State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 4293

03/09/2020 Authored by Huot
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health; making certain changes to electronic prescription drug program, health care cost containment, medical education programs, nursing home resident reimbursement classifications, health professional education loan forgiveness program and primary care residency grant program, elevated blood lead level, certain licensed facilities, nutritional supplement program, commissioner's duties, and food benefits provisions; amending Minnesota Statutes 2018, sections 62J.497, subdivisions 1, 3; 62J.63, subdivisions 1, 2; 62J.692, subdivisions 3, 4; 144.0724, subdivisions 4, 5, 8; 144.1501, subdivisions 1, 2, 3; 144.9501, subdivision 9; 145.893, subdivision 1; 145.894; 145.897; 145.899; 148.517, by adding a subdivision; 256R.17, subdivision 3; Minnesota Statutes 2019 Supplement, sections 152.29, subdivision 3; 256.98, subdivision 1; repealing Minnesota Statutes 2018, sections 62J.63, subdivision 3; 62J.692, subdivision 4a; 62Q.72, subdivision 2; 144.693.

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

Section 1. Minnesota Statutes 2018, section 62J.497, subdivision 1, is amended to read:

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

(b) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(c) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(d) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(e) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(f) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(g) "Electronic prescription drug program" means a program that provides for e-prescribing.

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

(i) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(j) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(k) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(l) "NCPDP Formulary and Benefits Standard" means the most recent version of the National Council for Prescription Drug Programs Formulary and Benefits Standard~~,~~ ~~Implementation Guide, Version 1, Release 0, October 2005.~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance.

(m) "NCPDP SCRIPT Standard" means the most recent version of the National Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard, ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act~~,~~ and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard~~

~~is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.~~

(n) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(o) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(p) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(q) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Sec. 2. Minnesota Statutes 2018, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following transactions:~~

~~(1) get message transaction;~~

~~(2) status response transaction;~~

~~(3) error response transaction;~~

~~(4) new prescription transaction;~~

~~(5) prescription change request transaction;~~

~~(6) prescription change response transaction;~~

~~(7) refill prescription request transaction;~~

~~(8) refill prescription response transaction;~~

~~(9) verification transaction;~~

~~(10) password change transaction;~~

~~(11) cancel prescription request transaction; and~~

~~(12) cancel prescription response transaction.~~

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Sec. 3. Minnesota Statutes 2018, section 62J.63, subdivision 1, is amended to read:

Subdivision 1. **Establishment; administration.** The commissioner of health shall ~~establish and administer the Center for Health Care Purchasing Improvement as an administrative unit within the Department of Health. The Center for Health Care Purchasing Improvement shall~~ support the state in its efforts to be a more prudent and efficient purchaser of quality health care services~~. The center shall~~, aid the state in developing and using more common strategies and approaches for health care performance measurement and health care purchasing~~. The common strategies and approaches shall~~, promote greater transparency of health care costs and quality~~,~~ and greater accountability for health care results and improvement~~. The center shall also~~, and identify barriers to more efficient, effective, quality health care and options for overcoming the barriers.

Sec. 4. Minnesota Statutes 2018, section 62J.63, subdivision 2, is amended to read:

Subd. 2. **Staffing; duties; scope.** ~~(a)~~ The commissioner of health may ~~appoint a director, and up to three additional senior-level staff or codirectors, and other staff as needed who are under the direction of the commissioner. The staff of the center are in the unclassified service.~~:

~~(b) With the authorization of the commissioner of health, and in consultation or interagency agreement with the appropriate commissioners of state agencies, the director, or codirectors, may:~~

~~(1) initiate projects to develop plan designs for state health care purchasing;~~

~~(2)~~ (1) require reports or surveys to evaluate the performance of current health care purchasing or administrative simplification strategies;

~~(3)~~ (2) calculate fiscal impacts, including net savings and return on investment, of health care purchasing strategies and initiatives;

~~(4) conduct policy audits of state programs to measure conformity to state statute or other purchasing initiatives or objectives;~~

~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50 and 62J.536 and other relevant groups or activities to advance agreement on health care administrative process streamlining;

~~(6) consult with the Health Economics Unit of the Department of Health regarding reports and assessments of the health care marketplace;~~

~~(7) consult with the Department of Commerce regarding health care regulatory issues and legislative initiatives;~~

~~(8) work with appropriate Department of Human Services staff and the Centers for Medicare and Medicaid Services to address federal requirements and conformity issues for health care purchasing;~~

~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing strategies;~~

~~(10) convene medical directors of agencies engaged in health care purchasing for advice, collaboration, and exploring possible synergies;~~

~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities, and similar efforts with regard to health care performance measurement and performance-based purchasing; and

~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding opportunities and may administer grants and externally funded projects.

Sec. 5. Minnesota Statutes 2018, section 62J.692, subdivision 3, is amended to read:

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, or community health workers is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

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

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number and national provider identification number of each training site used in the program; the federal tax identification number of each training site used in the program, where available; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the equitable distribution of funds.

~~(d) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) when requested, at the discretion of the commissioner:~~

~~(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;~~

~~(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and~~

~~(3) other revenue received for the purposes of clinical training.~~

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

Sec. 6. Minnesota Statutes 2018, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the available medical education funds to all qualifying applicants based on a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool.

Public program revenue for the distribution formula includes revenue from medical assistance and prepaid medical assistance. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. ~~For purposes of determining training-site level grants to be distributed under this paragraph, total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.~~ Training sites whose training site level grant is less than $5,000, based on the formula described in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for funds available under this subdivision. No training sites shall receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across all eligible training sites; grants in excess of this amount will be redistributed to other eligible sites based on the formula described in this paragraph.

~~(b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall include a supplemental public program volume factor, which is determined by providing a supplemental payment to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. The supplemental public program volume factor shall be equal to ten percent of each training site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year 2015. Grants to training sites whose public program revenue accounted for less than 0.98~~

~~percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment. For fiscal year 2016 and beyond, the distribution of funds shall be based solely on the public program volume factor as described in paragraph (a).~~

~~(c)~~ (b) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(d)~~ (c) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds allocated under ~~paragraphs~~ paragraph (a) ~~and (b)~~ to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(e)~~ (d) Use of funds is limited to expenses related to clinical training program costs for eligible programs.

~~(f)~~ (e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(g)~~ (f) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 7. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and

Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~; and

(7) modifications to the most recent assessments of clauses (1) to (6).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 8. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

(d) An admission assessment is not required if the admission date is equal to the date of discharge or death.

Sec. 9. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification, including any items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to ~~a copy of the MDS that determined the classification and other~~ documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order

and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for

reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 10. Minnesota Statutes 2018, section 144.1501, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

(i) ~~"Midlevel practitioner"~~ "Advanced practice professional" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

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

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2018, section 144.1501, subdivision 2, is amended to read:

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

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

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

(3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care facility for persons with developmental disability; a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; a housing with services establishment as defined in section 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43, subdivision 4; or

agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

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

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

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

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

Sec. 12. Minnesota Statutes 2018, section 144.1501, subdivision 3, is amended to read:

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

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

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

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training, with the exception of a nurse, who must agree to serve a minimum two-year full-time service obligation according to

subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 13. Minnesota Statutes 2018, section 144.9501, subdivision 9, is amended to read:

Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic blood lead test with a result that is equal to or greater than ~~ten~~ five micrograms of lead per deciliter of whole blood in any person, unless the commissioner finds that a lower concentration is necessary to protect public health.

Sec. 14. Minnesota Statutes 2018, section 145.893, subdivision 1, is amended to read:

Subdivision 1. ~~**Vouchers**~~ **Food benefits.** An eligible individual shall receive ~~vouchers~~ food benefits for the purchase of specified nutritional supplements in type and quantity approved by the commissioner. Alternate forms of delivery may be developed by the commissioner in appropriate cases.

Sec. 15. Minnesota Statutes 2018, section 145.894, is amended to read:

145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.

The commissioner of health shall:

(1) develop a comprehensive state plan for the delivery of nutritional supplements to pregnant and lactating women, infants, and children;

(2) contract with existing local public or private nonprofit organizations for the administration of the nutritional supplement program;

(3) develop and implement a public education program promoting the provisions of sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition education and counseling at project sites. The education programs must include a campaign to promote breast feeding;

(4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food benefit system for the delivery of nutritional supplements;

(5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly to some or all eligible individuals served by the agency, provided the agency demonstrates that the federal minimum requirements for providing nutrition education will continue to be met and that the quality of nutrition education and health services provided by the agency will not be adversely impacted;

(6) investigate and implement a system to reduce the cost of nutritional supplements and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to maximize cost savings;

(7) develop, analyze, and evaluate the health aspects of the nutritional supplement program and establish nutritional guidelines for the program;

(8) apply for, administer, and annually expend at least 99 percent of available federal or private funds;

(9) aggressively market services to eligible individuals by conducting ongoing outreach activities and by coordinating with and providing marketing materials and technical assistance to local human services and community service agencies and nonprofit service providers;

(10) determine, on July 1 of each year, the number of pregnant women participating in each special supplemental food program for women, infants, and children (WIC) ~~and, in 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program deliverer if the current deliverer fails to increase the participation of pregnant women in the program by at least ten percent over the previous year's participation rate~~;

(11) promulgate all rules necessary to carry out the provisions of sections 145.891 to 145.897; and

(12) ensure that any state appropriation to supplement the federal program is spent consistent with federal requirements.

Sec. 16. Minnesota Statutes 2018, section 145.897, is amended to read:

145.897 ~~VOUCHERS~~ FOOD BENEFITS.

~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only for the purchase of those foods determined by the ~~commissioner~~ United States Department of Agriculture to be desirable nutritional supplements for pregnant and lactating women, infants and children. ~~These foods shall include, but not be limited to, iron fortified infant formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

Sec. 17. Minnesota Statutes 2018, section 145.899, is amended to read:

145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.

~~Vouchers~~ Food benefits for the special supplemental nutrition program for women, infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable food. The commissioner of health shall regularly evaluate the list of WIC allowable food

in accordance with federal requirements and shall add to the list any organic WIC allowable foods determined to be cost-neutral.

Sec. 18. Minnesota Statutes 2018, section 148.517, is amended by adding a subdivision to read:

Subd. 5. **Dispensing audiologist exam requirements.** Audiologists must submit documentation of receiving a qualifying score on an examination meeting the requirements of section 148.515, subdivision 6.

Sec. 19. Minnesota Statutes 2019 Supplement, 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. A manufacturer may transport medical cannabis or medical cannabis products that have been cultivated, harvested, manufactured, packaged, and processed by that manufacturer to another registered manufacturer for the other manufacturer to distribute.

(b) A manufacturer may distribute medical cannabis products, whether or not the products have been manufactured by that manufacturer.

(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, legal guardian, or spouse 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, or spouse, 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 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 or to another registered manufacturer to carry identification showing that the person is an employee of the manufacturer.

Sec. 20. Minnesota Statutes 2019 Supplement, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or ~~vouchers~~ food benefits produced according

to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care, or by furnishing or concurring in a willfully false claim for child care assistance.

The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 21. Minnesota Statutes 2018, section 256R.17, subdivision 3, is amended to read:

Subd. 3. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix classification assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The case mix classifications established under section 144.0724, subdivision 3a, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual ~~and~~, quarterly, and significant correction assessments shall be the first day of the month following assessment reference date.

Sec. 22. **REPEALER.**

Minnesota Statutes 2018, sections 62J.63, subdivision 3; 62J.692, subdivision 4a; 62Q.72, subdivision 2; and 144.693, are repealed.

62J.63 CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT.

Subd. 3. **Report.** The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health website and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement.

62J.692 MEDICAL EDUCATION.

Subd. 4a. **Alternative distribution.** If federal approval is not received for the formula described in subdivision 4, paragraphs (a) and (b), 100 percent of available medical education and research funds shall be distributed based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, that is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, that is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

62Q.72 RECORD KEEPING; REPORTING.

Subd. 2. **Reporting.** Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days, or 30 business days as provided under section 72A.201, subdivision 4, clause (3), for insurance companies licensed under chapter 60A. The commissioner shall also make this information available to the public upon request.

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year

thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.