutes 2018, sections 16A.724, subdivision 2; and 256B.0625, subdivision 31c, are repealed.

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

ARTICLE 3
OPERATIONS

Section 1. Minnesota Statutes 2018, section 16A.055, subdivision 1a, is amended to read:

Subd. 1a. **Additional duties.** The commissioner may assist state agencies by providing analytical, statistical, program evaluation using experimental or quasi-experimental design, and organizational development services to state agencies in order to assist the agency to achieve the agency's mission and to operate efficiently and effectively. For purposes of this section, "experimental design" means a method of evaluating the impact of a service that uses random assignment to assign participants into groups that respectively receive the studied service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service; and "quasi-experimental design" means a method of evaluating the impact of a service that uses strategies other than random assignment to establish statistically similar groups that respectively receive the service and those that receive service as usual, so that any difference in outcomes found at the end of the evaluation can be attributed to the studied service.

Sec. 2. **[245I.01] OFFICE OF INSPECTOR GENERAL.**

Subdivision 1. **Creation.** A state Office of Inspector General is created.

Subd. 2. **Director.** (a) The office shall be under the direction of an inspector general who shall be appointed by the governor, with the advice and consent of the senate, for a term ending on June 30 of the sixth calendar year after appointment. Senate confirmation of the inspector general shall be as provided by section 15.066. The inspector general shall appoint deputies to serve in the office as necessary to fulfill the duties of the office. The inspector general may delegate to a subordinate employee the exercise of a specified statutory power or duty, subject to the control of the inspector general. Every delegation must be by written order filed with the secretary of state.

(b) The inspector general shall be in the unclassified service, but may be removed only for cause.

Subd. 3. **Duties.** The inspector general shall, in coordination with counties where applicable:

(1) develop and maintain the licensing and regulatory functions related to hospitals, boarding care homes, outpatient surgical centers, birthing centers, nursing homes, home care agencies, supplemental nursing services agencies, hospice providers, housing with services establishments, assisted living facilities, prescribed pediatric extended care centers,

and board and lodging establishments with special services consistent with chapters 144A, 144D, 144G, and 144H, and sections 144.50 to 144.58, 144.615, and 157.17;

(2) notwithstanding the requirement under section 144A.52, subdivision 1, that the director of the Office of Health Facility Complaints be appointed by the commissioner of health, assume the role of director of the Office of Health Facility Complaints;

(3) develop and maintain the licensing and regulatory functions related to adult day care, child care and early education, children's residential facilities, foster care, home and community-based services, independent living assistance for youth, outpatient mental health clinics or centers, residential mental health treatment for adults, and substance use disorder treatment consistent with chapters 245, 245A, 245D, 245F, 245G, 245H, 252, and 256;

(4) conduct background studies according to sections 144.058, 144A.476, 144A.62, 144A.754, and 157.17 and chapter 245C. For the purpose of completing background studies, the inspector general shall have authority to access maltreatment data maintained by local welfare agencies or agencies responsible for assessing or investigating reports under section 626.556, and names of substantiated perpetrators related to maltreatment of vulnerable adults maintained by the commissioner of human services under section 626.557;

(5) develop and maintain the background study requirements consistent with chapter 245C;

(6) be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, providers, and other participants in the human services programs administered by the Department of Human Services;

(7) require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the human services programs administered by the Department of Human Services; and

(8) develop, maintain, and administer the common entry point established on July 1, 2015, under section 626.557, subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2020.

Sec. 3. **[245I.02] TRANSFER OF DUTIES.**

Subdivision 1. **Transfer and reorganization orders.** (a) Section 15.039 applies to the transfer of duties required by this chapter.

(b) For an employee affected by the transfer of duties required by this chapter, the seniority accrued by the employee at the employee's former agency transfers to the employee's new agency.

Subd. 2. **Transfer of duties from the commissioner of human services.** The commissioner of administration, with approval of the governor, may issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties of the commissioner of human services required by this chapter. The provision of section 16B.37, subdivision 1, stating that transfers under that section may be made only to an agency that has been in existence for at least one year does not apply to transfers to an agency created by this chapter.

Subd. 3. **Transfer of duties from the commissioner of health.** The commissioner of administration, with approval of the governor, may issue reorganization orders under section 16B.37 as necessary to carry out the transfer of duties of the commissioner of health required by this chapter. The provision of section 16B.37, subdivision 1, stating that transfers under that section may be made only to an agency that has been in existence for at least one year does not apply to transfers to an agency created by this chapter.

Subd. 4. **Aggregate cost limit.** The commissioner of management and budget must ensure that the aggregate cost for the inspector general of the Office of Inspector General is not more than the aggregate cost of the primary executives in the Office of Inspector General at the Department of Human Services and the Health Regulation Division at the Department of Health immediately before the effective date of subdivision 2.

EFFECTIVE DATE. Subdivisions 1, 2, and 4, are effective July 1, 2020. Subdivision 3 is effective July 1, 2022.

Sec. 4. **INFORMATION TECHNOLOGY PROJECTS; PERFORMANCE REQUIREMENT.**

The commissioner of human services shall incorporate measurable indicators of progress toward completion into every information technology project contract. The indicators of progress toward completion must be periodic and at least measure progress for every 25 percent increment toward completion of the project. Every contract must withhold at least ten percent of the total contract amount until the project is complete. The contract must specify that in every instance where an indicator of progress toward completion is not met, a specified proportion of the contract shall be withheld. The minimum amount withheld shall be ten percent of the cumulative amount of the contract up to the date of the failure to meet the indicator of progress toward completion. If an information technology project is

not completed on time according to the original contract, the commissioner shall reduce the amount of the contract by ten percent.

Sec. 5. **REDUCING APPROPRIATIONS FOR UNFILLED POSITIONS.**

Subdivision 1. **Reduction required.** The general fund and nongeneral fund appropriations to the Department of Human Services for agency operations for the biennium ending June 30, 2021, are reduced for salary and benefit amounts attributable to any positions that are not filled within 180 days of the posting of the position. This section applies only to positions that are posted in fiscal years 2019, 2020, and 2021. Reductions made under this section must be reflected as reductions in agency base budgets for fiscal years 2022 and 2023.

Subd. 2. **Reporting.** The commissioner of management and budget must report to the chairs and ranking minority members of the senate and the house of representatives health and human services finance committees regarding the amount of reductions in appropriations under this section.

Sec. 6. **EVALUATION OF GRANT PROGRAMS; PROVEN-EFFECTIVE PRACTICES.**

(a) In consultation with the commissioner of management and budget, the commissioner of human services shall establish a schedule to review the services delivered under grant programs administered by the commissioner of human services to determine whether the grant program prioritizes proven-effective or promising practices.

(b) In accordance with the schedule established in paragraph (a), the commissioner of human services, in consultation with the commissioner of management and budget, shall identify services to evaluate using an experimental or quasi-experimental design to provide information needed to modify or develop grant programs to promote proven-effective practices to improve the intended outcomes of the grant program.

(c) The commissioner of human services, in consultation with the commissioner of management and budget, shall develop reports for the legislature and other stakeholders to provide information on incorporating proven-effective practices in program and budget decisions. The commissioner of management and budget, under Minnesota Statutes, section 15.08, may obtain additional relevant data to support the evaluation activities under this section.

(d) For purposes of this section, the following terms have the meanings given:

(1) "proven-effective practice" means a service or practice that offers a high level of research on effectiveness for at least one outcome of interest, as determined through multiple evaluations outside of Minnesota or one or more local evaluation in Minnesota. The research on effectiveness used to determine whether a service is proven-effective must use rigorously implemented experimental or quasi-experimental designs; and

(2) "promising practices" means a service or practice that is supported by research demonstrating effectiveness for at least one outcome of interest, and includes a single evaluation that is not contradicted by other studies, but does not meet the full criteria for the proven-effective designation. The research on effectiveness used to determine whether a service is a promising practice must use rigorously implemented experimental or quasi-experimental designs.

Sec. 7. **REVISOR INSTRUCTION.**

The revisor of statutes, in consultation with staff from the House Research Department; House Fiscal Analysis; the Office of Senate Counsel, Research, and Fiscal Analysis; and the respective departments shall prepare legislation for introduction in the 2020 legislative session proposing the statutory changes needed to implement the transfers of duties required by sections 245I.01 and 245I.02.

EFFECTIVE DATE. This section is effective July 1, 2019.

ARTICLE 4
MNSURE

Section 1. Minnesota Statutes 2018, section 62V.05, subdivision 2, is amended to read:

Subd. 2. **Operations funding.** ~~(a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.~~

~~(c)~~ (a) Beginning January 1, 2016, through December 31, 2019, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to $20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.~~

(b) Beginning January 1, 2020, MNsure shall retain or collect up to two percent of total premiums for individual and small group health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

~~(e)~~ (c) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

(d) Interagency agreements between MNsure and the Department of Human Services, and the Public Assistance Cost Allocation Plan for the Department of Human Services, shall not be modified to reflect any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section, and no additional funding shall be transferred from the Department of Human Services to MNsure as a result of any changes to the percentage of premiums that MNsure is allowed to retain or collect under this section.

Sec. 2. Minnesota Statutes 2018, section 62V.05, subdivision 5, is amended to read:

Subd. 5. **Health carrier and health plan requirements; participation.** (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health plans to be offered through MNsure that satisfy federal requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

(1) apply uniformly to all health carriers and health plans in the individual market;

(2) apply uniformly to all health carriers and health plans in the small group market; and

(3) satisfy minimum federal certification requirements under ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(c) In accordance with ~~section 1311(c) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e), the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under ~~section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(e)(1)(B). ~~The board may consider:~~

~~(1) affordability;~~

~~(2) quality and value of health plans;~~

~~(3) promotion of prevention and wellness;~~

~~(4) promotion of initiatives to reduce health disparities;~~

~~(5) market stability and adverse selection;~~

~~(6) meaningful choices and access;~~

~~(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and~~

~~(8) other criteria that the board determines appropriate.~~

(e) A health plan that meets the minimum certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section, is deemed to be in the interest of qualified individuals and qualified employers. The board shall not establish certification requirements for health carriers and health plans for participation in MNsure that are in addition to the certification requirements under paragraph (c) and United States Code, title 42, section 18031(c)(1), and any regulations and guidance issued under that section. The board shall not determine the cost of, cost-sharing elements of, or benefits provided in health plans sold through MNsure.

~~(e)~~ (f) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

~~(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.~~

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with ~~section 1311(c)(1) of the Affordable Care Act, Public Law 111-148~~ United States Code, title 42, section 18031(c)(1).

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Sec. 3. Minnesota Statutes 2018, section 62V.05, subdivision 10, is amended to read:

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

(c) The commissioner of human services shall not bear insurance risk or enter into any agreement with providers to pay claims for any health coverage administered by the commissioner that is made available for purchase through the MNsure website as a qualifying health plan or as an alternative to purchasing a qualifying health plan through MNsure or an individual health plan offered outside of MNsure.

(d) Nothing in this subdivision shall prohibit:

(1) the commissioner of human services from administering the medical assistance program under chapter 256B and the MinnesotaCare program under chapter 256L, as long as health coverage under these programs is not purchased by the individual through the MNsure Web site; and

(2) employees of the Department of Human Services from obtaining insurance from the state employee group insurance program.

Sec. 4. Minnesota Statutes 2018, section 62V.08, is amended to read:

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, and each January 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of data practices laws or procedures; and (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.

(b) MNsure must publish its administrative and operational costs on a website to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The website must be updated at least annually.

(c) As part of the report required to be submitted to the legislature in paragraph (a), and the information required to be published in paragraph (b), MNsure shall include the total amount spent on business continuity planning, data privacy protection, and cyber security provisions.

Sec. 5. Laws 2015, chapter 71, article 12, section 8, is amended to read:

Sec. 8. **EXPANDED ACCESS TO QUALIFIED HEALTH PLANS AND SUBSIDIES.**

The commissioner of commerce, in consultation with the Board of Directors of MNsure and the MNsure Legislative Oversight Committee, shall develop a proposal to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies and to allow eligible individuals to receive advanced premium tax credits and cost-sharing reductions when purchasing these health plans. The commissioner shall seek all federal waivers and approvals necessary to implement this proposal and shall submit the necessary federal waivers and approvals to the federal government no later than October 1, 2019. The commissioner shall submit a draft proposal to the MNsure board and the MNsure Legislative Oversight Committee ~~at least 30 days before submitting a final proposal to the federal government~~ no later than September 1, 2019, and shall notify the board and legislative oversight committee of any federal decision or action related to the proposal.

Sec. 6. **MNSURE PROGRAM DEVELOPMENT.**

No funds shall be appropriated to the Board of Directors of MNsure for new program development until 834 EDI transmissions are being processed automatically and are conveying accurate information without the intervention of manual reviews and processes.

Sec. 7. **RATES FOR INDIVIDUAL MARKET HEALTH AND DENTAL PLANS FOR 2020.**

(a) Health carriers must take into account the reduction in the premium withhold percentage under Minnesota Statutes, section 62V.05, subdivision 2, applicable beginning in calendar year 2020 for individual market health plans and dental plans sold through MNsure when setting rates for individual market health plans and dental plans for calendar year 2020.

(b) For purposes of this section, "dental plan," "health carrier," "health plan," and "individual market" have the meanings given in Minnesota Statutes, section 62V.02.

Sec. 8. **REQUEST FOR INFORMATION ON A PRIVATIZED STATE-BASED MARKETPLACE SYSTEM.**

(a) The commissioner of human services, in consultation with the commissioners of commerce and health, and interested stakeholders, shall develop a request for information to consider the feasibility for a private vendor to provide the technology functionality for

the individual market currently provided by MNsure. The request shall seek options for a privately run automated web-based broker system that provides certain core functions including eligibility and enrollment functions, consumer outreach and assistance, and the ability for consumers to compare and choose different qualified health plans. The system must have the ability to integrate with the federal data hub and have account transfer functionality to accept application handoffs compatible with the Medicaid and MinnesotaCare eligibility and enrollment system maintained by the Department of Human Services.

(b) The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health insurance by February 15, 2020, the results of the request for information and an analysis of the option for a privatized marketplace, including estimated costs.

ARTICLE 5
MISCELLANEOUS

Section 1. Minnesota Statutes 2018, section 62A.30, is amended by adding a subdivision to read:

Subd. 4. **Mammograms.** (a) For purposes of subdivision 2, coverage for a preventive mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventive item or service, as described under section 62Q.46.

(b) For purposes of this subdivision, "digital breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. "At risk for breast cancer" means:

(1) having a family history with one or more first- or second-degree relatives with breast cancer;

(2) testing positive for BRCA1 or BRCA2 mutations;

(3) having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or

(4) having a previous diagnosis of breast cancer.

(c) This subdivision does not apply to coverage provided through a public health care program under chapter 256B or 256L.

(d) Nothing in this subdivision limits the coverage of digital breast tomosynthesis in a policy, plan, certificate, or contract referred to in subdivision 1 that is in effect prior to January 1, 2020.

(e) Nothing in this subdivision prohibits a policy, plan, certificate, or contract referred to in subdivision 1 from covering digital breast tomosynthesis for an enrollee who is not at risk for breast cancer.

EFFECTIVE DATE. This section is effective January 1, 2020, and applies to health plans issued, sold, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 148.59, is amended to read:

148.59 LICENSE RENEWAL; LICENSE AND REGISTRATION FEES.

A licensed optometrist shall pay to the state Board of Optometry a fee as set by the board in order to renew a license as provided by board rule. No fees shall be refunded. Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board:

(1) optometry licensure application, $160;

(2) optometry annual licensure renewal, ~~$135~~ $170;

(3) optometry late penalty fee, $75;

(4) annual license renewal card, $10;

(5) continuing education provider application, $45;

(6) emeritus registration, $10;

(7) endorsement/reciprocity application, $160;

(8) replacement of initial license, $12; ~~and~~

(9) license verification, $50~~.~~;

(10) jurisprudence state examination, $75;

(11) Optometric Education Continuing Education data bank registration, $20; and

(12) data requests and labels, $50.

Sec. 3. Minnesota Statutes 2018, section 148E.180, is amended to read:

148E.180 FEE AMOUNTS.

Subdivision 1. **Application fees.** Nonrefundable application fees for licensure ~~are as follows~~ may not exceed the following amounts:

(1) for a licensed social worker, ~~$45~~ $54;

(2) for a licensed graduate social worker, ~~$45~~ $54;

(3) for a licensed independent social worker, ~~$45~~ $54;

(4) for a licensed independent clinical social worker, ~~$45~~ $54;

(5) for a temporary license, $50; and

(6) for a licensure by endorsement, ~~$85~~ $92.

The fee for criminal background checks is the fee charged by the Bureau of Criminal Apprehension. The criminal background check fee must be included with the application fee as required according to section 148E.055.

Subd. 2. **License fees.** Nonrefundable license fees ~~are as follows~~ may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $97;

(2) for a licensed graduate social worker, ~~$144~~ $172;

(3) for a licensed independent social worker, ~~$216~~ $258;

(4) for a licensed independent clinical social worker, ~~$238.50~~ $284;

(5) for an emeritus inactive license, ~~$43.20~~ $51;

(6) for an emeritus active license, one-half of the renewal fee specified in subdivision 3; and

(7) for a temporary leave fee, the same as the renewal fee specified in subdivision 3.

If the licensee's initial license term is less or more than 24 months, the required license fees must be prorated proportionately.

Subd. 3. **Renewal fees.** Nonrefundable renewal fees for ~~licensure are as follows~~ the two-year renewal term may not exceed the following amounts but may be adjusted lower by board action:

(1) for a licensed social worker, ~~$81~~ $97;

(2) for a licensed graduate social worker, ~~$144~~ $172;

(3) for a licensed independent social worker, ~~$216~~ $258; and

(4) for a licensed independent clinical social worker, ~~$238.50~~ $284.

Subd. 4. **Continuing education provider fees.** Continuing education provider fees are ~~as follows~~ the following nonrefundable amounts:

(1) for a provider who offers programs totaling one to eight clock hours in a one-year period according to section 148E.145, ~~$50~~ $60;

(2) for a provider who offers programs totaling nine to 16 clock hours in a one-year period according to section 148E.145, ~~$100~~ $120;

(3) for a provider who offers programs totaling 17 to 32 clock hours in a one-year period according to section 148E.145, ~~$200~~ $240;

(4) for a provider who offers programs totaling 33 to 48 clock hours in a one-year period according to section 148E.145, ~~$400~~ $480; and

(5) for a provider who offers programs totaling 49 or more clock hours in a one-year period according to section 148E.145, ~~$600~~ $720.

Subd. 5. **Late fees.** Late fees are ~~as follows~~ the following nonrefundable amounts:

(1) renewal late fee, one-fourth of the renewal fee specified in subdivision 3;

(2) supervision plan late fee, $40; and

(3) license late fee, $100 plus the prorated share of the license fee specified in subdivision 2 for the number of months during which the individual practiced social work without a license.

Subd. 6. **License cards and wall certificates.** (a) The fee for a license card as specified in section 148E.095 is $10.

(b) The fee for a license wall certificate as specified in section 148E.095 is $30.

Subd. 7. **Reactivation fees.** Reactivation fees are ~~as follows~~ the following nonrefundable amounts:

(1) reactivation from a temporary leave or emeritus status, the prorated share of the renewal fee specified in subdivision 3; and

(2) reactivation of an expired license, 1-1/2 times the renewal fees specified in subdivision 3.

Sec. 4. Minnesota Statutes 2018, section 152.126, subdivision 6, is amended to read:

Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision, the data submitted to the board under subdivision 4 is private data on individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

(b) Except as specified in subdivision 5, the following persons shall be considered permissible users and may access the data submitted under subdivision 4 in the same or similar manner, and for the same or similar purposes, as those persons who are authorized to access similar private data on individuals under federal and state law:

(1) a prescriber or an agent or employee of the prescriber to whom the prescriber has delegated the task of accessing the data, to the extent the information relates specifically to a current patient, to whom the prescriber is:

(i) prescribing or considering prescribing any controlled substance;

(ii) providing emergency medical treatment for which access to the data may be necessary;

(iii) providing care, and the prescriber has reason to believe, based on clinically valid indications, that the patient is potentially abusing a controlled substance; or

(iv) providing other medical treatment for which access to the data may be necessary for a clinically valid purpose and the patient has consented to access to the submitted data, and with the provision that the prescriber remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(2) a dispenser or an agent or employee of the dispenser to whom the dispenser has delegated the task of accessing the data, to the extent the information relates specifically to a current patient to whom that dispenser is dispensing or considering dispensing any controlled substance and with the provision that the dispenser remains responsible for the use or misuse of data accessed by a delegated agent or employee;

(3) a licensed pharmacist who is providing pharmaceutical care for which access to the data may be necessary to the extent that the information relates specifically to a current patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber who is requesting data in accordance with clause (1);

(4) an individual who is the recipient of a controlled substance prescription for which data was submitted under subdivision 4, or a guardian of the individual, parent or guardian of a minor, or health care agent of the individual acting under a health care directive under chapter 145C;

(5) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, or of the Emergency Medical Services Regulatory Board, assigned to conduct a bona fide investigation of a complaint received by that board that alleges that a specific licensee is impaired by use of a drug for which data is collected under subdivision 4, has engaged in activity that would constitute a crime as defined in section 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

(6) personnel of the board engaged in the collection, review, and analysis of controlled substance prescription information as part of the assigned duties and responsibilities under this section;

(7) authorized personnel of a vendor under contract with the state of Minnesota who are engaged in the design, implementation, operation, and maintenance of the prescription monitoring program as part of the assigned duties and responsibilities of their employment, provided that access to data is limited to the minimum amount necessary to carry out such duties and responsibilities, and subject to the requirement of de-identification and time limit on retention of data specified in subdivision 5, paragraphs (d) and (e);

(8) federal, state, and local law enforcement authorities acting pursuant to a valid search warrant;

(9) personnel of the Minnesota health care programs assigned to use the data collected under this section to identify and manage recipients whose usage of controlled substances may warrant restriction to a single primary care provider, a single outpatient pharmacy, and a single hospital;

(10) personnel of the Department of Human Services assigned to access the data pursuant to paragraph (i);

(11) personnel of the health professionals services program established under section 214.31, to the extent that the information relates specifically to an individual who is currently enrolled in and being monitored by the program, and the individual consents to access to that information. The health professionals services program personnel shall not provide this data to a health-related licensing board or the Emergency Medical Services Regulatory Board, except as permitted under section 214.33, subdivision 3.

For purposes of clause (4), access by an individual includes persons in the definition of an individual under section 13.02; and

(12) personnel or designees of a health-related licensing board listed in section 214.01, subdivision 2, assigned to conduct a bona fide investigation of a complaint received by that

board that alleges that a specific licensee is inappropriately prescribing controlled substances as defined in this section.

(c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe controlled substances for humans and who holds a current registration issued by the federal Drug Enforcement Administration, and every pharmacist licensed by the board and practicing within the state, shall register and maintain a user account with the prescription monitoring program. Data submitted by a prescriber, pharmacist, or their delegate during the registration application process, other than their name, license number, and license type, is classified as private pursuant to section 13.02, subdivision 12.

(d) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), may directly access the data electronically. No other permissible users may directly access the data electronically. If the data is directly accessed electronically, the permissible user shall implement and maintain a comprehensive information security program that contains administrative, technical, and physical safeguards that are appropriate to the user's size and complexity, and the sensitivity of the personal information obtained. The permissible user shall identify reasonably foreseeable internal and external risks to the security, confidentiality, and integrity of personal information that could result in the unauthorized disclosure, misuse, or other compromise of the information and assess the sufficiency of any safeguards in place to control the risks.

(e) The board shall not release data submitted under subdivision 4 unless it is provided with evidence, satisfactory to the board, that the person requesting the information is entitled to receive the data.

(f) The board shall maintain a log of all persons who access the data for a period of at least three years and shall ensure that any permissible user complies with paragraph ~~(c)~~ (d) prior to attaining direct access to the data.

(g) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant to subdivision 2. A vendor shall not use data collected under this section for any purpose not specified in this section.

(h) The board may participate in an interstate prescription monitoring program data exchange system provided that permissible users in other states have access to the data only as allowed under this section, and that section 13.05, subdivision 6, applies to any contract or memorandum of understanding that the board enters into under this paragraph.

(i) With available appropriations, the commissioner of human services shall establish and implement a system through which the Department of Human Services shall routinely access the data for the purpose of determining whether any client enrolled in an opioid treatment program licensed according to chapter 245A has been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

If determined necessary, the commissioner of human services shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34, paragraph (c), prior to implementing this paragraph.

(j) The board shall review the data submitted under subdivision 4 on at least a quarterly basis and shall establish criteria, in consultation with the advisory task force, for referring information about a patient to prescribers and dispensers who prescribed or dispensed the prescriptions in question if the criteria are met.

(k) The board shall conduct random audits, on at least a quarterly basis, of electronic access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (6), (7), (9), and (10), to the data in subdivision 4, to ensure compliance with permissible use as defined in this section. A permissible user whose account has been selected for a random audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice that an audit is being conducted. Failure to respond may result in deactivation of access to the electronic system and referral to the appropriate health licensing board, or the commissioner of human services, for further action.

(l) A permissible user who has delegated the task of accessing the data in subdivision 4 to an agent or employee shall audit the use of the electronic system by delegated agents or employees on at least a quarterly basis to ensure compliance with permissible use as defined in this section. When a delegated agent or employee has been identified as inappropriately accessing data, the permissible user must immediately remove access for that individual

and notify the board within seven days. The board shall notify all permissible users associated with the delegated agent or employee of the alleged violation.

Sec. 5. Minnesota Statutes 2018, section 525A.11, is amended to read:

525A.11 PERSONS THAT MAY RECEIVE ANATOMICAL GIFT; PURPOSE OF ANATOMICAL GIFT.

(a) An anatomical gift may be made to the following persons named in the document of gift:

(1) a hospital; accredited medical school, dental school, college, or university; organ procurement organization; or nonprofit organization in medical education or research, for research or education;

(2) subject to paragraph (b), an individual designated by the person making the anatomical gift if the individual is the recipient of the part; and

(3) an eye bank or tissue bank.

(b) If an anatomical gift to an individual under paragraph (a), clause (2), cannot be transplanted into the individual, the part passes in accordance with paragraph (g) in the absence of an express, contrary indication by the person making the anatomical gift.

(c) If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in paragraph (a) but identifies the purpose for which an anatomical gift may be used, the following rules apply:

(1) if the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank;

(2) if the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank;

(3) if the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ; and

(4) if the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

(d) For the purpose of paragraph (c), if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the

gift must be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

(e) If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in paragraph (a) and does not identify the purpose of the gift, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(f) If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used only for transplantation or therapy, and the gift passes in accordance with paragraph (g).

(g) For purposes of paragraphs (b), (e), and (f), the following rules apply:

(1) if the part is an eye, the gift passes to the appropriate eye bank;

(2) if the part is tissue, the gift passes to the appropriate tissue bank; and

(3) if the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

(h) An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under paragraph (a), clause (2), passes to the organ procurement organization as custodian of the organ.

(i) If an anatomical gift does not pass pursuant to paragraphs (a) to (h) or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

(j) A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section 525A.05 or 525A.10 or if the person knows that the decedent made a refusal under section 525A.07 that was not revoked. For purposes of this paragraph, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

(k) Except as otherwise provided in paragraph (a), clause (2), nothing in this chapter affects the allocation of organs for transplantation or therapy.

(l) For purposes of paragraphs (c), clauses (1) and (4), and (g), no gift of an eye or a part of an eye shall be directly or indirectly processed by or distributed to a for profit entity, and no gift shall be sold or distributed for profit.

Sec. 6. **GUIDELINES AUTHORIZING PATIENT-ASSISTED MEDICATION ADMINISTRATION IN EMERGENCIES.**

(a) Within the limits of the board's available appropriation, the Emergency Medical Services Regulatory Board shall propose guidelines authorizing EMTs, AEMTs, and paramedics certified under Minnesota Statutes, section 144E.28, to assist a patient in emergency situations with administering prescription medications that are:

(1) carried by a patient;

(2) intended to treat adrenal insufficiency or other rare conditions that require emergency treatment with a previously prescribed medication;

(3) intended to treat a specific life-threatening condition; and

(4) administered via routes of delivery that are within the scope of training of the EMT, AEMT, or paramedic.

(b) The Emergency Medical Services Regulatory Board shall submit the proposed guidelines and draft legislation as necessary to the chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 1, 2020.

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

ARTICLE 6
FORECAST ADJUSTMENT

Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2017, First Special Session chapter 6, article 18, from the general fund, or any other fund named, to the commissioner of human services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figure "2019" used in this article means that the appropriations listed are available for the fiscal year ending June 30, 2019.

	APPROPRIATIONS Available for the Year Ending June 30 2019
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	
Subdivision 1. **Total Appropriation**	**$ (318,423,000)**

	Appropriations by Fund	
	2019	
General	(317,538,000)	
Health Care Access	8,410,000	
Federal TANF	(9,295,000)	

Subd. 2. **Forecasted Programs**

(a) **Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP)**

	Appropriations by Fund	
General	(19,361,000)	
Federal TANF	(8,893,000)	

(b) **MFIP Child Care Assistance** (16,789,000)

(c) **General Assistance** (7,928,000)

(d) **Minnesota Supplemental Aid** (549,000)

(e) **Housing Support** (13,836,000)

(f) **Northstar Care for Children** (19,027,000)

(g) **MinnesotaCare** 8,410,000

This appropriation is from the health care access fund.

(h) **Medical Assistance**

	Appropriations by Fund	
General	(222,176,000)	
Health Care Access	-0-	

(i) **Alternative Care** -0-

(j) **Consolidated Chemical Dependency Treatment Fund (CCDTF) Entitlement** (17,872,000)

Subd. 3. **Technical Activities** (402,000)

This appropriation is from the federal TANF fund.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

ARTICLE 7

APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES 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 "2020" and "2021" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2020, or June 30, 2021, respectively. "The first year" is fiscal year 2020. "The second year" is fiscal year 2021. "The biennium" is fiscal years 2020 and 2021.

	APPROPRIATIONS	
	Available for the Year	
	Ending June 30	
	2020	2021
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$ 8,039,269,000**	**$ 8,076,725,000**

Appropriations by Fund

	2020	2021
General	7,249,360,000	7,282,307,000
State Government Special Revenue	4,299,000	4,299,000
Health Care Access	513,192,000	516,231,000
Federal TANF	270,522,000	271,992,000
Lottery Prize	1,896,000	1,896,000

(a) **Office of Ombudsman for Long-Term Care.** $1,312,000 in fiscal year 2020 and $1,501,000 in fiscal year 2021 are from the general fund for nine additional regional ombudsmen and one deputy director in the Office of Ombudsman for Long-Term Care,

to perform the duties in Minnesota Statutes, section 256.9742.

(b) **Transfer to Office of Legislative Auditor.** $300,000 in fiscal year 2020 and $300,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2b.

(c) **Transfer to Office of Legislative Auditor.** $400,000 in fiscal year 2020 and $400,000 in fiscal year 2021 are from the general fund for transfer to the Office of the Legislative Auditor for audit activities under Minnesota Statutes, section 3.972, subdivision 2a.

(d) **Fetal Alcohol Spectrum Disorders Grants.** $250,000 in fiscal year 2020 and $250,000 in fiscal year 2021 are from the general fund for a grant under Minnesota Statutes, section 254A.21, to a statewide organization that focuses solely on prevention of and intervention with fetal alcohol spectrum disorders.

Sec. 3. **COMMISSIONER OF HEALTH** **$ 222,424,000 $ 225,132,000**

Appropriations by Fund

	2020	2021
General	155,213,000	155,946,000
State Government Special Revenue	56,290,000	58,252,000
Health Care Access	(792,000)	(779,000)
Federal TANF	11,713,000	11,713,000

(a) **Perinatal Hospice Grants.** $500,000 in fiscal year 2020 is from the general fund for perinatal hospice development, training, and awareness grants. Eligible entities may apply

for multiple grants. This is a onetime appropriation and is available until June 30, 2023.

(b) **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.

(c) **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.

(d) **Safe Harbor for Sexually Exploited Youth.** $470,000 in fiscal year 2020 and $470,000 in fiscal year 2021 are from the general fund for grants for comprehensive services, including trauma-informed, culturally specific services for sexually exploited youth under Minnesota Statutes, section 145.4716.

(e) **Safe Harbor for Sexually Exploited Youth Evaluation.** $5,000 in fiscal year 2020 and $5,000 in fiscal year 2021 are from the general fund to the commissioner of health for evaluation activities under Minnesota Statutes, section 145.4718. The base appropriation includes $45,000 in fiscal year 2020 and $45,000 in fiscal year 2021 for evaluation activities under Minnesota Statutes, section 145.4718.

(f) **Safe Harbor for Sexually Exploited Youth Training and Protocol Implementation.** $25,000 in fiscal year 2020 and $25,000 in fiscal year 2021 are from the general fund to the commissioner of health for training and protocol implementation.

(g) **Study on Breastfeeding Disparities.** $79,000 in fiscal year 2020 is from the general fund for a study on breastfeeding disparities. The commissioner shall engage community stakeholders in Minnesota including but not limited to the Minnesota Breastfeeding Coalition; the women, infants, and children program; hospitals and clinics; local public health professionals and organizations; community-based organizations; and representatives of populations with low breastfeeding rates to carry out a study identifying barriers, challenges, and successes affecting initiation, duration, and exclusivity of breastfeeding. The study shall address policy, systemic, and environmental factors that support and create barriers to breastfeeding. The study shall identify and make recommendations regarding culturally appropriate practices that have been shown to increase breastfeeding rates in populations that have the greatest breastfeeding disparity rates. A report on the study must be completed and submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance on or before September 15, 2020. This is a onetime appropriation.

(h) **Palliative Care Advisory Council.** $44,000 in fiscal year 2020 and $44,000 in fiscal year 2021 are from the general fund for the Palliative Care Advisory Council under Minnesota Statutes, section 144.059. This is a onetime appropriation.

(i) **Study on the Increase in Abortions after 20 Weeks.** $42,000 in fiscal year 2020 is from the general fund for an evaluation of the increase in abortions occurring after the gestational age of 20 weeks and the reasons for the increase. The commissioner shall report the findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by February 15, 2020. This is a onetime appropriation.

(j) **Positive Abortion Alternatives Grants.** $336,000 in fiscal year 2020 and $336,000 in fiscal year 2021 are from the general fund for the positive abortion alternatives grants under Minnesota Statutes, section 145.4235.

Sec. 4. **HEALTH-RELATED BOARDS** **$ 19,992,000 $ 20,092,000**

$25,000 in fiscal year 2020 is appropriated from the state government special revenue to the Board of Pharmacy to implement the random audits under Minnesota Statutes, section 152.126, subdivision 6, paragraph (k). This is a onetime appropriation.

Sec. 5. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 4,588,000 $ 4,588,000**

Regional Emergency Medical Services Programs. $985,000 in fiscal year 2020 and $985,000 in fiscal year 2021 are to be deposited in the emergency medical services

system fund and distributed by the Emergency Medical Services Regulatory Board according to Minnesota Statutes, section 144E.50.

Sec. 6. **COUNCIL ON DISABILITY**	**$**	**858,000**	**$**	**860,000**
Sec. 7. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES**	**$**	**2,438,000**	**$**	**2,438,000**
Sec. 8. **OMBUDSPERSONS FOR FAMILIES**	**$**	**467,000**	**$**	**467,000**
Sec. 9. **COMMISSIONER OF MANAGEMENT AND BUDGET**	**$**	**498,000**	**$**	**498,000**

(a) By June 30, 2019, the commissioner shall transfer $399,000,000 from the general fund to the health care access fund. This is a onetime transfer.

(b) By June 30, 2020, the commissioner shall transfer $236,580,000 from the general fund to the health care access fund. This is a onetime transfer.

(c) By June 30, 2022, the commissioner shall transfer $47,451,000 from the general fund to the health care access fund. This is a onetime transfer.

(d) **Proven-Effective Practices Evaluation Activities.** $498,000 in fiscal year 2020 and $498,000 in fiscal year 2021 are from the general fund for evaluation activities under article ..., section ....

Sec. 10. **TRANSFERS.**

Subdivision 1. **Forecasted programs.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2021, within fiscal years among the MFIP, general assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid program, housing support, the entitlement portion of Northstar Care for Children under Minnesota Statutes,

chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Health and Human Services only to set up and maintain accounting and budget systems with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Committee and the house of representatives Health and Human Services Finance Committee quarterly about the transfers made under this subdivision.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

144.1464 SUMMER HEALTH CARE INTERNS.

Subdivision 1. **Summer internships.** The commissioner of health, through a contract with a nonprofit organization as required by subdivision 4, shall award grants, within available appropriations, to hospitals, clinics, nursing facilities, and home care providers to establish a secondary and postsecondary summer health care intern program. The purpose of the program is to expose interested secondary and postsecondary pupils to various careers within the health care profession.

Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall award grants to hospitals, clinics, nursing facilities, and home care providers that agree to:

(1) provide secondary and postsecondary summer health care interns with formal exposure to the health care profession;

(2) provide an orientation for the secondary and postsecondary summer health care interns;

(3) pay one-half the costs of employing the secondary and postsecondary summer health care intern;

(4) interview and hire secondary and postsecondary pupils for a minimum of six weeks and a maximum of 12 weeks; and

(5) employ at least one secondary student for each postsecondary student employed, to the extent that there are sufficient qualifying secondary student applicants.

(b) In order to be eligible to be hired as a secondary summer health intern by a hospital, clinic, nursing facility, or home care provider, a pupil must:

(1) intend to complete high school graduation requirements and be between the junior and senior year of high school; and

(2) be from a school district in proximity to the facility.

(c) In order to be eligible to be hired as a postsecondary summer health care intern by a hospital or clinic, a pupil must:

(1) intend to complete a health care training program or a two-year or four-year degree program and be planning on enrolling in or be enrolled in that training program or degree program; and

(2) be enrolled in a Minnesota educational institution or be a resident of the state of Minnesota; priority must be given to applicants from a school district or an educational institution in proximity to the facility.

(d) Hospitals, clinics, nursing facilities, and home care providers awarded grants may employ pupils as secondary and postsecondary summer health care interns beginning on or after June 15, 1993, if they agree to pay the intern, during the period before disbursement of state grant money, with money designated as the facility's 50 percent contribution towards internship costs.

Subd. 3. **Grants.** The commissioner, through the organization under contract, shall award separate grants to hospitals, clinics, nursing facilities, and home care providers meeting the requirements of subdivision 2. The grants must be used to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital, clinic, nursing facility, or home care setting during the course of the program. No more than 50 percent of the participants may be postsecondary students, unless the program does not receive enough qualified secondary applicants per fiscal year.

No more than five pupils may be selected from any secondary or postsecondary institution to participate in the program and no more than one-half of the number of pupils selected may be from the seven-county metropolitan area.

Subd. 4. **Contract.** The commissioner shall contract with a statewide, nonprofit organization representing facilities at which secondary and postsecondary summer health care interns will serve, to administer the grant program established by this section. Grant funds that are not used in one fiscal year may be carried over to the next fiscal year. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program, in the form and at the times specified by the commissioner.

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state.

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

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

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

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

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

Subd. 3. **Program administration.** In administering the international medical graduates assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational

Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. **Career guidance and support services.** (a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7. **Voluntary hospital programs.** A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8. **Board of Medical Practice.** Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9. **Consultation with stakeholders.** The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:

(i) organizations serving immigrant and refugee communities of Minnesota;

(ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and

(iii) the Minnesota Association of Community Health Centers;

(4) higher education:

(i) University of Minnesota;

(ii) Mayo Clinic School of Health Professions;

(iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and

(iv) Minnesota physician assistant education programs; and

(5) two international medical graduates.

Subd. 10. **Report.** The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

256B.0625 COVERED SERVICES.

Subd. 31c. **Preferred incontinence product program.** The commissioner shall implement a preferred incontinence product program by July 1, 2018. The program shall require the commissioner to volume purchase incontinence products and related supplies in accordance with section 256B.04, subdivision 14. Medical assistance coverage for incontinence products and related supplies shall conform to the limitations established under the program.