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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. **4571**

03/04/2024 Authored by Liebling

The bill was read for the first time and referred to the Committee on Health Finance and Policy

04/26/2024 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

1.1 A bill for an act

1.2 relating to state government; modifying provisions for human services health care

1.3 finance, human services health care policy, health care generally, health insurance,

1.4 Department of Health finance, Department of Health policy, emergency medical

1.5 services, pharmacy practice, mental health, Department of Human Services Office

1.6 of Inspector General; substance use disorder treatment licensing; imposing

1.7 penalties; making forecast adjustments; requiring reports; appropriating money;

1.8 amending Minnesota Statutes 2022, sections 62A.28, subdivision 2; 62D.02,

1.9 subdivisions 4, 7; 62D.03, subdivision 1; 62D.05, subdivision 1; 62D.06,

1.10 subdivision 1; 62D.12, subdivision 19; 62D.14, subdivision 1; 62D.19; 62D.20,

1.11 subdivision 1; 62D.22, subdivision 5, by adding a subdivision; 62E.02, subdivision

1.12 3; 62J.49, subdivision 1; 62J.61, subdivision 5; 62M.01, subdivision 3; 62M.02,

1.13 subdivisions 1a, 5, 11, 12, 21, by adding a subdivision; 62M.04, subdivision 1;

1.14 62M.05, subdivision 3a; 62M.07, subdivisions 2, 4, by adding a subdivision;

1.15 62M.10, subdivisions 7, 8; 62M.17, subdivision 2; 62Q.14; 62Q.1841, subdivision

1.16 2; 62Q.19, subdivisions 3, 5, by adding a subdivision; 62Q.73, subdivision 2;

1.17 62V.05, subdivision 12; 62V.08; 62V.11, subdivision 4; 103I.621, subdivisions

1.18 1, 2; 144.05, subdivisions 6, 7; 144.058; 144.0724, subdivisions 2, 3a, 4, 6, 7, 8,

1.19 9, 11; 144.1464, subdivisions 1, 2, 3; 144.1501, subdivision 5; 144.1911,

1.20 subdivision 2; 144.292, subdivision 6; 144.293, subdivisions 2, 4, 9, 10; 144.493,

1.21 by adding a subdivision; 144.494, subdivision 2; 144.551, subdivision 1; 144.555,

1.22 subdivisions 1a, 1b, 2, by adding subdivisions; 144.605, by adding a subdivision;

1.23 144.7067, subdivision 2; 144A.10, subdivisions 15, 16; 144A.44, subdivision 1;

1.24 144A.471, by adding a subdivision; 144A.474, subdivision 13; 144A.70,

1.25 subdivisions 3, 5, 6, 7; 144A.71, subdivision 2, by adding a subdivision; 144A.72,

1.26 subdivision 1; 144A.73; 144E.001, subdivision 3a, by adding subdivisions;

1.27 144E.101, by adding a subdivision; 144E.16, subdivisions 5, 7; 144E.19,

1.28 subdivision 3; 144E.27, subdivisions 3, 5, 6; 144E.28, subdivisions 3, 5, 6, 8;

1.29 144E.285, subdivisions 1, 2, 4, 6, by adding subdivisions; 144E.287; 144E.305,

1.30 subdivision 3; 144G.08, subdivision 29; 144G.10, by adding a subdivision;

1.31 144G.16, subdivision 6; 146B.03, subdivision 7a; 146B.10, subdivisions 1, 3;

1.32 148F.025, subdivision 2; 149A.02, subdivisions 3, 16, 26a, 27, 35, 37c, by adding

1.33 subdivisions; 149A.03; 149A.65; 149A.70, subdivisions 1, 2, 3, 5; 149A.71,

1.34 subdivisions 2, 4; 149A.72, subdivisions 3, 9; 149A.73, subdivision 1; 149A.74,

1.35 subdivision 1; 149A.93, subdivision 3; 149A.94, subdivisions 1, 3, 4; 151.01,

1.36 subdivisions 23, 27; 151.37, by adding a subdivision; 151.74, subdivision 6;

1.37 214.025; 214.04, subdivision 2a; 214.29; 214.31; 214.355; 245.462, subdivision

1.38 6; 245.4663, subdivision 2; 245A.04, by adding a subdivision; 245A.043,

2.1 subdivisions 2, 4, by adding subdivisions; 245A.07, subdivision 6; 245A.52,
2.2 subdivision 2; 245C.05, subdivision 5; 245C.08, subdivision 4; 245C.10,
2.3 subdivision 18; 245C.14, by adding a subdivision; 245C.22, subdivision 4; 245C.24,
2.4 subdivisions 2, 5, 6; 245C.30, by adding a subdivision; 245F.09, subdivision 2;
2.5 245F.14, by adding a subdivision; 245F.17; 245G.07, subdivision 4; 245G.08,
2.6 subdivisions 5, 6; 245G.10, by adding a subdivision; 245G.11, subdivisions 5, 7;
2.7 245G.22, subdivisions 6, 7; 245I.02, subdivisions 17, 19; 245I.04, subdivision 6;
2.8 245I.10, subdivision 9; 245I.11, subdivision 1, by adding a subdivision; 245I.20,
2.9 subdivision 4; 245I.23, subdivision 14; 256.9657, subdivision 8, by adding a
2.10 subdivision; 256.969, by adding subdivisions; 256B.056, subdivisions 1a, 10;
2.11 256B.0622, subdivisions 2a, 3a, 7a, 7d; 256B.0623, subdivision 5; 256B.0625,
2.12 subdivisions 12, 20, 32, by adding subdivisions; 256B.0757, subdivisions 4a, 4d;
2.13 256B.0943, subdivision 12; 256B.0947, subdivision 5; 256B.69, by adding a
2.14 subdivision; 256I.04, subdivision 2f; 256R.02, subdivision 20; 260E.33, subdivision
2.15 2, as amended; 317A.811, subdivision 1; 334.01, by adding a subdivision; 519.05;
2.16 524.3-801, as amended; Minnesota Statutes 2023 Supplement, sections 13.46,
2.17 subdivision 4, as amended; 15A.0815, subdivision 2; 43A.08, subdivision 1a;
2.18 62Q.46, subdivision 1; 62Q.522, subdivision 1; 62Q.523, subdivision 1; 144.0526,
2.19 subdivision 1; 144.1501, subdivision 2; 144.1505, subdivision 2; 144.587,
2.20 subdivisions 1, 4; 144A.4791, subdivision 10; 144E.101, subdivisions 6, 7, as
2.21 amended; 145.561, subdivision 4; 145D.01, subdivision 1; 151.555, subdivisions
2.22 1, 4, 5, 6, 7, 8, 9, 11, 12; 151.74, subdivision 3; 152.126, subdivision 6; 245.4889,
2.23 subdivision 1; 245.991, subdivision 1; 245A.03, subdivision 2, as amended;
2.24 245A.043, subdivision 3; 245A.07, subdivision 1, as amended; 245A.11,
2.25 subdivision 7; 245A.16, subdivision 1, as amended; 245A.211, subdivision 4;
2.26 245A.242, subdivision 2; 245C.02, subdivision 13e; 245C.033, subdivision 3;
2.27 245C.08, subdivision 1; 245C.10, subdivision 15; 245G.22, subdivisions 2, 17;
2.28 254B.04, subdivision 1a; 256.046, subdivision 3; 256.0471, subdivision 1, as
2.29 amended; 256.9631; 256.969, subdivision 2b; 256B.0622, subdivisions 7b, 8;
2.30 256B.0625, subdivisions 5m, 13e, as amended, 13f, 16; 256B.064, subdivision 4;
2.31 256B.0671, subdivision 5; 256B.0701, subdivision 6; 256B.0947, subdivision 7;
2.32 256B.764; 256D.01, subdivision 1a; 256I.05, subdivisions 1a, 11; 256L.03,
2.33 subdivision 1; 270A.03, subdivision 2; 342.06; 342.63, by adding a subdivision;
2.34 Laws 2020, chapter 73, section 8; Laws 2023, chapter 22, section 4, subdivision
2.35 2; Laws 2023, chapter 70, article 20, sections 2, subdivisions 5, 7, 29; 3, subdivision
2.36 2; 12, as amended; Laws 2024, chapter 80, article 2, sections 6, subdivisions 2, 3,
2.37 by adding subdivisions; 10, subdivisions 1, 6; proposing coding for new law in
2.38 Minnesota Statutes, chapters 62A; 62C; 62D; 62J; 62M; 62Q; 62V; 144; 144A;
2.39 144E; 145D; 149A; 151; 245C; 256B; 332; proposing coding for new law as
2.40 Minnesota Statutes, chapter 332C; repealing Minnesota Statutes 2022, sections
2.41 62A.041, subdivision 3; 144.497; 144E.001, subdivision 5; 144E.01; 144E.123,
2.42 subdivision 5; 144E.27, subdivisions 1, 1a; 144E.50, subdivision 3; 151.74,
2.43 subdivision 16; 245C.125; 256D.19, subdivisions 1, 2; 256D.20, subdivisions 1,
2.44 2, 3, 4; 256D.23, subdivisions 1, 2, 3; 256R.02, subdivision 46; Minnesota Statutes
2.45 2023 Supplement, sections 62J.312, subdivision 6; 62Q.522, subdivisions 3, 4;
2.46 144.0528, subdivision 5; 245C.08, subdivision 2; Laws 2023, chapter 70, article
2.47 20, section 2, subdivision 31, as amended; Laws 2023, chapter 75, section 10;
2.48 Laws 2024, chapter 80, article 2, section 6, subdivision 4; Minnesota Rules, parts
2.49 2960.0620, subpart 3; 9502.0425, subpart 5.

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

3.2 **ARTICLE 1**

3.3 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE**

3.4 Section 1. **[62V.12] STATE-FUNDED COST-SHARING REDUCTIONS.**

3.5 Subdivision 1. **Establishment.** (a) The board must develop and administer a state-funded
3.6 cost-sharing reduction program for eligible persons who enroll in a silver level qualified
3.7 health plan through MNsure. The board must implement the cost-sharing reduction program
3.8 for plan years beginning on or after January 1, 2027.

3.9 (b) For purposes of this section, an "eligible person" is an individual who meets the
3.10 eligibility criteria to receive a cost-sharing reduction under Code of Federal Regulations,
3.11 title 45, section 155.305(g).

3.12 Subd. 2. **Reduction in cost-sharing.** The cost-sharing reduction program must use state
3.13 money to reduce enrollee cost-sharing by increasing the actuarial value of silver level health
3.14 plans for eligible persons beyond the 73 percent value established in Code of Federal
3.15 Regulations, title 45, section 156.420(a)(3)(ii), to an actuarial value of 87 percent.

3.16 Subd. 3. **Administration.** The board, when administering the program, must:

3.17 (1) allow eligible persons to enroll in a silver level health plan with a state-funded
3.18 cost-sharing reduction;

3.19 (2) modify the MNsure shopping tool to display the total cost-sharing reduction benefit
3.20 available to individuals eligible under this section; and

3.21 (3) reimburse health carriers on a quarterly basis for the cost to the health plan providing
3.22 the state-funded cost-sharing reductions.

3.23 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.9631, is amended to read:

3.24 **256.9631 DIRECT PAYMENT SYSTEM ALTERNATIVE CARE DELIVERY**
3.25 **MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

3.26 Subdivision 1. **Direction to the commissioner.** (a) The commissioner, in order to deliver
3.27 services to eligible individuals, achieve better health outcomes, and reduce the cost of health
3.28 care for the state, shall develop an implementation plan plans for a direct payment system
3.29 to deliver services to eligible individuals in order to achieve better health outcomes and
3.30 reduce the cost of health care for the state. Under this system, at least three care delivery
3.31 models that:

4.1 (1) are alternatives to the use of commercial managed care plans to deliver health care
4.2 to Minnesota health care program enrollees; and

4.3 (2) do not shift financial risk to nongovernmental entities.

4.4 (b) One of the alternative models must be a direct payment system under which eligible
4.5 individuals must receive services through the medical assistance fee-for-service system,
4.6 county-based purchasing plans, or and county-owned health maintenance organizations. At
4.7 least one additional model must include county-based purchasing plans and county-owned
4.8 health maintenance organizations in their design, and must allow these entities to deliver
4.9 care in geographic areas on a single plan basis, if:

4.10 (1) these entities contract with all providers that agree to contract terms for network
4.11 participation; and

4.12 (2) the commissioner of human services determines that an entity's provider network is
4.13 adequate to ensure enrollee access and choice.

4.14 (c) Before determining the alternative models for which implementation plans will be
4.15 developed, the commissioner shall consult with the chairs and ranking minority members
4.16 of the legislative committees with jurisdiction over health care finance and policy.

4.17 (d) The commissioner shall present an implementation plan plans for the direct payment
4.18 system selected models to the chairs and ranking minority members of the legislative
4.19 committees with jurisdiction over health care finance and policy by January 15, 2026. The
4.20 commissioner may contract for technical assistance in developing the implementation plan
4.21 plans and conducting related studies and analyses.

4.22 ~~(b) For the purposes of the direct payment system, the commissioner shall make the~~
4.23 ~~following assumptions:~~

4.24 ~~(1) health care providers are reimbursed directly for all medical assistance covered~~
4.25 ~~services provided to eligible individuals, using the fee-for-service payment methods specified~~
4.26 ~~in chapters 256, 256B, 256R, and 256S;~~

4.27 ~~(2) payments to a qualified hospital provider are equivalent to the payments that would~~
4.28 ~~have been received based on managed care direct payment arrangements. If necessary, a~~
4.29 ~~qualified hospital provider may use a county-owned health maintenance organization to~~
4.30 ~~receive direct payments as described in section 256B.1973; and~~

4.31 ~~(3) county-based purchasing plans and county-owned health maintenance organizations~~
4.32 ~~must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.~~

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

5.3 (b) "Eligible individuals" means ~~qualified~~ all medical assistance enrollees, ~~defined as~~
5.4 ~~persons eligible for medical assistance as families and children and adults without children~~
5.5 and MinnesotaCare enrollees.

5.6 (c) "Minnesota health care programs" means the medical assistance and MinnesotaCare
5.7 programs.

5.8 ~~(e)~~ (d) "Qualified hospital provider" means a nonstate government teaching hospital
5.9 with high medical assistance utilization and a level 1 trauma center, and all of the hospital's
5.10 owned or affiliated health care professionals, ambulance services, sites, and clinics.

5.11 Subd. 3. **Implementation ~~plan~~ plans.** (a) ~~The~~ Each implementation plan must include:

5.12 (1) a timeline for the development and recommended implementation date of the ~~direct~~
5.13 ~~payment system~~ alternative model. In recommending a timeline, the commissioner must
5.14 consider:

5.15 (i) timelines required by the existing contracts with managed care plans and county-based
5.16 purchasing plans to sunset existing delivery models;

5.17 (ii) in counties that choose to operate a county-based purchasing plan under section
5.18 256B.692, timelines for any new procurements required for those counties to establish a
5.19 new county-based purchasing plan or participate in an existing county-based purchasing
5.20 plan;

5.21 (iii) in counties that choose to operate a county-owned health maintenance organization
5.22 under section 256B.69, timelines for any new procurements required for those counties to
5.23 establish a new county-owned health maintenance organization or to continue serving
5.24 enrollees through an existing county-owned health maintenance organization; and

5.25 (iv) a recommendation on whether the commissioner should contract with a third-party
5.26 administrator to administer the ~~direct payment system~~ alternative model, and the timeline
5.27 needed for procuring an administrator;

5.28 (2) the procedures to be used to ensure continuity of care for enrollees who transition
5.29 from managed care to fee-for-service and any administrative resources needed to carry out
5.30 these procedures;

5.31 (3) recommended quality measures for health care service delivery;

6.1 (4) any changes to fee-for-service payment rates that the commissioner determines are
6.2 necessary to ensure provider access and high-quality care and to reduce health disparities;

6.3 (5) recommendations on ensuring effective care coordination under the ~~direct payment~~
6.4 ~~system~~ alternative model, especially for enrollees who:

6.5 (i) are age 65 or older, blind, or have disabilities;

6.6 (ii) have complex medical conditions, ~~who;~~

6.7 (iii) face socioeconomic barriers to receiving care, ~~or who;~~ or

6.8 (iv) are from underserved populations that experience health disparities;

6.9 (6) recommendations on ~~whether the direct payment system should provide supplemental~~
6.10 ~~payments~~ payment arrangements for care coordination, including:

6.11 (i) the provider types eligible for ~~supplemental~~ care coordination payments;

6.12 (ii) procedures to coordinate ~~supplemental~~ care coordination payments with existing
6.13 supplemental or cost-based payment methods or to replace these existing methods; and

6.14 (iii) procedures to align care coordination initiatives funded ~~through supplemental~~
6.15 ~~payments~~ under this section the alternative model with existing care coordination initiatives;

6.16 (7) recommendations on whether the ~~direct payment system~~ alternative model should
6.17 include funding to providers for outreach initiatives to patients who, because of mental
6.18 illness, homelessness, or other circumstances, are unlikely to obtain needed care and
6.19 treatment;

6.20 (8) recommendations for a supplemental payment to qualified hospital providers to offset
6.21 any potential revenue losses resulting from the shift from managed care payments; and

6.22 ~~(9) recommendations on whether and how the direct payment system should be expanded~~
6.23 ~~to deliver services and care coordination to medical assistance enrollees who are age 65 or~~
6.24 ~~older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and~~

6.25 ~~(10)~~ (9) recommendations for statutory changes necessary to implement the ~~direct~~
6.26 ~~payment system~~ alternative model.

6.27 (b) In developing ~~the~~ each implementation plan, the commissioner shall:

6.28 (1) calculate the projected cost of a ~~direct payment system~~ the alternative model relative
6.29 to the cost of the current system;

6.30 (2) assess gaps in care coordination under the current medical assistance and
6.31 MinnesotaCare programs;

7.1 (3) evaluate the effectiveness of approaches other states have taken to coordinate care
 7.2 under a fee-for-service system, including the coordination of care provided to persons who
 7.3 are age 65 or older, are blind, or have disabilities;

7.4 (4) estimate the loss of revenue and cost savings from other payment enhancements
 7.5 based on managed care plan directed payments and pass-throughs;

7.6 (5) estimate cost trends under ~~a direct payment system~~ the alternative model for managed
 7.7 care payments to county-based purchasing plans and county-owned health maintenance
 7.8 organizations;

7.9 (6) estimate the impact of ~~a direct payment system~~ the alternative model on other revenue,
 7.10 including taxes, surcharges, or other federally approved in lieu of services and on other
 7.11 arrangements allowed under managed care;

7.12 (7) consider allowing eligible individuals to opt out of managed care as an alternative
 7.13 approach;

7.14 ~~(8) assess the feasibility of a medical assistance outpatient prescription drug benefit~~
 7.15 ~~carve-out under section 256B.69, subdivision 6d, and in consultation with the commissioners~~
 7.16 ~~of commerce and health, assess the feasibility of including MinnesotaCare enrollees and~~
 7.17 ~~private sector enrollees of health plan companies in the drug benefit carve-out. The~~
 7.18 ~~assessment of feasibility must address and include recommendations related to the process~~
 7.19 ~~and terms by which the commissioner would contract with health plan companies to~~
 7.20 ~~administer prescription drug benefits and develop and manage a drug formulary, and the~~
 7.21 ~~impact of the drug benefit carve-out on health care providers, including small pharmacies;~~

7.22 ~~(9)~~ (8) consult with the commissioners of health and commerce and the contractor or
 7.23 contractors analyzing the Minnesota Health Plan ~~under section 19~~ and other health reform
 7.24 models on plan design and assumptions; and

7.25 ~~(10)~~ (9) conduct other analyses necessary to develop the implementation plan.

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

7.27 Sec. 3. Minnesota Statutes 2022, section 256.9657, is amended by adding a subdivision
 7.28 to read:

7.29 **Subd. 2a. Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the
 7.30 medical assistance account a surcharge equal to 0.01 percent of net non-Medicare patient
 7.31 care revenue. The initial surcharge must be paid 60 days after both this subdivision and

8.1 section 256.969, subdivision 2g, have received federal approval, and subsequent surcharge
8.2 payments must be made annually in the form and manner specified by the commissioner.

8.3 (b) The commissioner shall use revenue from the surcharge only to pay the nonfederal
8.4 share of the medical assistance supplemental payments described in section 256.969,
8.5 subdivision 2g, and to supplement, and not supplant, medical assistance reimbursement to
8.6 teaching hospitals. The surcharge must comply with Code of Federal Regulations, title 42,
8.7 section 433.63.

8.8 (c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital,
8.9 except facilities of the federal Indian Health Service and regional treatment centers, with a
8.10 Centers for Medicare and Medicaid Services designation of "teaching hospital" as reported
8.11 on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement under
8.12 section 256.969, subdivision 2g.

8.13 **EFFECTIVE DATE.** This section is effective the later of January 1, 2025, or federal
8.14 approval of this section and sections 4 and 5. The commissioner of human services shall
8.15 notify the revisor of statutes when federal approval is obtained.

8.16 Sec. 4. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended
8.17 to read:

8.18 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
8.19 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
8.20 to the following:

8.21 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
8.22 methodology;

8.23 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
8.24 under subdivision 25;

8.25 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
8.26 distinct parts as defined by Medicare shall be paid according to the methodology under
8.27 subdivision 12; and

8.28 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

8.29 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
8.30 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
8.31 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
8.32 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on

9.1 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
9.2 years are updated, a Minnesota long-term hospital's base year shall remain within the same
9.3 period as other hospitals.

9.4 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
9.5 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
9.6 area, except for the hospitals paid under the methodologies described in paragraph (a),
9.7 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
9.8 manner similar to Medicare. The base year or years for the rates effective November 1,
9.9 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
9.10 ensuring that the total aggregate payments under the rebased system are equal to the total
9.11 aggregate payments that were made for the same number and types of services in the base
9.12 year. Separate budget neutrality calculations shall be determined for payments made to
9.13 critical access hospitals and payments made to hospitals paid under the DRG system. Only
9.14 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
9.15 rebased during the entire base period shall be incorporated into the budget neutrality
9.16 calculation.

9.17 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
9.18 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
9.19 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
9.20 a five percent increase or decrease from the base year payments for any hospital. Any
9.21 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
9.22 shall maintain budget neutrality as described in paragraph (c).

9.23 (e) For discharges occurring on or after November 1, 2014, the commissioner may make
9.24 additional adjustments to the rebased rates, and when evaluating whether additional
9.25 adjustments should be made, the commissioner shall consider the impact of the rates on the
9.26 following:

9.27 (1) pediatric services;

9.28 (2) behavioral health services;

9.29 (3) trauma services as defined by the National Uniform Billing Committee;

9.30 (4) transplant services;

9.31 (5) obstetric services, newborn services, and behavioral health services provided by
9.32 hospitals outside the seven-county metropolitan area;

9.33 (6) outlier admissions;

10.1 (7) low-volume providers; and

10.2 (8) services provided by small rural hospitals that are not critical access hospitals.

10.3 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

10.4 (1) for hospitals paid under the DRG methodology, the base year payment rate per
10.5 admission is standardized by the applicable Medicare wage index and adjusted by the
10.6 hospital's disproportionate population adjustment;

10.7 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
10.8 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
10.9 October 31, 2014;

10.10 (3) the cost and charge data used to establish hospital payment rates must only reflect
10.11 inpatient services covered by medical assistance; and

10.12 (4) in determining hospital payment rates for discharges occurring on or after the rate
10.13 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
10.14 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
10.15 program in effect during the base year or years. In determining hospital payment rates for
10.16 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
10.17 methods and allowable costs of the Medicare program in effect during the base year or
10.18 years.

10.19 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
10.20 the rates established under paragraph (c), and any adjustments made to the rates under
10.21 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
10.22 total aggregate payments for the same number and types of services under the rebased rates
10.23 are equal to the total aggregate payments made during calendar year 2013.

10.24 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
10.25 thereafter, payment rates under this section shall be rebased to reflect only those changes
10.26 in hospital costs between the existing base year or years and the next base year or years. In
10.27 any year that inpatient claims volume falls below the threshold required to ensure a
10.28 statistically valid sample of claims, the commissioner may combine claims data from two
10.29 consecutive years to serve as the base year. Years in which inpatient claims volume is
10.30 reduced or altered due to a pandemic or other public health emergency shall not be used as
10.31 a base year or part of a base year if the base year includes more than one year. Changes in
10.32 costs between base years shall be measured using the lower of the hospital cost index defined
10.33 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per

11.1 claim. The commissioner shall establish the base year for each rebasing period considering
11.2 the most recent year or years for which filed Medicare cost reports are available, except
11.3 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.
11.4 The estimated change in the average payment per hospital discharge resulting from a
11.5 scheduled rebasing must be calculated and made available to the legislature by January 15
11.6 of each year in which rebasing is scheduled to occur, and must include by hospital the
11.7 differential in payment rates compared to the individual hospital's costs.

11.8 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
11.9 for critical access hospitals located in Minnesota or the local trade area shall be determined
11.10 using a new cost-based methodology. The commissioner shall establish within the
11.11 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
11.12 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
11.13 the total cost for critical access hospitals as reflected in base year cost reports. Until the
11.14 next rebasing that occurs, the new methodology shall result in no greater than a five percent
11.15 decrease from the base year payments for any hospital, except a hospital that had payments
11.16 that were greater than 100 percent of the hospital's costs in the base year shall have their
11.17 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
11.18 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
11.19 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
11.20 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
11.21 following criteria:

11.22 (1) hospitals that had payments at or below 80 percent of their costs in the base year
11.23 shall have a rate set that equals 85 percent of their base year costs;

11.24 (2) hospitals that had payments that were above 80 percent, up to and including 90
11.25 percent of their costs in the base year shall have a rate set that equals 95 percent of their
11.26 base year costs; and

11.27 (3) hospitals that had payments that were above 90 percent of their costs in the base year
11.28 shall have a rate set that equals 100 percent of their base year costs.

11.29 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
11.30 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
11.31 methodology may include, but are not limited to:

11.32 (1) the ratio between the hospital's costs for treating medical assistance patients and the
11.33 hospital's charges to the medical assistance program;

12.1 (2) the ratio between the hospital's costs for treating medical assistance patients and the
12.2 hospital's payments received from the medical assistance program for the care of medical
12.3 assistance patients;

12.4 (3) the ratio between the hospital's charges to the medical assistance program and the
12.5 hospital's payments received from the medical assistance program for the care of medical
12.6 assistance patients;

12.7 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

12.8 (5) the proportion of that hospital's costs that are administrative and trends in
12.9 administrative costs; and

12.10 (6) geographic location.

12.11 (k) Subject to section 256.969, subdivision 2g, paragraph (i), effective for discharges
12.12 occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a),
12.13 clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a
12.14 medical education and research cost distribution under section 62J.692, subdivision 4,
12.15 paragraph (a).

12.16 **EFFECTIVE DATE.** This section is effective the later of January 1, 2025, or federal
12.17 approval of this section and sections 3 and 5. The commissioner of human services shall
12.18 notify the revisor of statutes when federal approval is obtained.

12.19 Sec. 5. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
12.20 read:

12.21 **Subd. 2g. Annual supplemental payments; direct and indirect physician graduate**
12.22 **medical education.** (a) For discharges occurring on or after January 1, 2025, the
12.23 commissioner shall determine and pay annual supplemental payments to all eligible hospitals
12.24 as provided in this subdivision for direct and indirect physician graduate medical education
12.25 cost reimbursement. A hospital must be an eligible hospital to receive an annual supplemental
12.26 payment under this subdivision.

12.27 (b) The commissioner must use the following information to calculate the total cost of
12.28 direct graduate medical education incurred by each eligible hospital:

12.29 (1) the total allowable direct graduate medical education cost, as calculated by adding
12.30 form CMS-2552-10, worksheet B, part 1, columns 21 and 22, line 202; and

12.31 (2) the Medicaid share of total allowable direct graduate medical education cost
12.32 percentage, representing the allocation of total graduate medical education costs to Medicaid

13.1 based on the share of all Medicaid inpatient days, as reported on form CMS-2552-10,
13.2 worksheets S-2 and S-3, divided by the hospital's total inpatient days, as reported on
13.3 worksheet S-3.

13.4 (c) The commissioner may obtain the information in paragraph (b) from an eligible
13.5 hospital upon request by the commissioner or from the eligible hospital's most recently filed
13.6 form CMS-2552-10.

13.7 (d) The commissioner must use the following information to calculate the total allowable
13.8 indirect cost of graduate medical education incurred by each eligible hospital:

13.9 (1) for eligible hospitals that are not children's hospitals, the indirect graduate medical
13.10 education amount attributable to Medicaid, calculated based on form CMS-2552-10,
13.11 worksheet E, part A, including:

13.12 (i) the Medicare indirect medical education formula, using Medicaid variables;

13.13 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
13.14 as determined by the commissioner in consultation with each eligible hospital;

13.15 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet E, part
13.16 A, line 4; and

13.17 (iv) full-time employees, as determined by adding form CMS-2552-10, worksheet E,
13.18 part A, lines 10 and 11; and

13.19 (2) for eligible hospitals that are children's hospitals:

13.20 (i) the Medicare indirect medical education formula, using Medicaid variables;

13.21 (ii) Medicaid payments for inpatient services under fee-for-service and managed care,
13.22 as determined by the commissioner in consultation with each eligible hospital;

13.23 (iii) total inpatient beds available, as reported on form CMS-2552-10, worksheet S-3,
13.24 part 1; and

13.25 (iv) full-time equivalent interns and residents, as determined by adding form
13.26 CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01.

13.27 (e) The commissioner shall determine each eligible hospital's maximum allowable
13.28 Medicaid direct graduate medical education supplemental payment amount by calculating
13.29 the sum of:

14.1 (1) the total allowable direct graduate medical education costs determined under paragraph
14.2 (b), clause (1), multiplied by the Medicaid share of total allowable direct graduate medical
14.3 education cost percentage in paragraph (b), clause (2); and

14.4 (2) the total allowable direct graduate medical education costs determined under paragraph
14.5 (b), clause (1), multiplied by the most recently updated Medicaid utilization percentage
14.6 from form CMS-2552-10, as submitted to Medicare by each eligible hospital.

14.7 (f) The commissioner shall determine each eligible hospital's indirect graduate medical
14.8 education supplemental payment amount by multiplying the total allowable indirect cost
14.9 of graduate medical education amount calculated in paragraph (d) by:

14.10 (1) 0.95 for prospective payment system, for hospitals that are not children's hospitals
14.11 and have fewer than 50 full-time equivalent trainees;

14.12 (2) 1.0 for prospective payment system, for hospitals that are not children's hospitals
14.13 and have equal to or greater than 50 full-time equivalent trainees; and

14.14 (3) 1.05 for children's hospitals.

14.15 (g) An eligible hospital's annual supplemental payment under this subdivision equals
14.16 the sum of the amount calculated for the eligible hospital under paragraph (e) and the amount
14.17 calculated for the eligible hospital under paragraph (f).

14.18 (h) The annual supplemental payments under this subdivision are contingent upon federal
14.19 approval and must conform with the requirements for permissible supplemental payments
14.20 for direct and indirect graduate medical education under all applicable federal laws.

14.21 (i) An eligible hospital is only eligible for reimbursement under section 62J.692 for
14.22 nonphysician graduate medical education training costs that are not accounted for in the
14.23 calculation of an annual supplemental payment under this section. An eligible hospital must
14.24 not accept reimbursement under section 62J.692 for physician graduate medical education
14.25 training costs that are accounted for in the calculation of an annual supplemental payment
14.26 under this section.

14.27 (j) For purposes of this subdivision, "children's hospital" means a Minnesota hospital
14.28 designated as a children's hospital under Medicare.

14.29 (k) For purposes of this subdivision, "eligible hospital" means a hospital located in
14.30 Minnesota:

14.31 (1) participating in Minnesota's medical assistance program;

15.1 (2) that has received fee-for-service medical assistance payments in the payment year;
15.2 and

15.3 (3) that is either:

15.4 (i) eligible to receive graduate medical education payments from the Medicare program
15.5 under Code of Federal Regulations, title 42, section 413.75; or

15.6 (ii) a children's hospital.

15.7 **EFFECTIVE DATE.** This section is effective the later of January 1, 2025, or federal
15.8 approval of this section and sections 3 and 4. The commissioner of human services shall
15.9 notify the revisor of statutes when federal approval is obtained.

15.10 Sec. 6. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to
15.11 read:

15.12 Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively
15.13 from January 1, 2024, in any rate year in which a children's hospital discharge is included
15.14 in the federally required disproportionate share hospital payment audit where the patient
15.15 discharged had resided in a children's hospital for over 20 years, the commissioner shall
15.16 compute an alternate inpatient rate for the children's hospital. The alternate payment rate
15.17 must be the rate computed under this section excluding the disproportionate share hospital
15.18 payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to
15.19 99 percent of what the disproportionate share hospital payment would have been under
15.20 subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

15.21 (b) In any rate year in which payment to a children's hospital is made using this alternate
15.22 payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

15.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
15.24 of human services shall notify the revisor of statutes when federal approval is obtained.

15.25 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as
15.26 amended by Laws 2024, chapter 85, section 66, is amended to read:

15.27 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
15.28 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the
15.29 usual and customary price charged to the public. The usual and customary price means the
15.30 lowest price charged by the provider to a patient who pays for the prescription by cash,
15.31 check, or charge account and includes prices the pharmacy charges to a patient enrolled in
15.32 a prescription savings club or prescription discount club administered by the pharmacy or

16.1 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
16.2 amounts applied to the charge by any third-party provider/insurer agreement or contract for
16.3 submitted charges to medical assistance programs. The net submitted charge may not be
16.4 greater than the patient liability for the service. The professional dispensing fee shall be
16.5 ~~\$10.77~~ \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered
16.6 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The
16.7 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall
16.8 be ~~\$10.77~~ \$11.55 per claim. The professional dispensing fee for prescriptions filled with
16.9 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.77~~
16.10 \$11.55 for dispensed quantities equal to or greater than the number of units contained in
16.11 the manufacturer's original package. The professional dispensing fee shall be prorated based
16.12 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
16.13 than the number of units contained in the manufacturer's original package. The pharmacy
16.14 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
16.15 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units
16.16 contained in the manufacturer's original package and shall be prorated based on the
16.17 percentage of the package dispensed when the pharmacy dispenses a quantity less than the
16.18 number of units contained in the manufacturer's original package. The National Average
16.19 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.
16.20 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient
16.21 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for
16.22 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B
16.23 Drug Pricing Program ceiling price established by the Health Resources and Services
16.24 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as
16.25 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in
16.26 the United States, not including prompt pay or other discounts, rebates, or reductions in
16.27 price, for the most recent month for which information is available, as reported in wholesale
16.28 price guides or other publications of drug or biological pricing data. The maximum allowable
16.29 cost of a multisource drug may be set by the commissioner and it shall be comparable to
16.30 the actual acquisition cost of the drug product and no higher than the NADAC of the generic
16.31 product. Establishment of the amount of payment for drugs shall not be subject to the
16.32 requirements of the Administrative Procedure Act.

16.33 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
16.34 an automated drug distribution system meeting the requirements of section 151.58, or a
16.35 packaging system meeting the packaging standards set forth in Minnesota Rules, part
16.36 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ

17.1 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
17.2 retrospectively billing pharmacy must submit a claim only for the quantity of medication
17.3 used by the enrolled recipient during the defined billing period. A retrospectively billing
17.4 pharmacy must use a billing period not less than one calendar month or 30 days.

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

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

17.16 (e) The basis for determining the amount of payment for drugs administered in an
17.17 outpatient setting shall be the lower of the usual and customary cost submitted by the
17.18 provider, 106 percent of the average sales price as determined by the United States
17.19 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
17.20 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
17.21 set by the commissioner. If average sales price is unavailable, the amount of payment must
17.22 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
17.23 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
17.24 The commissioner shall discount the payment rate for drugs obtained through the federal
17.25 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an
17.26 outpatient setting shall be made to the administering facility or practitioner. A retail or
17.27 specialty pharmacy dispensing a drug for administration in an outpatient setting is not
17.28 eligible for direct reimbursement.

17.29 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy
17.30 products that are lower than the ingredient cost formulas specified in paragraph (a). The
17.31 commissioner may require individuals enrolled in the health care programs administered
17.32 by the department to obtain specialty pharmacy products from providers with whom the
17.33 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are
17.34 defined as those used by a small number of recipients or recipients with complex and chronic
17.35 diseases that require expensive and challenging drug regimens. Examples of these conditions

18.1 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,
18.2 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of
18.3 cancer. Specialty pharmaceutical products include injectable and infusion therapies,
18.4 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that
18.5 require complex care. The commissioner shall consult with the Formulary Committee to
18.6 develop a list of specialty pharmacy products subject to maximum allowable cost
18.7 reimbursement. In consulting with the Formulary Committee in developing this list, the
18.8 commissioner shall take into consideration the population served by specialty pharmacy
18.9 products, the current delivery system and standard of care in the state, and access to care
18.10 issues. The commissioner shall have the discretion to adjust the maximum allowable cost
18.11 to prevent access to care issues.

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

18.14 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey
18.15 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient
18.16 drugs under medical assistance. The commissioner shall ensure that the vendor has prior
18.17 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the
18.18 department to dispense outpatient prescription drugs to fee-for-service members must
18.19 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under
18.20 section 256B.064 for failure to respond. The commissioner shall require the vendor to
18.21 measure a single statewide cost of dispensing for specialty prescription drugs and a single
18.22 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies
18.23 to measure the mean, mean weighted by total prescription volume, mean weighted by
18.24 medical assistance prescription volume, median, median weighted by total prescription
18.25 volume, and median weighted by total medical assistance prescription volume. The
18.26 commissioner shall post a copy of the final cost of dispensing survey report on the
18.27 department's website. The initial survey must be completed no later than January 1, 2021,
18.28 and repeated every three years. The commissioner shall provide a summary of the results
18.29 of each cost of dispensing survey and provide recommendations for any changes to the
18.30 dispensing fee to the chairs and ranking minority members of the legislative committees
18.31 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section
18.32 256.01, subdivision 42, this paragraph does not expire.

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

19.1 **EFFECTIVE DATE.** This section is effective July 1, 2024.

19.2 Sec. 8. Minnesota Statutes 2022, section 256B.69, is amended by adding a subdivision to
19.3 read:

19.4 Subd. 38. **Reimbursement of network providers.** (a) A managed care plan that is a
19.5 staff model health plan company, when reimbursing network providers for services provided
19.6 to medical assistance and MinnesotaCare enrollees, must not reimburse network providers
19.7 who are employees at a higher rate than network providers who provide services under
19.8 contract for each separate service or grouping of services. This requirement does not apply
19.9 to reimbursement:

19.10 (1) of network providers when participating in value-based purchasing models that are
19.11 intended to recognize value or outcomes over volume of services, including:

19.12 (i) total cost of care and risk/gain sharing arrangements under section 256B.0755; and

19.13 (ii) other pay-for-performance arrangements or service payments, as long as the terms
19.14 and conditions of the value-based purchasing model are applied uniformly to all participating
19.15 network providers; and

19.16 (2) for services furnished by providers who are out-of-network.

19.17 (b) Any contract or agreement between a managed care plan and a network administrator,
19.18 for purposes of delivering services to medical assistance and MinnesotaCare enrollees, must
19.19 require the network administrator to comply with the requirements that apply to a managed
19.20 care plan that is a staff model health plan company under paragraph (a) when reimbursing
19.21 providers who are employees of the network administrator and providers who provide
19.22 services under contract with the network administrator. This provision applies whether or
19.23 not the managed care plan, network administrator, and providers are under the same corporate
19.24 ownership.

19.25 (c) For purposes of this subdivision, "network provider" has the meaning specified in
19.26 subdivision 37. For purposes of this subdivision, "network administrator" means any entity
19.27 that furnishes a provider network for a managed care plan company, or furnishes individual
19.28 health care providers or provider groups to a managed care plan for inclusion in the managed
19.29 care plan's provider network.

19.30 Sec. 9. **COUNTY-ADMINISTERED MEDICAL ASSISTANCE MODEL.**

19.31 Subdivision 1. **Model development.** (a) The commissioner of human services, in
19.32 collaboration with the Association of Minnesota Counties and county-based purchasing

20.1 plans, shall develop a county-administered medical assistance (CAMA) model and a detailed
20.2 plan for implementing the CAMA model.

20.3 (b) The CAMA model must be designed to achieve the following objectives:

20.4 (1) provide a distinct county owned and administered alternative to the prepaid medical
20.5 assistance program;

20.6 (2) facilitate greater integration of health care and social services to address social
20.7 determinants of health in rural and nonrural communities, with the degree of integration of
20.8 social services varying with each county's needs and resources;

20.9 (3) account for differences between counties in the number of medical assistance enrollees
20.10 and locally available providers of behavioral health, oral health, specialty and tertiary care,
20.11 nonemergency medical transportation, and other health care services in rural communities;
20.12 and

20.13 (4) promote greater accountability for health outcomes, health equity, customer service,
20.14 community outreach, and cost of care.

20.15 Subd. 2. **County participation.** (a) The CAMA model must give each rural and nonrural
20.16 county the option of applying to participate in the CAMA model as an alternative to
20.17 participation in the prepaid medical assistance program. The CAMA model must include a
20.18 process for the commissioner to determine whether and how a county can participate.

20.19 (b) The CAMA model may allow a county-administered managed care organization to
20.20 deliver care on a single-plan basis to all medical assistance enrollees residing in a county
20.21 if:

20.22 (1) the managed care organization contracts with all health care providers that agree to
20.23 accept the contract terms for network participation; and

20.24 (2) the commissioner determines that the health care provider network of the managed
20.25 care organization is adequate to ensure enrollee access to care and enrollee choice of
20.26 providers.

20.27 Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations
20.28 and an implementation plan for the CAMA model to the chairs and ranking minority members
20.29 of the legislative committees with jurisdiction over health care policy and finance by January
20.30 15, 2025. The CAMA model and implementation plan must address the issues and consider
20.31 the recommendations identified in the document titled "Recommendations Not Contingent
20.32 on Outcome(s) of Current Litigation," attached to the September 13, 2022, e-filing to the
20.33 Second Judicial District Court (Correspondence for Judicial Approval Index #102), that

21.1 relates to the final contract decisions of the commissioner of human services regarding
 21.2 *South Country Health Alliance v. Minnesota Department of Human Services*, No.
 21.3 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

21.4 (b) The report must also identify the clarifications, approvals, and waivers that are needed
 21.5 from the Centers for Medicare and Medicaid Services and include any draft legislation
 21.6 necessary to implement the CAMA model.

21.7 Sec. 10. **REVISOR INSTRUCTION.**

21.8 When the proposed rule published at Federal Register, volume 88, page 25313, becomes
 21.9 effective, the revisor of statutes must change: (1) the reference in Minnesota Statutes, section
 21.10 256B.06, subdivision 4, paragraph (d), from Code of Federal Regulations, title 8, section
 21.11 103.12, to Code of Federal Regulations, title 42, section 435.4; and (2) the reference in
 21.12 Minnesota Statutes, section 256L.04, subdivision 10, paragraph (a), from Code of Federal
 21.13 Regulations, title 8, section 103.12, to Code of Federal Regulations, title 45, section 155.20.
 21.14 The commissioner of human services shall notify the revisor of statutes when the proposed
 21.15 rule published at Federal Register, volume 88, page 25313, becomes effective.

21.16 **ARTICLE 2**

21.17 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY**

21.18 Section 1. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as
 21.19 amended by Laws 2024, chapter 80, article 1, section 76, is amended to read:

21.20 Subdivision 1. **Qualifying overpayment.** Any overpayment for state-funded medical
 21.21 assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted
 21.22 pursuant to section 256.045, subdivision 10; ~~chapter 256B for state-funded medical~~
 21.23 ~~assistance~~; and chapters 256D, 256I, 256K, and 256L for state-funded MinnesotaCare except
 21.24 agency error claims, become a judgment by operation of law 90 days after the notice of
 21.25 overpayment is personally served upon the recipient in a manner that is sufficient under
 21.26 rule 4.03(a) of the Rules of Civil Procedure for district courts, or by certified mail, return
 21.27 receipt requested. This judgment shall be entitled to full faith and credit in this and any
 21.28 other state.

21.29 **EFFECTIVE DATE.** This section is effective July 1, 2024.

22.1 Sec. 2. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

22.2 Subd. 8. **Commissioner's duties.** ~~(a) Beginning October 1, 2023, the commissioner of~~
22.3 ~~human services shall annually report to the chairs and ranking minority members of the~~
22.4 ~~legislative committees with jurisdiction over health care policy and finance regarding the~~
22.5 ~~provider surcharge program. The report shall include information on total billings, total~~
22.6 ~~collections, and administrative expenditures for the previous fiscal year. This paragraph~~
22.7 ~~expires January 1, 2032.~~

22.8 ~~(b)~~ (a) The surcharge shall be adjusted by inflationary and caseload changes in future
22.9 bienniums to maintain reimbursement of health care providers in accordance with the
22.10 requirements of the state and federal laws governing the medical assistance program,
22.11 including the requirements of the Medicaid moratorium amendments of 1991 found in
22.12 Public Law No. 102-234.

22.13 ~~(c)~~ (b) The commissioner shall request the Minnesota congressional delegation to support
22.14 a change in federal law that would prohibit federal disallowances for any state that makes
22.15 a good faith effort to comply with Public Law 102-234 by enacting conforming legislation
22.16 prior to the issuance of federal implementing regulations.

22.17 Sec. 3. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

22.18 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law
22.19 or rule or federal law or regulation, the methodologies used in counting income and assets
22.20 to determine eligibility for medical assistance for persons whose eligibility category is based
22.21 on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental
22.22 Security Income program shall be used, except as provided ~~under~~ in clause (2) and
22.23 subdivision 3, paragraph (a), clause (6).

22.24 (2) State tax credits, rebates, and refunds must not be counted as income. State tax credits,
22.25 rebates, and refunds must not be counted as assets for a period of 12 months after the month
22.26 of receipt.

22.27 ~~(2)~~ (3) Increases in benefits under title II of the Social Security Act shall not be counted
22.28 as income for purposes of this subdivision until July 1 of each year. Effective upon federal
22.29 approval, for children eligible under section 256B.055, subdivision 12, or for home and
22.30 community-based waiver services whose eligibility for medical assistance is determined
22.31 without regard to parental income, child support payments, including any payments made
22.32 by an obligor in satisfaction of or in addition to a temporary or permanent order for child
22.33 support, and Social Security payments are not counted as income.

23.1 (b)(1) The modified adjusted gross income methodology as defined in United States
23.2 Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

23.3 (i) children under age 19 and their parents and relative caretakers as defined in section
23.4 256B.055, subdivision 3a;

23.5 (ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

23.6 (iii) pregnant women as defined in section 256B.055, subdivision 6;

23.7 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision
23.8 1; and

23.9 (v) adults without children as defined in section 256B.055, subdivision 15.

23.10 For these purposes, a "methodology" does not include an asset or income standard, or
23.11 accounting method, or method of determining effective dates.

23.12 (2) For individuals whose income eligibility is determined using the modified adjusted
23.13 gross income methodology in clause (1):

23.14 (i) the commissioner shall subtract from the individual's modified adjusted gross income
23.15 an amount equivalent to five percent of the federal poverty guidelines; and

23.16 (ii) the individual's current monthly income and household size is used to determine
23.17 eligibility for the 12-month eligibility period. If an individual's income is expected to vary
23.18 month to month, eligibility is determined based on the income predicted for the 12-month
23.19 eligibility period.

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

23.21 Sec. 4. Minnesota Statutes 2022, section 256B.056, subdivision 10, is amended to read:

23.22 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are
23.23 applying for the continuation of medical assistance coverage following the end of the
23.24 12-month postpartum period to update their income and asset information and to submit
23.25 any required income or asset verification.

23.26 (b) The commissioner shall determine the eligibility of private-sector health care coverage
23.27 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
23.28 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is
23.29 determined to be cost-effective.

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

24.1 (d) The commissioner shall utilize information obtained through the electronic service
24.2 established by the secretary of the United States Department of Health and Human Services
24.3 and other available electronic data sources in Code of Federal Regulations, title 42, sections
24.4 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
24.5 standards to define when information obtained electronically is reasonably compatible with
24.6 information provided by applicants and enrollees, including use of self-attestation, to
24.7 accomplish real-time eligibility determinations and maintain program integrity.

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

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

24.20 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is amended
24.21 to read:

24.22 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for
24.23 facility costs and must be paid from state money in an amount equal to the ~~medical assistance~~
24.24 ~~room and board~~ MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the
24.25 time the recuperative care services were provided. The eligibility standards in chapter 256I
24.26 do not apply to the recuperative care facility rate. The recuperative care facility rate is only
24.27 paid when the recuperative care services rate is paid to a provider. Providers may opt to
24.28 only receive the recuperative care services rate.

24.29 (b) Before a recipient is discharged from a recuperative care setting, the provider must
24.30 ensure that the recipient's medical condition is stabilized or that the recipient is being
24.31 discharged to a setting that is able to meet that recipient's needs.

25.1 Sec. 6. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

25.2 Subd. 4a. **Behavioral health home services provider requirements.** A behavioral
25.3 health home services provider must:

25.4 (1) be an enrolled Minnesota Health Care Programs provider;

25.5 (2) provide a medical assistance covered primary care or behavioral health service;

25.6 (3) utilize an electronic health record;

25.7 (4) utilize an electronic patient registry that contains data elements required by the
25.8 commissioner;

25.9 (5) demonstrate the organization's capacity to administer screenings approved by the
25.10 commissioner for substance use disorder or alcohol and tobacco use;

25.11 (6) demonstrate the organization's capacity to refer an individual to resources appropriate
25.12 to the individual's screening results;

25.13 (7) have policies and procedures to track referrals to ensure that the referral met the
25.14 individual's needs;

25.15 (8) conduct a brief needs assessment when an individual begins receiving behavioral
25.16 health home services. The brief needs assessment must be completed with input from the
25.17 individual and the individual's identified supports. The brief needs assessment must address
25.18 the individual's immediate safety and transportation needs and potential barriers to
25.19 participating in behavioral health home services;

25.20 (9) conduct a health wellness assessment within 60 days after intake that contains all
25.21 required elements identified by the commissioner;

25.22 (10) conduct a health action plan that contains all required elements identified by the
25.23 commissioner. The plan must be completed within 90 days after intake and must be updated
25.24 at least once every six months, or more frequently if significant changes to an individual's
25.25 needs or goals occur;

25.26 (11) agree to cooperate with and participate in the state's monitoring and evaluation of
25.27 behavioral health home services; and

25.28 (12) obtain the individual's ~~written~~ consent to begin receiving behavioral health home
25.29 services using a form approved by the commissioner.

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

- 26.1 Sec. 7. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:
- 26.2 Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health
- 26.3 home services provider must meet the following service delivery standards:
- 26.4 (1) establish and maintain processes to support the coordination of an individual's primary
- 26.5 care, behavioral health, and dental care;
- 26.6 (2) maintain a team-based model of care, including regular coordination and
- 26.7 communication between behavioral health home services team members;
- 26.8 (3) use evidence-based practices that recognize and are tailored to the medical, social,
- 26.9 economic, behavioral health, functional impairment, cultural, and environmental factors
- 26.10 affecting the individual's health and health care choices;
- 26.11 (4) use person-centered planning practices to ensure the individual's health action plan
- 26.12 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for
- 26.13 the individual and the individual's identified supports;
- 26.14 (5) use the patient registry to identify individuals and population subgroups requiring
- 26.15 specific levels or types of care and provide or refer the individual to needed treatment,
- 26.16 intervention, or services;
- 26.17 (6) ~~utilize the Department of Human Services Partner Portal to~~ identify past and current
- 26.18 treatment or services and identify potential gaps in care using a tool approved by the
- 26.19 commissioner;
- 26.20 (7) deliver services consistent with the standards for frequency and face-to-face contact
- 26.21 required by the commissioner;
- 26.22 (8) ensure that a diagnostic assessment is completed for each individual receiving
- 26.23 behavioral health home services within six months of the start of behavioral health home
- 26.24 services;
- 26.25 (9) deliver services in locations and settings that meet the needs of the individual;
- 26.26 (10) provide a central point of contact to ensure that individuals and the individual's
- 26.27 identified supports can successfully navigate the array of services that impact the individual's
- 26.28 health and well-being;
- 26.29 (11) have capacity to assess an individual's readiness for change and the individual's
- 26.30 capacity to integrate new health care or community supports into the individual's life;

27.1 (12) offer or facilitate the provision of wellness and prevention education on
27.2 evidenced-based curriculums specific to the prevention and management of common chronic
27.3 conditions;

27.4 (13) help an individual set up and prepare for medical, behavioral health, social service,
27.5 or community support appointments, including accompanying the individual to appointments
27.6 as appropriate, and providing follow-up with the individual after these appointments;

27.7 (14) offer or facilitate the provision of health coaching related to chronic disease
27.8 management and how to navigate complex systems of care to the individual, the individual's
27.9 family, and identified supports;

27.10 (15) connect an individual, the individual's family, and identified supports to appropriate
27.11 support services that help the individual overcome access or service barriers, increase
27.12 self-sufficiency skills, and improve overall health;

27.13 (16) provide effective referrals and timely access to services; and

27.14 (17) establish a continuous quality improvement process for providing behavioral health
27.15 home services.

27.16 (b) The behavioral health home services provider must also create a plan, in partnership
27.17 with the individual and the individual's identified supports, to support the individual after
27.18 discharge from a hospital, residential treatment program, or other setting. The plan must
27.19 include protocols for:

27.20 (1) maintaining contact between the behavioral health home services team member, the
27.21 individual, and the individual's identified supports during and after discharge;

27.22 (2) linking the individual to new resources as needed;

27.23 (3) reestablishing the individual's existing services and community and social supports;
27.24 and

27.25 (4) following up with appropriate entities to transfer or obtain the individual's service
27.26 records as necessary for continued care.

27.27 (c) If the individual is enrolled in a managed care plan, a behavioral health home services
27.28 provider must:

27.29 (1) notify the behavioral health home services contact designated by the managed care
27.30 plan within 30 days of when the individual begins behavioral health home services; and

27.31 (2) adhere to the managed care plan communication and coordination requirements
27.32 described in the behavioral health home services manual.

28.1 (d) Before terminating behavioral health home services, the behavioral health home
28.2 services provider must:

28.3 (1) provide a 60-day notice of termination of behavioral health home services to all
28.4 individuals receiving behavioral health home services, the commissioner, and managed care
28.5 plans, if applicable; and

28.6 (2) refer individuals receiving behavioral health home services to a new behavioral
28.7 health home services provider.

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

28.9 Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

28.10 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

28.11 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
28.12 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
28.13 when these services are provided by a community clinic as defined in section 145.9268,
28.14 subdivision 1.

28.15 (b) Effective for services rendered on or after July 1, 2013, payment rates for family
28.16 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,
28.17 when these services are provided by a community clinic as defined in section 145.9268,
28.18 subdivision 1. The commissioner shall adjust capitation rates to managed care and
28.19 county-based purchasing plans to reflect this increase, and shall require plans to pass on the
28.20 full amount of the rate increase to eligible community clinics, in the form of higher payment
28.21 rates for family planning services.

28.22 (c) Effective for services provided on or after January 1, 2024, payment rates for family
28.23 planning, when such services are provided by an eligible community clinic as defined in
28.24 section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent.
28.25 This increase does not apply to federally qualified health centers, rural health centers, or
28.26 Indian health services.

28.27 Sec. 9. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended
28.28 to read:

28.29 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
28.30 services reimbursed under chapter 256B, with the exception of special education services,
28.31 home care nursing services, ~~adult dental care services other than services covered under~~
28.32 ~~section 256B.0625, subdivision 9, orthodontic services,~~ nonemergency medical transportation

29.1 services, personal care assistance and case management services, community first services
29.2 and supports under section 256B.85, behavioral health home services under section
29.3 256B.0757, housing stabilization services under section 256B.051, and nursing home or
29.4 intermediate care facilities services.

29.5 (b) Covered health services shall be expanded as provided in this section.

29.6 (c) For the purposes of covered health services under this section, "child" means an
29.7 individual younger than 19 years of age.

29.8 Sec. 10. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter
29.9 79, article 9, section 20, is amended to read:

29.10 **524.3-801 NOTICE TO CREDITORS.**

29.11 (a) Unless notice has already been given under this section, upon appointment of a
29.12 general personal representative in informal proceedings or upon the filing of a petition for
29.13 formal appointment of a general personal representative, notice thereof, in the form prescribed
29.14 by court rule, shall be given under the direction of the court administrator by publication
29.15 once a week for two successive weeks in a legal newspaper in the county wherein the
29.16 proceedings are pending giving the name and address of the general personal representative
29.17 and notifying creditors of the estate to present their claims within four months after the date
29.18 of the court administrator's notice which is subsequently published or be forever barred,
29.19 unless they are entitled to further service of notice under paragraph (b) or (c).

29.20 (b) The personal representative shall, within three months after the date of the first
29.21 publication of the notice, serve a copy of the notice upon each then known and identified
29.22 creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse
29.23 of the decedent received assistance for which a claim could be filed under section 246.53,
29.24 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care
29.25 and treatment executive board, as applicable, must be given under paragraph (d) instead of
29.26 under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative
29.27 knows that the creditor has asserted a claim that arose during the decedent's life against
29.28 either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose
29.29 during the decedent's life and the fact is clearly disclosed in accessible financial records
29.30 known and available to the personal representative; or (iii) the claim of the creditor would
29.31 be revealed by a reasonably diligent search for creditors of the decedent in accessible
29.32 financial records known and available to the personal representative. Under this section, a
29.33 creditor is "identified" if the personal representative's knowledge of the name and address
29.34 of the creditor will permit service of notice to be made under paragraph (c).

30.1 (c) Unless the claim has already been presented to the personal representative or paid,
30.2 the personal representative shall serve a copy of the notice required by paragraph (b) upon
30.3 each creditor of the decedent who is then known to the personal representative and identified
30.4 either by delivery of a copy of the required notice to the creditor, or by mailing a copy of
30.5 the notice to the creditor by certified, registered, or ordinary first class mail addressed to
30.6 the creditor at the creditor's office or place of residence.

30.7 (d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a
30.8 predeceased spouse of the decedent received assistance for which a claim could be filed
30.9 under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the
30.10 attorney for the personal representative shall serve the commissioner or executive board,
30.11 as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a
30.12 manner prescribed by the commissioner, as soon as practicable after the appointment of the
30.13 personal representative. The notice must state the decedent's full name, date of birth, and
30.14 Social Security number and, to the extent then known after making a reasonably diligent
30.15 inquiry, the full name, date of birth, and Social Security number for each of the decedent's
30.16 predeceased spouses. The notice may also contain a statement that, after making a reasonably
30.17 diligent inquiry, the personal representative has determined that the decedent did not have
30.18 any predeceased spouses or that the personal representative has been unable to determine
30.19 one or more of the previous items of information for a predeceased spouse of the decedent.
30.20 A copy of the notice to creditors must be attached to and be a part of the notice to the
30.21 commissioner or executive board.

30.22 (2) Notwithstanding a will or other instrument or law to the contrary, except as allowed
30.23 in this paragraph, no property subject to administration by the estate may be distributed by
30.24 the estate or the personal representative until 70 days after the date the notice is served on
30.25 the commissioner or executive board as provided in paragraph (c), unless the local agency
30.26 consents as provided for in clause (6). This restriction on distribution does not apply to the
30.27 personal representative's sale of real or personal property, but does apply to the net proceeds
30.28 the estate receives from these sales. The personal representative, or any person with personal
30.29 knowledge of the facts, may provide an affidavit containing the description of any real or
30.30 personal property affected by this paragraph and stating facts showing compliance with this
30.31 paragraph. If the affidavit describes real property, it may be filed or recorded in the office
30.32 of the county recorder or registrar of titles for the county where the real property is located.
30.33 This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or
30.34 when a duly authorized agent of a county is acting as the personal representative of the
30.35 estate.

31.1 (3) At any time before an order or decree is entered under section 524.3-1001 or
31.2 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal
31.3 representative or the attorney for the personal representative may serve an amended notice
31.4 on the commissioner or executive board to add variations or other names of the decedent
31.5 or a predeceased spouse named in the notice, the name of a predeceased spouse omitted
31.6 from the notice, to add or correct the date of birth or Social Security number of a decedent
31.7 or predeceased spouse named in the notice, or to correct any other deficiency in a prior
31.8 notice. The amended notice must state the decedent's name, date of birth, and Social Security
31.9 number, the case name, case number, and district court in which the estate is pending, and
31.10 the date the notice being amended was served on the commissioner or executive board. If
31.11 the amendment adds the name of a predeceased spouse omitted from the notice, it must also
31.12 state that spouse's full name, date of birth, and Social Security number. The amended notice
31.13 must be served on the commissioner or executive board in the same manner as the original
31.14 notice. Upon service, the amended notice relates back to and is effective from the date the
31.15 notice it amends was served, and the time for filing claims arising under section 246.53,
31.16 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended
31.17 notice. Claims filed during the 60-day period are undischarged and unbarred claims, may
31.18 be prosecuted by the entities entitled to file those claims in accordance with section
31.19 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal
31.20 representative or any person with personal knowledge of the facts may provide and file or
31.21 record an affidavit in the same manner as provided for in clause (1).

31.22 (4) Within one year after the date an order or decree is entered under section 524.3-1001
31.23 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has
31.24 an interest in property that was subject to administration by the estate may serve an amended
31.25 notice on the commissioner or executive board to add variations or other names of the
31.26 decedent or a predeceased spouse named in the notice, the name of a predeceased spouse
31.27 omitted from the notice, to add or correct the date of birth or Social Security number of a
31.28 decedent or predeceased spouse named in the notice, or to correct any other deficiency in
31.29 a prior notice. The amended notice must be served on the commissioner or executive board
31.30 in the same manner as the original notice and must contain the information required for
31.31 amendments under clause (3). If the amendment adds the name of a predeceased spouse
31.32 omitted from the notice, it must also state that spouse's full name, date of birth, and Social
31.33 Security number. Upon service, the amended notice relates back to and is effective from
31.34 the date the notice it amends was served. If the amended notice adds the name of an omitted
31.35 predeceased spouse or adds or corrects the Social Security number or date of birth of the
31.36 decedent or a predeceased spouse already named in the notice, then, notwithstanding any

32.1 other laws to the contrary, claims against the decedent's estate on account of those persons
32.2 resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or
32.3 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to
32.4 file those claims in accordance with section 524.3-1004, and the limitations in section
32.5 524.3-1006 do not apply. The person filing the amendment or any other person with personal
32.6 knowledge of the facts may provide and file or record an affidavit describing affected real
32.7 or personal property in the same manner as clause (1).

32.8 (5) After one year from the date an order or decree is entered under section 524.3-1001
32.9 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission,
32.10 or defect of any kind in the notice to the commissioner or executive board required under
32.11 this paragraph or in the process of service of the notice on the commissioner or executive
32.12 board, or the failure to serve the commissioner or executive board with notice as required
32.13 by this paragraph, makes any distribution of property by a personal representative void or
32.14 voidable. The distributee's title to the distributed property shall be free of any claims based
32.15 upon a failure to comply with this paragraph.

32.16 (6) The local agency may consent to a personal representative's request to distribute
32.17 property subject to administration by the estate to distributees during the 70-day period after
32.18 service of notice on the commissioner or executive board. The local agency may grant or
32.19 deny the request in whole or in part and may attach conditions to its consent as it deems
32.20 appropriate. When the local agency consents to a distribution, it shall give the estate a written
32.21 certificate evidencing its consent to the early distribution of assets at no cost. The certificate
32.22 must include the name, case number, and district court in which the estate is pending, the
32.23 name of the local agency, describe the specific real or personal property to which the consent
32.24 applies, state that the local agency consents to the distribution of the specific property
32.25 described in the consent during the 70-day period following service of the notice on the
32.26 commissioner or executive board, state that the consent is unconditional or list all of the
32.27 terms and conditions of the consent, be dated, and may include other contents as may be
32.28 appropriate. The certificate must be signed by the director of the local agency or the director's
32.29 designees and is effective as of the date it is dated unless it provides otherwise. The signature
32.30 of the director or the director's designee does not require any acknowledgment. The certificate
32.31 shall be prima facie evidence of the facts it states, may be attached to or combined with a
32.32 deed or any other instrument of conveyance and, when so attached or combined, shall
32.33 constitute a single instrument. If the certificate describes real property, it shall be accepted
32.34 for recording or filing by the county recorder or registrar of titles in the county in which the
32.35 property is located. If the certificate describes real property and is not attached to or combined

33.1 with a deed or other instrument of conveyance, it shall be accepted for recording or filing
33.2 by the county recorder or registrar of titles in the county in which the property is located.
33.3 The certificate constitutes a waiver of the 70-day period provided for in clause (2) with
33.4 respect to the property it describes and is prima facie evidence of service of notice on the
33.5 commissioner or executive board. The certificate is not a waiver or relinquishment of any
33.6 claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise
33.7 constitute a waiver of any of the personal representative's duties under this paragraph.
33.8 Distributees who receive property pursuant to a consent to an early distribution shall remain
33.9 liable to creditors of the estate as provided for by law.

33.10 (7) All affidavits provided for under this paragraph:

33.11 (i) shall be provided by persons who have personal knowledge of the facts stated in the
33.12 affidavit;

33.13 (ii) may be filed or recorded in the office of the county recorder or registrar of titles in
33.14 the county in which the real property they describe is located for the purpose of establishing
33.15 compliance with the requirements of this paragraph; and

33.16 (iii) are prima facie evidence of the facts stated in the affidavit.

33.17 (8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.
33.18 Clause (5) also applies with respect to all notices served on the commissioner of human
33.19 services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices
33.20 served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article
33.21 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were
33.22 intended, notwithstanding any errors, omissions or other defects.

33.23

ARTICLE 3

33.24

HEALTH CARE

33.25 Section 1. **[62J.805] DEFINITIONS.**

33.26 Subdivision 1. **Application.** For purposes of sections 62J.805 to 62J.808, the following
33.27 terms have the meanings given.

33.28 Subd. 2. **Group practice.** "Group practice" has the meaning given to health care provider
33.29 group practice in section 145D.01, subdivision 1.

33.30 Subd. 3. **Health care provider.** "Health care provider" means:

34.1 (1) a health professional who is licensed or registered by the state to provide health
34.2 treatments and services within the professional's scope of practice and in accordance with
34.3 state law;

34.4 (2) a group practice; or

34.5 (3) a hospital.

34.6 Subd. 4. **Health plan.** "Health plan" has the meaning given in section 62A.011,
34.7 subdivision 3.

34.8 Subd. 5. **Hospital.** "Hospital" means a health care facility licensed as a hospital under
34.9 sections 144.50 to 144.56.

34.10 Subd. 6. **Medically necessary.** "Medically necessary" means:

34.11 (1) safe and effective;

34.12 (2) not experimental or investigational, except as provided in Code of Federal Regulations,
34.13 title 42, section 411.15(o);

34.14 (3) furnished in accordance with acceptable medical standards of medical practice for
34.15 the diagnosis or treatment of the patient's condition or to improve the function of a malformed
34.16 body member;

34.17 (4) furnished in a setting appropriate to the patient's medical need and condition;

34.18 (5) ordered and furnished by qualified personnel;

34.19 (6) meets, but does not exceed, the patient's medical need; and

34.20 (7) is at least as beneficial as an existing and available medically appropriate alternative.

34.21 Subd. 7. **Miscode.** "Miscode" means a health care provider or a health care provider's
34.22 designee, using a coding system and for billing purposes, assigns a numeric or alphanumeric
34.23 code to a health treatment or service provided to a patient and the code assigned does not
34.24 accurately reflect the health treatment or service provided based on factors that include the
34.25 patient's diagnosis and the complexity of the patient's condition.

34.26 Subd. 8. **Payment.** "Payment" includes co-payments and coinsurance and deductible
34.27 payments made by a patient.

35.1 **Sec. 2. [62J.806] POLICY FOR COLLECTION OF MEDICAL DEBT.**

35.2 Subdivision 1. Requirement. Each health care provider must make available to the
35.3 public the health care provider's policy for the collection of medical debt from patients. This
35.4 policy must be made available by:

35.5 (1) clearly posting it on the health care provider's website or, for health professionals,
35.6 on the website of the health clinic, group practice, or hospital at which the health professional
35.7 is employed or under contract; and

35.8 (2) providing a copy of the policy to any individual who requests it.

35.9 Subd. 2. Content. A policy made available under this section must at least specify the
35.10 procedures followed by the health care provider for:

35.11 (1) communicating with patients about the medical debt owed and collecting medical
35.12 debt;

35.13 (2) referring medical debt to a collection agency or law firm for collection; and

35.14 (3) identifying medical debt as uncollectible or satisfied, and ending collection activities.

35.15 **Sec. 3. [62J.807] DENIAL OF HEALTH TREATMENTS OR SERVICES DUE TO**
35.16 **OUTSTANDING MEDICAL DEBT.**

35.17 (a) A health care provider must not deny medically necessary health treatments or services
35.18 to a patient or any member of the patient's family or household because of outstanding
35.19 medical debt owed by the patient or any member of the patient's family or household to the
35.20 health care provider, regardless of whether the health treatment or service may be available
35.21 from another health care provider.

35.22 (b) As a condition of providing medically necessary health treatments or services in the
35.23 circumstances described in paragraph (a), a health care provider may require the patient to
35.24 enroll in a payment plan for the outstanding medical debt owed to the health care provider.

35.25 **Sec. 4. [62J.808] BILLING AND PAYMENT FOR MISCODED HEALTH**
35.26 **TREATMENTS AND SERVICES.**

35.27 Subdivision 1. Participation and cooperation required. Each health care provider
35.28 must participate in, and cooperate with, all processes and investigations to identify, review,
35.29 and correct the coding of health treatments and services that are miscoded by the health
35.30 care provider or a designee.

36.1 Subd. 2. **Notice; billing and payment during review.** (a) When a health care provider
36.2 receives notice, other than notice from a health plan company as provided in paragraph (b),
36.3 or otherwise determines that a health treatment or service may have been miscoded, the
36.4 health care provider must notify the health plan company administering the patient's health
36.5 plan in a timely manner of the potentially miscoded health treatment or service.

36.6 (b) When a health plan company receives notice, other than notice from a health care
36.7 provider as provided in paragraph (a), or otherwise determines that a health treatment or
36.8 service may have been miscoded, the health plan company must notify the health care
36.9 provider who provided the health treatment or service of the potentially miscoded health
36.10 treatment or service.

36.11 (c) When a review of a potentially miscoded health treatment or service is commenced,
36.12 the health care provider and health plan company must notify the patient that a miscoding
36.13 review is being conducted and that the patient will not be billed for any health treatment or
36.14 service subject to the review and is not required to submit payments for any health treatment
36.15 or service subject to the review until the review is complete and any miscoded health
36.16 treatments or services are correctly coded.

36.17 (d) While a review of a potentially miscoded health treatment or service is being
36.18 conducted, the health care provider and health plan company must not bill the patient for,
36.19 or accept payment from the patient for, any health treatment or service subject to the review.

36.20 Subd. 3. **Billing and payment after completion of review.** The health care provider
36.21 and health plan company may bill the patient for, and accept payment from the patient for,
36.22 the health treatment or service that was subject to the miscoding review only after the review
36.23 is complete and any miscoded health treatments or services have been correctly coded.

36.24 Sec. 5. Minnesota Statutes 2023 Supplement, section 144.587, subdivision 1, is amended
36.25 to read:

36.26 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
36.27 and sections 144.588 to 144.589.

36.28 (b) "Charity care" means the provision of free or discounted care to a patient according
36.29 to a hospital's financial assistance policies.

36.30 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections
36.31 144.50 to 144.56.

36.32 (d) "Insurance affordability program" has the meaning given in section 256B.02,
36.33 subdivision 19.

37.1 (e) "Navigator" has the meaning given in section 62V.02, subdivision 9.

37.2 (f) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision
37.3 12.

37.4 ~~(g) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.~~

37.5 ~~(h)~~ (g) "Uninsured service or treatment" means any service or treatment that is not
37.6 covered by:

37.7 (1) a health plan, contract, or policy that provides health coverage to a patient; or

37.8 (2) any other type of insurance coverage, including but not limited to no-fault automobile
37.9 coverage, workers' compensation coverage, or liability coverage.

37.10 ~~(i)~~ (h) "Unreasonable burden" includes requiring a patient to apply for enrollment in a
37.11 state or federal program for which the patient is obviously or categorically ineligible or has
37.12 been found to be ineligible in the previous 12 months.

37.13 Sec. 6. Minnesota Statutes 2023 Supplement, section 144.587, subdivision 4, is amended
37.14 to read:

37.15 Subd. 4. **Prohibited actions.** (a) A hospital must not initiate one or more of the following
37.16 actions until the hospital determines that the patient is ineligible for charity care or denies
37.17 an application for charity care:

37.18 (1) offering to enroll or enrolling the patient in a payment plan;

37.19 (2) changing the terms of a patient's payment plan;

37.20 (3) offering the patient a loan or line of credit, application materials for a loan or line of
37.21 credit, or assistance with applying for a loan or line of credit, for the payment of medical
37.22 debt;

37.23 (4) referring a patient's debt for collections, including in-house collections, third-party
37.24 collections, ~~revenue recapture~~, or any other process for the collection of debt; or

37.25 ~~(5) denying health care services to the patient or any member of the patient's household~~
37.26 ~~because of outstanding medical debt, regardless of whether the services are deemed necessary~~
37.27 ~~or may be available from another provider; or~~

37.28 ~~(6)~~ (5) accepting a credit card payment of over \$500 for the medical debt owed to the
37.29 hospital.

37.30 (b) A hospital is subject to section 62J.807.

38.1 Sec. 7. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 1, is amended
38.2 to read:

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

38.5 (b) "Central repository" means a wholesale distributor that meets the requirements under
38.6 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
38.7 section.

38.8 (c) "Distribute" means to deliver, other than by administering or dispensing.

38.9 (d) "Donor" means:

38.10 (1) ~~a health care facility as defined in this subdivision~~ an individual at least 18 years of
38.11 age, provided that the drug or medical supply that is donated was obtained legally and meets
38.12 the requirements of this section for donation; or

38.13 (2) ~~a skilled nursing facility licensed under chapter 144A;~~ any entity legally authorized
38.14 to possess medicine with a license or permit in good standing in the state in which it is
38.15 located, without further restrictions, including but not limited to a health care facility, skilled
38.16 nursing facility, assisted living facility, pharmacy, wholesaler, and drug manufacturer.

38.17 (3) ~~an assisted living facility licensed under chapter 144G;~~

38.18 (4) ~~a pharmacy licensed under section 151.19, and located either in the state or outside~~
38.19 ~~the state;~~

38.20 (5) ~~a drug wholesaler licensed under section 151.47;~~

38.21 (6) ~~a drug manufacturer licensed under section 151.252; or~~

38.22 (7) ~~an individual at least 18 years of age, provided that the drug or medical supply that~~
38.23 ~~is donated was obtained legally and meets the requirements of this section for donation.~~

38.24 (e) "Drug" means any prescription drug that has been approved for medical use in the
38.25 United States, is listed in the United States Pharmacopoeia or National Formulary, and
38.26 meets the criteria established under this section for donation; or any over-the-counter
38.27 medication that meets the criteria established under this section for donation. This definition
38.28 includes cancer drugs and antirejection drugs, but does not include controlled substances,
38.29 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
38.30 to a patient registered with the drug's manufacturer in accordance with federal Food and
38.31 Drug Administration requirements.

38.32 (f) "Health care facility" means:

39.1 (1) a physician's office or health care clinic where licensed practitioners provide health
39.2 care to patients;

39.3 (2) a hospital licensed under section 144.50;

39.4 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

39.5 (4) a nonprofit community clinic, including a federally qualified health center; a rural
39.6 health clinic; public health clinic; or other community clinic that provides health care utilizing
39.7 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

39.8 (g) "Local repository" means a health care facility that elects to accept donated drugs
39.9 and medical supplies and meets the requirements of subdivision 4.

39.10 (h) "Medical supplies" or "supplies" means any prescription or nonprescription medical
39.11 supplies needed to administer a drug.

39.12 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
39.13 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
39.14 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
39.15 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
39.16 part 6800.3750.

39.17 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
39.18 it does not include a veterinarian.

39.19 Sec. 8. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 4, is amended
39.20 to read:

39.21 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the
39.22 medication repository program, a health care facility must agree to comply with all applicable
39.23 federal and state laws, rules, and regulations pertaining to the medication repository program,
39.24 drug storage, and dispensing. The facility must also agree to maintain in good standing any
39.25 required state license or registration that may apply to the facility.

39.26 (b) A local repository may elect to participate in the program by submitting the following
39.27 information to the central repository on a form developed by the board and made available
39.28 on the board's website:

39.29 (1) the name, street address, and telephone number of the health care facility and any
39.30 state-issued license or registration number issued to the facility, including the issuing state
39.31 agency;

40.1 (2) the name and telephone number of a responsible pharmacist or practitioner who is
40.2 employed by or under contract with the health care facility; and

40.3 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating
40.4 that the health care facility meets the eligibility requirements under this section and agrees
40.5 to comply with this section.

40.6 (c) Participation in the medication repository program is voluntary. A local repository
40.7 may withdraw from participation in the medication repository program at any time by
40.8 providing written notice to the central repository on a form developed by the board and
40.9 made available on the board's website. ~~The central repository shall provide the board with
40.10 a copy of the withdrawal notice within ten business days from the date of receipt of the
40.11 withdrawal notice.~~

40.12 Sec. 9. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 5, is amended
40.13 to read:

40.14 Subd. 5. **Individual eligibility and application requirements.** (a) ~~To be eligible for~~
40.15 ~~the medication repository program~~ At the time of or before receiving donated drugs or
40.16 supplies as a new eligible patient, an individual must submit to a local repository an electronic
40.17 or physical intake application form that is signed by the individual and attests that the
40.18 individual:

40.19 (1) is a resident of Minnesota;

40.20 (2) is uninsured ~~and is not enrolled in the medical assistance program under chapter~~
40.21 ~~256B or the MinnesotaCare program under chapter 256L~~, has no prescription drug coverage,
40.22 or is underinsured;

40.23 (3) acknowledges that the drugs or medical supplies to be received through the program
40.24 may have been donated; and

40.25 (4) consents to a waiver of the child-resistant packaging requirements of the federal
40.26 Poison Prevention Packaging Act.

40.27 ~~(b) Upon determining that an individual is eligible for the program, the local repository~~
40.28 ~~shall furnish the individual with an identification card. The card shall be valid for one year~~
40.29 ~~from the date of issuance and may be used at any local repository. A new identification card~~
40.30 ~~may be issued upon expiration once the individual submits a new application form.~~

41.1 ~~(e)~~ (b) The local repository shall send a copy of the intake application form to the central
41.2 repository by regular mail, facsimile, or secured email within ten days from the date the
41.3 application is approved by the local repository.

41.4 ~~(d)~~ (c) The board shall develop and make available on the board's website an application
41.5 form ~~and the format for the identification card.~~

41.6 Sec. 10. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 6, is amended
41.7 to read:

41.8 Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a)
41.9 Notwithstanding any other law or rule, a donor may donate drugs or medical supplies to
41.10 the central repository or a local repository if the drug or supply meets the requirements of
41.11 this section as determined by a pharmacist or practitioner who is employed by or under
41.12 contract with the central repository or a local repository.

41.13 (b) A drug is eligible for donation under the medication repository program if the
41.14 following requirements are met:

41.15 ~~(1) the donation is accompanied by a medication repository donor form described under~~
41.16 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~
41.17 ~~donor's knowledge in accordance with paragraph (d);~~

41.18 ~~(2)~~ (1) the drug's expiration date is at least six months after the date the drug was donated.
41.19 If a donated drug bears an expiration date that is less than six months from the donation
41.20 date, the drug may be accepted and distributed if the drug is in high demand and can be
41.21 dispensed for use by a patient before the drug's expiration date;

41.22 ~~(3)~~ (2) the drug is in its original, sealed, unopened, tamper-evident packaging that includes
41.23 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging
41.24 is unopened;

41.25 ~~(4)~~ (3) the drug or the packaging does not have any physical signs of tampering,
41.26 misbranding, deterioration, compromised integrity, or adulteration;

41.27 ~~(5)~~ (4) the drug does not require storage temperatures other than normal room temperature
41.28 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being
41.29 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located
41.30 in Minnesota; and

41.31 ~~(6)~~ (5) the drug is not a controlled substance.

42.1 (c) A medical supply is eligible for donation under the medication repository program
42.2 if the following requirements are met:

42.3 (1) the supply has no physical signs of tampering, misbranding, or alteration and there
42.4 is no reason to believe it has been adulterated, tampered with, or misbranded;

42.5 (2) the supply is in its original, unopened, sealed packaging; and

42.6 ~~(3) the donation is accompanied by a medication repository donor form described under~~
42.7 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~
42.8 ~~donor's knowledge in accordance with paragraph (d); and~~

42.9 ~~(4)~~ (3) if the supply bears an expiration date, the date is at least six months later than
42.10 the date the supply was donated. If the donated supply bears an expiration date that is less
42.11 than six months from the date the supply was donated, the supply may be accepted and
42.12 distributed if the supply is in high demand and can be dispensed for use by a patient before
42.13 the supply's expiration date.

42.14 (d) The board shall develop the medication repository donor form and make it available
42.15 on the board's website. ~~The form must state that to the best of the donor's knowledge the~~
42.16 ~~donated drug or supply has been properly stored under appropriate temperature and humidity~~
42.17 ~~conditions and that the drug or supply has never been opened, used, tampered with,~~
42.18 ~~adulterated, or misbranded.~~ Prior to the first donation from a new donor, a central repository
42.19 or local repository shall verify and record the following information on the donor form:

42.20 (1) the donor's name, address, phone number, and license number, if applicable;

42.21 (2) that the donor will only make donations in accordance with the program;

42.22 (3) to the best of the donor's knowledge, only drugs or supplies that have been properly
42.23 stored under appropriate temperature and humidity conditions will be donated; and

42.24 (4) to the best of the donor's knowledge, only drugs or supplies that have never been
42.25 opened, used, tampered with, adulterated, or misbranded will be donated.

42.26 (e) Notwithstanding any other law or rule, a central repository or a local repository may
42.27 receive donated drugs from donors. Donated drugs and supplies may be shipped or delivered
42.28 to the premises of the central repository or a local repository, and shall be inspected by a
42.29 pharmacist or an authorized practitioner who is employed by or under contract with the
42.30 repository and who has been designated by the repository to accept donations prior to
42.31 dispensing. A drop box must not be used to deliver or accept donations.

43.1 (f) The central repository and local repository shall maintain a written or electronic
43.2 inventory of all drugs and supplies donated to the repository upon acceptance of each drug
43.3 or supply. For each drug, the inventory must include the drug's name, strength, quantity,
43.4 manufacturer, expiration date, and the date the drug was donated. For each medical supply,
43.5 the inventory must include a description of the supply, its manufacturer, the date the supply
43.6 was donated, and, if applicable, the supply's brand name and expiration date. The board
43.7 may waive the requirement under this paragraph if an entity is under common ownership
43.8 or control with a central repository or local repository and either the entity or the repository
43.9 maintains an inventory containing all the information required under this paragraph.

43.10 Sec. 11. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 7, is amended
43.11 to read:

43.12 Subd. 7. **Standards and procedures for inspecting and storing donated drugs and**
43.13 **supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract
43.14 with the central repository or a local repository shall inspect all donated drugs and supplies
43.15 before the drug or supply is dispensed to determine, to the extent reasonably possible in the
43.16 professional judgment of the pharmacist or practitioner, that the drug or supply is not
43.17 adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing,
43.18 has not been subject to a recall, and meets the requirements for donation. ~~The pharmacist~~
43.19 ~~or practitioner who inspects the drugs or supplies shall sign an inspection record stating that~~
43.20 ~~the requirements for donation have been met.~~ If a local repository receives drugs and supplies
43.21 from the central repository, the local repository does not need to reinspect the drugs and
43.22 supplies.

43.23 (b) The central repository and local repositories shall store donated drugs and supplies
43.24 in a secure storage area under environmental conditions appropriate for the drug or supply
43.25 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

43.26 (c) The central repository and local repositories shall dispose of all drugs and medical
43.27 supplies that are not suitable for donation in compliance with applicable federal and state
43.28 statutes, regulations, and rules concerning hazardous waste.

43.29 (d) In the event that controlled substances or drugs that can only be dispensed to a patient
43.30 registered with the drug's manufacturer are shipped or delivered to a central or local repository
43.31 for donation, the shipment delivery must be documented by the repository and returned
43.32 immediately to the donor or the donor's representative that provided the drugs.

43.33 (e) Each repository must develop drug and medical supply recall policies and procedures.
43.34 If a repository receives a recall notification, the repository shall destroy all of the drug or

44.1 medical supply in its inventory that is the subject of the recall and complete a record of
44.2 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
44.3 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
44.4 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
44.5 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
44.6 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

44.7 (f) A record of destruction of donated drugs and supplies that are not dispensed under
44.8 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
44.9 shall be maintained by the repository for at least two years. For each drug or supply destroyed,
44.10 the record shall include the following information:

44.11 (1) the date of destruction;

44.12 (2) the name, strength, and quantity of the drug destroyed; and

44.13 (3) the name of the person or firm that destroyed the drug.

44.14 No other record of destruction is required.

44.15 Sec. 12. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 8, is amended
44.16 to read:

44.17 Subd. 8. **Dispensing requirements.** (a) Donated prescription drugs and supplies may
44.18 be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible
44.19 individual and are dispensed by a pharmacist or practitioner. A repository shall dispense
44.20 drugs and supplies to eligible individuals in the following priority order: (1) individuals
44.21 who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals
44.22 who are underinsured. A repository shall dispense donated drugs in compliance with
44.23 applicable federal and state laws and regulations for dispensing drugs, including all
44.24 requirements relating to packaging, labeling, record keeping, drug utilization review, and
44.25 patient counseling.

44.26 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner
44.27 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date
44.28 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be
44.29 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

44.30 (c) Before a the first drug or supply is dispensed or administered to an individual, the
44.31 individual must sign a an electronic or physical drug repository recipient form acknowledging
44.32 that the individual understands ~~the information stated on the form. The board shall develop~~

45.1 ~~the form and make it available on the board's website. The form must include the following~~
45.2 ~~information:~~

45.3 (1) that the drug or supply being dispensed or administered has been donated and may
45.4 have been previously dispensed;

45.5 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure
45.6 that the drug or supply has not expired, has not been adulterated or misbranded, and is in
45.7 its original, unopened packaging; and

45.8 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the
45.9 central repository or local repository, the Board of Pharmacy, and any other participant of
45.10 the medication repository program cannot guarantee the safety of the drug or medical supply
45.11 being dispensed or administered and that the pharmacist or practitioner has determined that
45.12 the drug or supply is safe to dispense or administer based on the accuracy of the donor's
45.13 form submitted with the donated drug or medical supply and the visual inspection required
45.14 to be performed by the pharmacist or practitioner before dispensing or administering.

45.15 Sec. 13. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 9, is amended
45.16 to read:

45.17 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual
45.18 receiving a drug or supply a handling fee of no more than 250 percent of the medical
45.19 assistance program dispensing fee for each drug or medical supply dispensed or administered
45.20 by that repository.

45.21 (b) A repository that dispenses or administers a drug or medical supply through the
45.22 medication repository program shall not receive reimbursement under the medical assistance
45.23 program or the MinnesotaCare program for that dispensed or administered drug or supply.

45.24 (c) A supply or handling fee must not be charged to an individual enrolled in the medical
45.25 assistance or MinnesotaCare program.

45.26 Sec. 14. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 11, is amended
45.27 to read:

45.28 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
45.29 for the administration of this program ~~shall be utilized by the participants of the program~~
45.30 ~~and~~ shall be available on the board's website:

45.31 (1) intake application form described under subdivision 5;

- 46.1 (2) local repository participation form described under subdivision 4;
- 46.2 (3) local repository withdrawal form described under subdivision 4;
- 46.3 (4) medication repository donor form described under subdivision 6;
- 46.4 (5) record of destruction form described under subdivision 7; and
- 46.5 (6) medication repository recipient form described under subdivision 8.

46.6 Participants may use substantively similar electronic or physical forms.

46.7 (b) All records, including drug inventory, ~~inspection~~, and disposal of donated drugs and
46.8 medical supplies, must be maintained by a repository for a minimum of two years. Records
46.9 required as part of this program must be maintained pursuant to all applicable practice acts.

46.10 (c) Data collected by the medication repository program from all local repositories shall
46.11 be submitted quarterly or upon request to the central repository. Data collected may consist
46.12 of the information, records, and forms required to be collected under this section.

46.13 (d) The central repository shall submit reports to the board as required by the contract
46.14 or upon request of the board.

46.15 Sec. 15. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 12, is amended
46.16 to read:

46.17 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal
46.18 or civil liability for injury, death, or loss to a person or to property for causes of action
46.19 described in clauses (1) and (2). A manufacturer is not liable for:

46.20 (1) the intentional or unintentional alteration of the drug or supply by a party not under
46.21 the control of the manufacturer; or

46.22 (2) the failure of a party not under the control of the manufacturer to transfer or
46.23 communicate product or consumer information or the expiration date of the donated drug
46.24 or supply.

46.25 (b) A health care facility participating in the program, a pharmacist dispensing a drug
46.26 or supply pursuant to the program, a practitioner dispensing or administering a drug or
46.27 supply pursuant to the program, ~~or a donor of a drug or medical supply, or a person or entity~~
46.28 that facilitates any of the above is immune from civil liability for an act or omission that
46.29 causes injury to or the death of an individual to whom the drug or supply is dispensed and
46.30 no disciplinary action by a health-related licensing board shall be taken against a ~~pharmacist~~
46.31 ~~or practitioner~~ person or entity so long as the drug or supply is donated, accepted, distributed,

47.1 and dispensed according to the requirements of this section. This immunity does not apply
47.2 if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice
47.3 unrelated to the quality of the drug or medical supply.

47.4 Sec. 16. Minnesota Statutes 2023 Supplement, section 151.74, subdivision 3, is amended
47.5 to read:

47.6 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form
47.7 to be used by an individual who is in urgent need of insulin. The application must ask the
47.8 individual to attest to the eligibility requirements described in subdivision 2. The form shall
47.9 be accessible through MNsure's website. MNsure shall also make the form available to
47.10 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency
47.11 departments, urgent care clinics, and community health clinics. By submitting a completed,
47.12 signed, and dated application to a pharmacy, the individual attests that the information
47.13 contained in the application is correct.

47.14 (b) If the individual is in urgent need of insulin, the individual may present a completed,
47.15 signed, and dated application form to a pharmacy. The individual must also:

47.16 (1) have a valid insulin prescription; and

47.17 (2) present the pharmacist with identification indicating Minnesota residency in the form
47.18 of a valid Minnesota identification card, driver's license or permit, individual taxpayer
47.19 identification number, or Tribal identification card as defined in section 171.072, paragraph

47.20 (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent
47.21 or legal guardian must provide the pharmacist with proof of residency.

47.22 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense
47.23 the prescribed insulin in an amount that will provide the individual with a 30-day supply.
47.24 The pharmacy must notify the health care practitioner who issued the prescription order no
47.25 later than 72 hours after the insulin is dispensed.

47.26 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or
47.27 to the manufacturer's vendor a claim for payment that is in accordance with the National
47.28 Council for Prescription Drug Program standards for electronic claims processing, unless
47.29 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin
47.30 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the
47.31 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the
47.32 pharmacy in an amount that covers the pharmacy's acquisition cost.

48.1 (e) The pharmacy may collect an insulin co-payment from the individual to cover the
48.2 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day
48.3 supply of insulin dispensed.

48.4 (f) The pharmacy shall also provide each eligible individual with the information sheet
48.5 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy
48.6 for the individual to contact if the individual ~~is in need of~~ accessing needs to access ongoing
48.7 insulin coverage options, including assistance in:

48.8 (1) applying for medical assistance or MinnesotaCare;

48.9 (2) applying for a qualified health plan offered through MNsure, subject to open and
48.10 special enrollment periods;

48.11 (3) accessing information on providers who participate in prescription drug discount
48.12 programs, including providers who are authorized to participate in the 340B program under
48.13 section 340b of the federal Public Health Services Act, United States Code, title 42, section
48.14 256b; and

48.15 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance
48.16 programs, and other foundation-based programs.

48.17 (g) The pharmacist shall retain a copy of the application form submitted by the individual
48.18 to the pharmacy for reporting and auditing purposes.

48.19 (h) A manufacturer may submit to the commissioner of administration a request for
48.20 reimbursement in an amount not to exceed \$35 for each 30-day supply of insulin the
48.21 manufacturer provides under paragraph (d). The commissioner of administration shall
48.22 determine the manner and format for submitting and processing requests for reimbursement.
48.23 After receiving a reimbursement request, the commissioner of administration shall reimburse
48.24 the manufacturer in an amount not to exceed \$35 for each 30-day supply of insulin the
48.25 manufacturer provided under paragraph (d).

48.26 **EFFECTIVE DATE.** This section is effective July 1, 2024.

48.27 Sec. 17. Minnesota Statutes 2022, section 151.74, subdivision 6, is amended to read:

48.28 Subd. 6. **Continuing safety net program; process.** (a) The individual shall submit to
48.29 a pharmacy the statement of eligibility provided by the manufacturer under subdivision 5,
48.30 paragraph (b). Upon receipt of an individual's eligibility status, the pharmacy shall submit
48.31 an order containing the name of the insulin product and the daily dosage amount as contained
48.32 in a valid prescription to the product's manufacturer.

49.1 (b) The pharmacy must include with the order to the manufacturer the following
49.2 information:

49.3 (1) the pharmacy's name and shipping address;

49.4 (2) the pharmacy's office telephone number, fax number, email address, and contact
49.5 name; and

49.6 (3) any specific days or times when deliveries are not accepted by the pharmacy.

49.7 (c) Upon receipt of an order from a pharmacy and the information described in paragraph
49.8 (b), the manufacturer shall send to the pharmacy a 90-day supply of insulin as ordered,
49.9 unless a lesser amount is requested in the order, at no charge to the individual or pharmacy.

49.10 (d) Except as authorized under paragraph (e), the pharmacy shall provide the insulin to
49.11 the individual at no charge to the individual. The pharmacy shall not provide insulin received
49.12 from the manufacturer to any individual other than the individual associated with the specific
49.13 order. The pharmacy shall not seek reimbursement for the insulin received from the
49.14 manufacturer or from any third-party payer.

49.15 (e) The pharmacy may collect a co-payment from the individual to cover the pharmacy's
49.16 costs for processing and dispensing in an amount not to exceed \$50 for each 90-day supply
49.17 if the insulin is sent to the pharmacy.

49.18 (f) The pharmacy may submit to a manufacturer a reorder for an individual if the
49.19 individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy,
49.20 the manufacturer must send to the pharmacy an additional 90-day supply of the product,
49.21 unless a lesser amount is requested, at no charge to the individual or pharmacy if the
49.22 individual's eligibility statement has not expired.

49.23 (g) Notwithstanding paragraph (c), a manufacturer may send the insulin as ordered
49.24 directly to the individual if the manufacturer provides a mail order service option.

49.25 (h) A manufacturer may submit to the commissioner of administration a request for
49.26 reimbursement in an amount not to exceed \$105 for each 90-day supply of insulin the
49.27 manufacturer provides under paragraphs (c) and (f). The commissioner of administration
49.28 shall determine the manner and format for submitting and processing requests for
49.29 reimbursement. After receiving a reimbursement request, the commissioner of administration
49.30 shall reimburse the manufacturer in an amount not to exceed \$105 for each 90-day supply
49.31 of insulin the manufacturer provided under paragraphs (c) and (f). If the manufacturer
49.32 provides less than a 90-day supply of insulin under paragraphs (c) and (f), the manufacturer

50.1 may submit a request for reimbursement not to exceed \$35 for each 30-day supply of insulin
50.2 provided.

50.3 **EFFECTIVE DATE.** This section is effective July 1, 2024.

50.4 Sec. 18. **[151.741] INSULIN MANUFACTURER REGISTRATION FEE.**

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

50.7 (b) "Board" means the Minnesota Board of Pharmacy under section 151.02.

50.8 (c) "Manufacturer" means a manufacturer licensed under section 151.252 and engaged
50.9 in the manufacturing of prescription insulin.

50.10 Subd. 2. **Assessment of registration fee.** (a) The board shall assess each manufacturer
50.11 an annual registration fee of \$100,000, except as provided in paragraph (b). The board shall
50.12 notify each manufacturer of this requirement beginning November 1, 2024, and each
50.13 November 1 thereafter.

50.14 (b) A manufacturer may request an exemption from the annual registration fee. The
50.15 board shall exempt a manufacturer from the annual registration fee if the manufacturer can
50.16 demonstrate to the board, in the form and manner specified by the board, that sales of
50.17 prescription insulin produced by that manufacturer and sold or delivered within or into the
50.18 state totaled \$2,000,000 or less in the previous calendar year.

50.19 Subd. 3. **Payment of the registration fee; deposit of fee.** (a) Each manufacturer must
50.20 pay the registration fee by March 1, 2025, and by each March 1 thereafter. In the event of
50.21 a change in ownership of the manufacturer, the new owner must pay the registration fee
50.22 that the original owner would have been assessed had the original owner retained ownership.
50.23 The board may assess a late fee of ten percent per month or any portion of a month that the
50.24 registration fee is paid after the due date.

50.25 (b) The registration fee, including any late fees, must be deposited in the insulin safety
50.26 net program account.

50.27 Subd. 4. **Insulin safety net program account.** The insulin safety net program account
50.28 is established in the special revenue fund in the state treasury. Money in the account is
50.29 appropriated each fiscal year to:

50.30 (1) the MNsure board in an amount sufficient to carry out assigned duties under section
50.31 151.74, subdivision 7; and

51.1 (2) the Board of Pharmacy in an amount sufficient to cover costs incurred by the board
51.2 in assessing and collecting the registration fee under this section and in administering the
51.3 insulin safety net program under section 151.74.

51.4 Subd. 5. **Insulin repayment account; annual transfer from health care access fund.** (a)
51.5 The insulin repayment account is established in the special revenue fund in the state treasury.
51.6 Money in the account is appropriated each fiscal year to the commissioner of administration
51.7 in an amount sufficient for the commissioner to reimburse manufacturers for insulin dispensed
51.8 under the insulin safety net program in section 151.74, in accordance with section 151.74,
51.9 subdivisions 3, paragraph (h), and 6, paragraph (h), and to cover costs incurred by the
51.10 commissioner in providing these reimbursement payments.

51.11 (b) The commissioner of management and budget shall transfer from the health care
51.12 access fund to the insulin repayment account, beginning July 1, 2025, and each July 1
51.13 thereafter, an amount sufficient for the commissioner of administration to implement
51.14 paragraph (a).

51.15 Subd. 6. **Contingent transfer by commissioner.** If subdivisions 2 and 3, or the
51.16 application of subdivisions 2 and 3 to any person or circumstance, are held invalid for any
51.17 reason in a court of competent jurisdiction, the validity of subdivisions 2 and 3 does not
51.18 affect other provisions of this act, and the commissioner of management and budget shall
51.19 annually transfer from the health care access fund to the insulin safety net program account
51.20 an amount sufficient to implement subdivision 4.

51.21 **EFFECTIVE DATE.** This section is effective July 1, 2024.

51.22 Sec. 19. Minnesota Statutes 2023 Supplement, section 270A.03, subdivision 2, is amended
51.23 to read:

51.24 Subd. 2. **Claimant agency.** "Claimant agency" means any state agency, as defined by
51.25 section 14.02, subdivision 2, the regents of the University of Minnesota, any district court
51.26 of the state, any county, any statutory or home rule charter city, including a city that is
51.27 presenting a claim for a ~~municipal hospital~~ or a public library or a ~~municipal ambulance~~
51.28 ~~service, a hospital district, any ambulance service licensed under chapter 144E,~~ any public
51.29 agency responsible for child support enforcement, any public agency responsible for the
51.30 collection of court-ordered restitution, and any public agency established by general or
51.31 special law that is responsible for the administration of a low-income housing program.

52.1 Sec. 20. **[332.371] MEDICAL DEBT CREDIT REPORTING PROHIBITED.**

52.2 (a) A consumer reporting agency is prohibited from making a consumer report containing
52.3 an item of information that the consumer reporting agency knows or should know concerns
52.4 (1) medical information; or (2) debt arising from: (i) the provision of medical care, treatment,
52.5 services, devices, or medicines; or (ii) procedures to maintain, diagnose, or treat a person's
52.6 physical or mental health.

52.7 (b) For purposes of this section, "consumer report," "consumer reporting agency," and
52.8 "medical information" have the meanings given in the Fair Credit Reporting Act, United
52.9 States Code, title 15, section 1681a.

52.10 Sec. 21. **[332C.01] DEFINITIONS.**

52.11 Subdivision 1. **Application.** For purposes of this chapter, the following terms have the
52.12 meanings given.

52.13 Subd. 2. **Collecting party.** "Collecting party" means a party engaged in the collection
52.14 of medical debt for any account, bill, or other indebtedness, except as hereinafter provided.

52.15 Subd. 3. **Debtor.** "Debtor" means a person obligated or alleged to be obligated to pay
52.16 any debt.

52.17 Subd. 4. **Medical debt.** "Medical debt" means debt incurred primarily for necessary
52.18 medical care and related services. Medical debt does not include debt charged to a credit
52.19 card unless the credit card is issued under a credit plan offered solely for the payment of
52.20 health care treatment or services.

52.21 Subd. 5. **Person.** "Person" means any individual, partnership, association, or corporation.

52.22 Sec. 22. **[332C.02] PROHIBITED PRACTICES.**

52.23 No collecting party shall:

52.24 (1) in a collection letter, publication, invoice, or any oral or written communication,
52.25 threaten wage garnishment or legal suit by a particular lawyer, unless the collecting party
52.26 has actually retained the lawyer to do so;

52.27 (2) use or employ sheriffs or any other officer authorized to serve legal papers in
52.28 connection with the collection of a claim, except when performing their legally authorized
52.29 duties;

52.30 (3) use or threaten to use methods of collection which violate Minnesota law;

53.1 (4) furnish legal advice to debtors or represent that the collecting party is competent or
53.2 able to furnish legal advice to debtors;

53.3 (5) communicate with debtors in a misleading or deceptive manner by falsely using the
53.4 stationery of a lawyer, forms or instruments which only lawyers are authorized to prepare,
53.5 or instruments which simulate the form and appearance of judicial process;

53.6 (6) publish or cause to be published any list of debtors, use shame cards or shame
53.7 automobiles, advertise or threaten to advertise for sale any claim as a means of forcing
53.8 payment thereof, or use similar devices or methods of intimidation;

53.9 (7) operate under a name or in a manner which falsely implies the collecting party is a
53.10 branch of or associated with any department of federal, state, county, or local government
53.11 or an agency thereof;

53.12 (8) transact business or hold itself out as a debt settlement company, debt management
53.13 company, debt adjuster, or any person who settles, adjusts, prorates, pools, liquidates, or
53.14 pays the indebtedness of a debtor, unless there is no charge to the debtor, or the pooling or
53.15 liquidation is done pursuant to court order or under the supervision of a creditor's committee;

53.16 (9) unless an exemption in the law exists, violate Code of Federal Regulations, title 12,
53.17 part 1006, while attempting to collect on any account, bill, or other indebtedness. For
53.18 purposes of this section, Public Law 95-109 and Code of Federal Regulations, title 12, part
53.19 1006, apply to collecting parties;

53.20 (10) communicate with a debtor by use of an automatic telephone dialing system or an
53.21 artificial or prerecorded voice after the debtor expressly informs the collecting party to cease
53.22 communication utilizing an automatic telephone dialing system or an artificial or prerecorded
53.23 voice. For purposes of this clause, an automatic telephone dialing system or an artificial or
53.24 prerecorded voice includes but is not limited to (i) artificial intelligence chat bots, and (ii)
53.25 the usage of the term under the Telephone Consumer Protection Act, United States Code,
53.26 title 47, section 227(b)(1)(A);

53.27 (11) in collection letters or publications, or in any oral or written communication, imply
53.28 or suggest that medically necessary health treatment or services will be denied as a result
53.29 of a medical debt;

53.30 (12) when a debtor has a listed telephone number, enlist the aid of a neighbor or third
53.31 party to request that the debtor contact the collecting party, except a person who resides
53.32 with the debtor or a third party with whom the debtor has authorized with the collecting
53.33 party to place the request. This clause does not apply to a call back message left at the

54.1 debtor's place of employment which is limited solely to the collecting party's telephone
54.2 number and name;

54.3 (13) when attempting to collect a medical debt, fail to provide the debtor with the full
54.4 name of the collecting party, as registered with the secretary of state;

54.5 (14) fail to return any amount of overpayment from a debtor to the debtor or to the state
54.6 of Minnesota pursuant to the requirements of chapter 345;

54.7 (15) accept currency or coin as payment for a medical debt without issuing an original
54.8 receipt to the debtor and maintaining a duplicate receipt in the debtor's payment records;

54.9 (16) attempt to collect any amount, including any interest, fee, charge, or expense
54.10 incidental to the charge-off obligation, from a debtor unless the amount is expressly
54.11 authorized by the agreement creating the medical debt or is otherwise permitted by law;

54.12 (17) falsify any documents with the intent to deceive;

54.13 (18) when initially contacting a Minnesota debtor by mail to collect a medical debt, fail
54.14 to include a disclosure on the contact notice, in a type size or font which is equal to or larger
54.15 than the largest other type of type size or font used in the text of the notice, that includes
54.16 and identifies the Office of the Minnesota Attorney General's general telephone number,
54.17 and states: "You have the right to hire your own attorney to represent you in this matter.";

54.18 (19) commence legal action to collect a medical debt outside the limitations period set
54.19 forth in section 541.053;

54.20 (20) report to a credit reporting agency any medical debt which the collecting party
54.21 knows or should know is or was originally owed to a health care provider, as defined in
54.22 section 62J.805, subdivision 2; or

54.23 (21) challenge a debtor's claim of exemption to garnishment or levy in a manner that is
54.24 baseless, frivolous, or otherwise in bad faith.

54.25 Sec. 23. **[332C.04] DEFENDING MEDICAL DEBT CASES.**

54.26 A debtor who successfully defends against a claim for payment of medical debt that is
54.27 alleged by a collecting party must be awarded the debtor's costs, including a reasonable
54.28 attorney fee, incurred in defending against the collecting party's claim for debt payment.

54.29 Sec. 24. **[332C.05] ENFORCEMENT.**

54.30 (a) The attorney general may enforce this chapter under section 8.31.

55.1 (b) A collecting party that violates this chapter is strictly liable to the debtor in question
55.2 for the sum of:

55.3 (1) actual damage sustained by the debtor as a result of the violation;

55.4 (2) additional damages as the court may allow, but not exceeding \$1,000 per violation;

55.5 and

55.6 (3) in the case of any successful action to enforce the foregoing, the costs of the action,
55.7 together with a reasonable attorney fee as determined by the court.

55.8 (c) A collecting party that willfully and maliciously violates this chapter is strictly liable
55.9 to the debtor for three times the sums allowable under paragraph (b), clauses (1) and (2).

55.10 (d) The dollar amount limit under paragraph (b), clause (2), changes on July 1 of each
55.11 even-numbered year in an amount equal to changes made in the Consumer Price Index,
55.12 compiled by the United States Bureau of Labor Statistics. The Consumer Price Index for
55.13 December 2024 is the reference base index. If the Consumer Price Index is revised, the
55.14 percentage of change made under this section must be calculated on the basis of the revised
55.15 Consumer Price Index. If a Consumer Price Index revision changes the reference base index,
55.16 a revised reference base index must be determined by multiplying the reference base index
55.17 that is effective at the time by the rebasing factor furnished by the Bureau of Labor Statistics.

55.18 (e) If the Consumer Price Index is superseded, the Consumer Price Index referred to in
55.19 this section is the Consumer Price Index represented by the Bureau of Labor Statistics as
55.20 most accurately reflecting changes in the prices paid by consumers for consumer goods and
55.21 services.

55.22 (f) The attorney general must publish the base reference index under paragraph (c) in
55.23 the State Register no later than September 1, 2024. The attorney general must calculate and
55.24 then publish the revised Consumer Price Index under paragraph (c) in the State Register no
55.25 later than September 1 each even-numbered year.

55.26 (g) An action brought under this section benefits the public.

55.27 Sec. 25. Minnesota Statutes 2022, section 334.01, is amended by adding a subdivision to
55.28 read:

55.29 Subd. 4. **Contracts for medical care.** Interest for any debt owed to a health care provider
55.30 incurred in exchange for care, treatment, services, devices, medicines, or procedures to
55.31 maintain, diagnose, or treat a person's physical or mental health shall be at a rate of \$4 upon
55.32 \$100 for a year.

56.1 Sec. 26. Minnesota Statutes 2022, section 519.05, is amended to read:

56.2 **519.05 LIABILITY OF HUSBAND AND WIFE SPOUSES.**

56.3 (a) A spouse is not liable to a creditor for any debts of the other spouse. ~~Where husband~~
56.4 ~~and wife are living together, they~~ Spouses shall be jointly and severally liable for ~~necessary~~
56.5 ~~medical services that have been furnished to either spouse, including~~ any claims arising
56.6 under section ~~246.53, 256B.15, 256D.16, or 261.04, and necessary household articles and~~
56.7 ~~supplies furnished to and used by the family.~~ Notwithstanding this paragraph, in a proceeding
56.8 under chapter 518 the court may apportion such debt between the spouses.

56.9 (b) Either spouse may close a credit card account or other unsecured consumer line of
56.10 credit on which both spouses are contractually liable, by giving written notice to the creditor.

56.11 Sec. 27. Laws 2020, chapter 73, section 8, is amended to read:

56.12 **Sec. 8. APPROPRIATIONS.**

56.13 (a) \$297,000 is appropriated in fiscal year 2020 from the health care access fund to the
56.14 Board of Directors of MNsure ~~to train navigators to assist individuals and provide~~
56.15 ~~compensation as required~~ for the insulin safety net program under Minnesota Statutes,
56.16 section 151.74, ~~subdivision 7. Of this appropriation, \$108,000 is for implementing the~~
56.17 ~~training requirements for navigators and \$189,000 is for application assistance bonus~~
56.18 ~~payments.~~ This is a onetime appropriation and is available until ~~December 31, 2024~~ June
56.19 30, 2027.

56.20 (b) \$250,000 is appropriated in fiscal year 2020 from the health care access fund to the
56.21 Board of Directors of MNsure for a public awareness campaign for the insulin safety net
56.22 program established under Minnesota Statutes, section 151.74. This is a onetime appropriation
56.23 and is available until December 31, 2024.

56.24 (c) \$76,000 is appropriated in fiscal year 2021 from the health care access fund to the
56.25 Board of Pharmacy to implement Minnesota Statutes, section 151.74. The base for this
56.26 appropriation is \$76,000 in fiscal year 2022; \$76,000 in fiscal year 2023; \$76,000 in fiscal
56.27 year 2024; \$38,000 in fiscal year 2025; and \$0 in fiscal year 2026.

56.28 (d) \$136,000 in fiscal year 2021 is appropriated from the health care access fund to the
56.29 commissioner of health to implement the survey to assess program satisfaction in Minnesota
56.30 Statutes, section 151.74, subdivision 12. The base for this appropriation is \$80,000 in fiscal
56.31 year 2022 and \$0 in fiscal year 2023. This is a onetime appropriation.

57.1 Sec. 28. **REPEALER; SUNSET FOR THE LONG-TERM SAFETY NET INSULIN**
57.2 **PROGRAM.**

57.3 Minnesota Statutes 2022, section 151.74, subdivision 16, is repealed.

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

57.5 **ARTICLE 4**

57.6 **HEALTH INSURANCE**

57.7 Section 1. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

57.8 Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to
57.9 in subdivision 1 issued or renewed after August 1, 1987, must provide coverage for scalp
57.10 hair prostheses, including all equipment and accessories necessary of regular use of scalp
57.11 hair prostheses, worn for hair loss suffered as a result of a health condition, including, but
57.12 not limited to, alopecia areata or the treatment for cancer, unless there is a clinical basis for
57.13 limitation.

57.14 (b) The coverage required by this section is subject to the co-payment, coinsurance,
57.15 deductible, and other enrollee cost-sharing requirements that apply to similar types of items
57.16 under the policy, plan, certificate, or contract and may be limited to one prosthesis per
57.17 benefit year.

57.18 (c) The coverage required by this section for scalp hair prostheses is limited to \$1,000
57.19 per benefit year.

57.20 (d) A scalp hair prostheses must be prescribed by a doctor to be covered under this
57.21 section.

57.22 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all policies,
57.23 plans, certificates, and contracts offered, issued, or renewed on or after that date.

57.24 Sec. 2. **[62A.3098] RAPID WHOLE GENOME SEQUENCING; COVERAGE.**

57.25 Subdivision 1. **Definition.** For purposes of this section, "rapid whole genome sequencing"
57.26 or "rWGS" means an investigation of the entire human genome, including coding and
57.27 noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing
57.28 genetic changes that returns the final results in 14 days. Rapid whole genome sequencing
57.29 includes patient-only whole genome sequencing and duo and trio whole genome sequencing
57.30 of the patient and the patient's biological parent or parents.

58.1 Subd. 2. Required coverage. A health plan that provides coverage to Minnesota residents
58.2 must cover rWGS testing if the enrollee:

58.3 (1) is 21 years of age or younger;

58.4 (2) has a complex or acute illness of unknown etiology that is not confirmed to have
58.5 been caused by an environmental exposure, toxic ingestion, an infection with a normal
58.6 response to therapy, or trauma; and

58.7 (3) is receiving inpatient hospital services in an intensive care unit or a neonatal or high
58.8 acuity pediatric care unit.

58.9 Subd. 3. Coverage criteria. Coverage may be based on the following medical necessity
58.10 criteria:

58.11 (1) the enrollee has symptoms that suggest a broad differential diagnosis that would
58.12 require an evaluation by multiple genetic tests if rWGS testing is not performed;

58.13 (2) timely identification of a molecular diagnosis is necessary in order to guide clinical
58.14 decision making, and the rWGS testing may aid in guiding the treatment or management
58.15 of the enrollee's condition; and

58.16 (3) the enrollee's complex or acute illness of unknown etiology includes at least one of
58.17 the following conditions:

58.18 (i) congenital anomalies involving at least two organ systems, or complex or multiple
58.19 congenital anomalies in one organ system;

58.20 (ii) specific organ malformations that are highly suggestive of a genetic etiology;

58.21 (iii) abnormal laboratory tests or abnormal chemistry profiles suggesting the presence
58.22 of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

58.23 (iv) refractory or severe hypoglycemia or hyperglycemia;

58.24 (v) abnormal response to therapy related to an underlying medical condition affecting
58.25 vital organs or bodily systems;

58.26 (vi) severe muscle weakness, rigidity, or spasticity;

58.27 (vii) refractory seizures;

58.28 (viii) a high-risk stratification on evaluation for a brief resolved unexplained event with
58.29 any of the following features:

58.30 (A) a recurrent event without respiratory infection;

59.1 (B) a recurrent seizure-like event; or

59.2 (C) a recurrent cardiopulmonary resuscitation;

59.3 (ix) abnormal cardiac diagnostic testing results that are suggestive of possible
59.4 channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;

59.5 (x) abnormal diagnostic imaging studies that are suggestive of underlying genetic
59.6 condition;

59.7 (xi) abnormal physiologic function studies that are suggestive of an underlying genetic
59.8 etiology; or

59.9 (xii) family genetic history related to the patient's condition.

59.10 Subd. 4. **Cost sharing.** Coverage provided in this section is subject to the enrollee's
59.11 health plan cost-sharing requirements, including any deductibles, co-payments, or coinsurance
59.12 requirements that apply to diagnostic testing services.

59.13 Subd. 5. **Payment for services provided.** If the enrollee's health plan uses a capitated
59.14 or bundled payment arrangement to reimburse a provider for services provided in an inpatient
59.15 setting, reimbursement for services covered under this section must be paid separately and
59.16 in addition to any reimbursement otherwise payable to the provider under the capitated or
59.17 bundled payment arrangement, unless the health carrier and the provider have negotiated
59.18 an increased capitated or bundled payment rate that includes the services covered under this
59.19 section.

59.20 Subd. 6. **Genetic data.** Genetic data generated as a result of performing rWGS and
59.21 covered under this section: (1) must be used for the primary purpose of assisting the ordering
59.22 provider and treating care team to diagnose and treat the patient; (2) is protected health
59.23 information as set forth under the Health Insurance Portability and Accountability Act
59.24 (HIPAA), the Health Information Technology for Economic and Clinical Health Act, and
59.25 any promulgated regulations, including but not limited to Code of Federal Regulations, title
59.26 45, parts 160 and 164, subparts A and E; and (3) is a protected health record under sections
59.27 144.291 to 144.298.

59.28 Subd. 7. **Reimbursement.** The commissioner of commerce must reimburse health
59.29 carriers for coverage under this section. Reimbursement is available only for coverage that
59.30 would not have been provided by the health carrier without the requirements of this section.
59.31 Each fiscal year, an amount necessary to make payments to health carriers to defray the
59.32 cost of providing coverage under this section is appropriated to the commissioner of
59.33 commerce. Health carriers must report to the commissioner quantified costs attributable to

60.1 the additional benefit under this section in a format developed by the commissioner. The
60.2 commissioner must evaluate submissions and make payments to health carriers as provided
60.3 in Code of Federal Regulations, title 45, section 155.170.

60.4 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to a health
60.5 plan offered, issued, or sold on or after that date.

60.6 Sec. 3. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

60.7 Subdivision 1. **Service for which prior authorization not required.** A health carrier
60.8 must not retrospectively deny or limit coverage of a health care service for which prior
60.9 authorization was not required by the health carrier, unless there is evidence that the health
60.10 care service was provided based on fraud or misinformation.

60.11 Subd. 2. **Service for which prior authorization required but not obtained.** A health
60.12 carrier must not deny or limit coverage of a health care service which the enrollee has already
60.13 received solely on the basis of lack of prior authorization if the service would otherwise
60.14 have been covered had the prior authorization been obtained.

60.15 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health
60.16 plans offered, sold, issued, or renewed on or after that date.

60.17 Sec. 4. **[62C.045] APPLICATION OF OTHER LAW.**

60.18 Sections 145D.30 to 145D.37 apply to service plan corporations operating under this
60.19 chapter.

60.20 Sec. 5. Minnesota Statutes 2022, section 62D.02, subdivision 4, is amended to read:

60.21 Subd. 4. **Health maintenance organization.** "Health maintenance organization" means
60.22 a ~~foreign or domestic~~ nonprofit corporation organized under chapter 317A, or a local
60.23 governmental unit as defined in subdivision 11, controlled and operated as provided in
60.24 sections 62D.01 to 62D.30, which provides, either directly or through arrangements with
60.25 providers or other persons, comprehensive health maintenance services, or arranges for the
60.26 provision of these services, to enrollees on the basis of a fixed prepaid sum without regard
60.27 to the frequency or extent of services furnished to any particular enrollee.

60.28 Sec. 6. Minnesota Statutes 2022, section 62D.02, subdivision 7, is amended to read:

60.29 Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health
60.30 maintenance services" means a set of comprehensive health services which the enrollees

61.1 might reasonably require to be maintained in good health including as a minimum, but not
61.2 limited to, emergency care, emergency ground ambulance transportation services, inpatient
61.3 hospital and physician care, outpatient health services and preventive health services.
61.4 ~~Elective, induced abortion, except as medically necessary to prevent the death of the mother,~~
61.5 ~~whether performed in a hospital, other abortion facility or the office of a physician, shall~~
61.6 ~~not be mandatory for any health maintenance organization.~~

61.7 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
61.8 plans offered, sold, issued, or renewed on or after that date.

61.9 Sec. 7. Minnesota Statutes 2022, section 62D.03, subdivision 1, is amended to read:

61.10 Subdivision 1. **Certificate of authority required.** Notwithstanding any law of this state
61.11 to the contrary, any ~~foreign or domestic~~ nonprofit corporation organized to do so or a local
61.12 governmental unit may apply to the commissioner of health for a certificate of authority to
61.13 establish and operate a health maintenance organization in compliance with sections 62D.01
61.14 to 62D.30. No person shall establish or operate a health maintenance organization in this
61.15 state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic
61.16 consideration in conjunction with a health maintenance organization or health maintenance
61.17 contract unless the organization has a certificate of authority under sections 62D.01 to
61.18 62D.30.

61.19 Sec. 8. Minnesota Statutes 2022, section 62D.05, subdivision 1, is amended to read:

61.20 Subdivision 1. **Authority granted.** Any nonprofit corporation or local governmental
61.21 unit may, upon obtaining a certificate of authority as required in sections 62D.01 to 62D.30,
61.22 operate as a health maintenance organization.

61.23 Sec. 9. Minnesota Statutes 2022, section 62D.06, subdivision 1, is amended to read:

61.24 Subdivision 1. **Governing body composition; enrollee advisory body.** The governing
61.25 body of any health maintenance organization which is a nonprofit corporation may include
61.26 enrollees, providers, or other individuals; provided, however, that after a health maintenance
61.27 organization which is a nonprofit corporation has been authorized under sections 62D.01
61.28 to 62D.30 for one year, at least 40 percent of the governing body shall be composed of
61.29 enrollees and members elected by the enrollees and members from among the enrollees and
61.30 members. For purposes of this section, "member" means a consumer who receives health
61.31 care services through a self-insured contract that is administered by the health maintenance
61.32 organization or its related third-party administrator. The number of members elected to the

62.1 governing body shall not exceed the number of enrollees elected to the governing body. An
62.2 enrollee or member elected to the governing board may not be a person:

62.3 (1) whose occupation involves, or before retirement involved, the administration of
62.4 health activities or the provision of health services;

62.5 (2) who is or was employed by a health care facility as a licensed health professional;

62.6 or

62.7 (3) who has or had a direct substantial financial or managerial interest in the rendering
62.8 of a health service, other than the payment of a reasonable expense reimbursement or
62.9 compensation as a member of the board of a health maintenance organization.

62.10 After a health maintenance organization which is a local governmental unit has been
62.11 authorized under sections 62D.01 to 62D.30 for one year, an enrollee advisory body shall
62.12 be established. The enrollees who make up this advisory body shall be elected by the enrollees
62.13 from among the enrollees.

62.14 Sec. 10. Minnesota Statutes 2022, section 62D.12, subdivision 19, is amended to read:

62.15 Subd. 19. **Coverage of service.** A health maintenance organization may not deny or
62.16 limit coverage of a service which the enrollee has already received solely on the basis of
62.17 lack of prior authorization or second opinion, to the extent that the service would otherwise
62.18 have been covered under the member's contract by the health maintenance organization had
62.19 prior authorization or second opinion been obtained. This subdivision expires December
62.20 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

62.21 Sec. 11. Minnesota Statutes 2022, section 62D.19, is amended to read:

62.22 **62D.19 UNREASONABLE EXPENSES.**

62.23 No health maintenance organization shall incur or pay for any expense of any nature
62.24 which is unreasonably high in relation to the value of the service or goods provided. The
62.25 commissioner of health shall implement and enforce this section by rules adopted under
62.26 this section.

62.27 In an effort to achieve the stated purposes of sections 62D.01 to 62D.30, in order to
62.28 safeguard the underlying nonprofit status of health maintenance organizations, and in order
62.29 to ensure that the payment of health maintenance organization money to major participating
62.30 entities results in a corresponding benefit to the health maintenance organization and its
62.31 enrollees, when determining whether an organization has incurred an unreasonable expense
62.32 in relation to a major participating entity, due consideration shall be given to, in addition

63.1 to any other appropriate factors, whether the officers and trustees of the health maintenance
63.2 organization have acted with good faith and in the best interests of the health maintenance
63.3 organization in entering into, and performing under, a contract under which the health
63.4 maintenance organization has incurred an expense. The commissioner has standing to sue,
63.5 on behalf of a health maintenance organization, officers or trustees of the health maintenance
63.6 organization who have breached their fiduciary duty in entering into and performing such
63.7 contracts.

63.8 Sec. 12. Minnesota Statutes 2022, section 62D.20, subdivision 1, is amended to read:

63.9 Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14,
63.10 promulgate such reasonable rules as are necessary or proper to carry out the provisions of
63.11 sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum
63.12 requirements for the provision of comprehensive health maintenance services, as defined
63.13 in section 62D.02, subdivision 7, and reasonable exclusions therefrom. ~~Nothing in such~~
63.14 ~~rules shall force or require a health maintenance organization to provide elective, induced~~
63.15 ~~abortions, except as medically necessary to prevent the death of the mother, whether~~
63.16 ~~performed in a hospital, other abortion facility, or the office of a physician; the rules shall~~
63.17 ~~provide every health maintenance organization the option of excluding or including elective,~~
63.18 ~~induced abortions, except as medically necessary to prevent the death of the mother, as part~~
63.19 ~~of its comprehensive health maintenance services.~~

63.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
63.21 plans offered, sold, issued, or renewed on or after that date.

63.22 Sec. 13. Minnesota Statutes 2022, section 62D.22, subdivision 5, is amended to read:

63.23 Subd. 5. **Other state law.** Except as otherwise provided in sections 62A.01 to 62A.42
63.24 and 62D.01 to 62D.30, ~~and except as they eliminate elective, induced abortions, wherever~~
63.25 ~~performed, from health or maternity benefits,~~ provisions of the insurance laws and provisions
63.26 of nonprofit health service plan corporation laws shall not be applicable to any health
63.27 maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

63.28 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
63.29 plans offered, sold, issued, or renewed on or after that date.

64.1 Sec. 14. Minnesota Statutes 2022, section 62D.22, is amended by adding a subdivision to
64.2 read:

64.3 Subd. 5a. **Application of other law.** Sections 145D.30 to 145D.37 apply to nonprofit
64.4 health maintenance organizations operating under this chapter.

64.5 Sec. 15. **[62D.221] OVERSIGHT OF TRANSACTIONS.**

64.6 Subdivision 1. **Insurance provisions applicable to health maintenance**
64.7 **organizations.** (a) Health maintenance organizations are subject to sections 60A.135,
64.8 60A.136, 60A.137, 60A.16, 60A.161, 60D.17, 60D.18, and 60D.20 and must comply with
64.9 the provisions of these sections applicable to insurers. In applying these sections to health
64.10 maintenance organizations, "the commissioner" means the commissioner of health. Health
64.11 maintenance organizations are subject to Minnesota Rules, chapter 2720, as applicable to
64.12 sections 60D.17, 60D.18, and 60D.20, and must comply with those provisions of the chapter
64.13 applicable to insurers unless the commissioner of health adopts rules to implement this
64.14 subdivision.

64.15 (b) In addition to the conditions in section 60D.17, subdivision 1, subjecting a health
64.16 maintenance organization to filing requirements, no person other than the issuer shall acquire
64.17 all or substantially all of the assets of a domestic nonprofit health maintenance organization
64.18 through any means unless at the time the offer, request, or invitation is made or the agreement
64.19 is entered into the person has filed with the commissioner and has sent to the health
64.20 maintenance organization a statement containing the information required in section 60D.17
64.21 and the offer, request, invitation, agreement, or acquisition has been approved by the
64.22 commissioner of health in the manner prescribed in section 60D.17.

64.23 Subd. 2. **Conversion transactions.** If a health maintenance organization must notify or
64.24 report a transaction to the commissioner under subdivision 1, the health maintenance
64.25 organization must include information regarding the plan for a conversion benefit entity,
64.26 in the form and manner determined by the commissioner, if the reportable transaction
64.27 qualifies as a conversion transaction as defined in section 145D.30, subdivision 5. The
64.28 commissioner may consider information regarding the conversion transaction and the
64.29 conversion benefit entity plan in any actions taken under subdivision 1, including in decisions
64.30 to approve or disapprove transactions, and may extend time frames to a total of 90 days,
64.31 with notice to the parties to the transaction.

65.1 Sec. 16. Minnesota Statutes 2022, section 62E.02, subdivision 3, is amended to read:

65.2 Subd. 3. **Health maintenance organization.** "Health maintenance organization" means
65.3 a nonprofit corporation licensed and operated as provided in chapter 62D.

65.4 Sec. 17. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

65.5 Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission
65.6 to determine eligibility for benefits under a health benefit plan. The appeal procedure
65.7 described in section 62M.06 applies to any complaint as defined under section 62Q.68,
65.8 subdivision 2, that requires a medical determination in its resolution.

65.9 (b) Effective January 1, 2026, this chapter does not apply applies to managed care plans
65.10 or county-based purchasing plans when the plan is providing coverage to state public health
65.11 care program enrollees under chapter 256B or 256L.

65.12 (c) Effective January 1, 2026, the following sections of this chapter apply to services
65.13 delivered through fee-for-service under chapters 256B and 256L: 62M.02, subdivisions 1
65.14 to 5, 7 to 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions
65.15 1 to 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2.

65.16 Sec. 18. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

65.17 Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a
65.18 utilization review organization relating to an admission, extension of stay, or health care
65.19 service that is partially or wholly adverse to the enrollee, including:

65.20 (1) a decision to deny an admission, extension of stay, or health care service on the basis
65.21 that it is not medically necessary; or

65.22 (2) an authorization for a health care service that is less intensive than the health care
65.23 service specified in the original request for authorization.

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

65.25 Sec. 19. Minnesota Statutes 2022, section 62M.02, subdivision 5, is amended to read:

65.26 Subd. 5. **Authorization.** "Authorization" means a determination by a utilization review
65.27 organization that an admission, extension of stay, or other health care service has been
65.28 reviewed and that, based on the information provided, it satisfies the utilization review
65.29 requirements of the applicable health benefit plan and the health plan company or
65.30 commissioner will then pay for the covered benefit, provided the preexisting limitation

66.1 provisions, the general exclusion provisions, and any deductible, co-payment, coinsurance,
66.2 or other policy requirements have been met.

66.3 Sec. 20. Minnesota Statutes 2022, section 62M.02, is amended by adding a subdivision
66.4 to read:

66.5 Subd. 8a. **Commissioner.** "Commissioner" means, effective January 1, 2026, for the
66.6 sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of
66.7 human services, unless otherwise specified.

66.8 Sec. 21. Minnesota Statutes 2022, section 62M.02, subdivision 11, is amended to read:

66.9 Subd. 11. **Enrollee.** "Enrollee" means:

66.10 (1) an individual covered by a health benefit plan and includes an insured policyholder,
66.11 subscriber, contract holder, member, covered person, or certificate holder; or

66.12 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision
66.13 3, paragraph (c), a recipient receiving coverage through fee-for-service under chapters 256B
66.14 and 256L.

66.15 Sec. 22. Minnesota Statutes 2022, section 62M.02, subdivision 12, is amended to read:

66.16 Subd. 12. **Health benefit plan.** (a) "Health benefit plan" means:

66.17 (1) a policy, contract, or certificate issued by a health plan company for the coverage of
66.18 medical, dental, or hospital benefits; or

66.19 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision
66.20 3, paragraph (c), coverage of medical, dental, or hospital benefits through fee-for-service
66.21 under chapters 256B and 256L, as specified by the commissioner on the agency's public
66.22 website or through other forms of recipient and provider guidance.

66.23 (b) A health benefit plan does not include coverage that is:

66.24 (1) limited to disability or income protection coverage;

66.25 (2) automobile medical payment coverage;

66.26 (3) supplemental to liability insurance;

66.27 (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense
66.28 incurred basis;

66.29 (5) credit accident and health insurance issued under chapter 62B;

- 67.1 (6) blanket accident and sickness insurance as defined in section 62A.11;
- 67.2 (7) accident only coverage issued by a licensed and tested insurance agent; or
- 67.3 (8) workers' compensation.

67.4 Sec. 23. Minnesota Statutes 2022, section 62M.02, subdivision 21, is amended to read:

67.5 Subd. 21. **Utilization review organization.** "Utilization review organization" means an
67.6 entity including but not limited to an insurance company licensed under chapter 60A to
67.7 offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;
67.8 a prepaid limited health service organization issued a certificate of authority and operating
67.9 under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a
67.10 health maintenance organization licensed under chapter 62D; a community integrated service
67.11 network licensed under chapter 62N; an accountable provider network operating under
67.12 chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance
67.13 employee health plan operating under chapter 62H; a multiple employer welfare arrangement,
67.14 as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA),
67.15 United States Code, title 29, section 1103, as amended; a third-party administrator licensed
67.16 under section 60A.23, subdivision 8, which conducts utilization review and authorizes or
67.17 makes adverse determinations regarding an admission, extension of stay, or other health
67.18 care services for a Minnesota resident; effective January 1, 2026, for the sections specified
67.19 in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services for
67.20 purposes of delivering services through fee-for-service under chapters 256B and 256L; any
67.21 other entity that provides, offers, or administers hospital, outpatient, medical, prescription
67.22 drug, or other health benefits to individuals treated by a health professional under a policy,
67.23 plan, or contract; or any entity performing utilization review that is affiliated with, under
67.24 contract with, or conducting utilization review on behalf of, a business entity in this state.
67.25 Utilization review organization does not include a clinic or health care system acting pursuant
67.26 to a written delegation agreement with an otherwise regulated utilization review organization
67.27 that contracts with the clinic or health care system. The regulated utilization review
67.28 organization is accountable for the delegated utilization review activities of the clinic or
67.29 health care system.

67.30 Sec. 24. Minnesota Statutes 2022, section 62M.04, subdivision 1, is amended to read:

67.31 Subdivision 1. **Responsibility for obtaining authorization.** A health benefit plan that
67.32 includes utilization review requirements must specify the process for notifying the utilization
67.33 review organization in a timely manner and obtaining authorization for health care services.

68.1 Each health plan company must provide a clear and concise description of this process to
68.2 an enrollee as part of the policy, subscriber contract, or certificate of coverage. Effective
68.3 January 1, 2026, the commissioner must provide a clear and concise description of this
68.4 process to fee-for-service recipients receiving services under chapters 256B and 256L,
68.5 through the agency's public website or through other forms of recipient guidance. In addition
68.6 to the enrollee, the utilization review organization must allow any provider or provider's
68.7 designee, or responsible patient representative, including a family member, to fulfill the
68.8 obligations under the health benefit plan.

68.9 A claims administrator that contracts directly with providers for the provision of health
68.10 care services to enrollees may, through contract, require the provider to notify the review
68.11 organization in a timely manner and obtain authorization for health care services.

68.12 Sec. 25. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

68.13 Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a~~
68.14 ~~standard review determination on all requests for utilization review must be communicated~~
68.15 ~~to the provider and enrollee in accordance with this subdivision within five business days~~
68.16 ~~after receiving the request if the request is received electronically, or within six business~~
68.17 ~~days if received through nonelectronic means, provided that all information reasonably~~
68.18 ~~necessary to make a determination on the request has been made available to the utilization~~
68.19 ~~review organization. Effective January 1, 2022, A standard review determination on all~~
68.20 requests for utilization review must be communicated to the provider and enrollee in
68.21 accordance with this subdivision within five business days after receiving the request,
68.22 regardless of how the request was received, provided that all information reasonably
68.23 necessary to make a determination on the request has been made available to the utilization
68.24 review organization.

68.25 (b) When a determination is made to authorize, notification must be provided promptly
68.26 by telephone to the provider. The utilization review organization shall send written
68.27 notification to the provider or shall maintain an audit trail of the determination and telephone
68.28 notification. For purposes of this subdivision, "audit trail" includes documentation of the
68.29 telephone notification, including the date; the name of the person spoken to; the enrollee;
68.30 the service, procedure, or admission authorized; and the date of the service, procedure, or
68.31 admission. If the utilization review organization indicates authorization by use of a number,
68.32 the number must be called the "authorization number." For purposes of this subdivision,
68.33 notification may also be made by facsimile to a verified number or by electronic mail to a

69.1 secure electronic mailbox. These electronic forms of notification satisfy the "audit trail"
69.2 requirement of this paragraph.

69.3 (c) When an adverse determination is made, notification must be provided within the
69.4 time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or
69.5 by electronic mail to a secure electronic mailbox to the attending health care professional
69.6 and hospital or physician office as applicable. Written notification must also be sent to the
69.7 hospital or physician office as applicable and attending health care professional if notification
69.8 occurred by telephone. For purposes of this subdivision, notification may be made by
69.9 facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written
69.10 notification must be sent to the enrollee and may be sent by United States mail, facsimile
69.11 to a verified number, or by electronic mail to a secure mailbox. The written notification
69.12 must include all reasons relied on by the utilization review organization for the determination
69.13 and the process for initiating an appeal of the determination. Upon request, the utilization
69.14 review organization shall provide the provider or enrollee with the criteria used to determine
69.15 the necessity, appropriateness, and efficacy of the health care service and identify the
69.16 database, professional treatment parameter, or other basis for the criteria. Reasons for an
69.17 adverse determination may include, among other things, the lack of adequate information
69.18 to authorize after a reasonable attempt has been made to contact the provider or enrollee.

69.19 (d) When an adverse determination is made, the written notification must inform the
69.20 enrollee and the attending health care professional of the right to submit an appeal to the
69.21 internal appeal process described in section 62M.06 and the procedure for initiating the
69.22 internal appeal. The written notice shall be provided in a culturally and linguistically
69.23 appropriate manner consistent with the provisions of the Affordable Care Act as defined
69.24 under section 62A.011, subdivision 1a.

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

69.26 Sec. 26. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

69.27 Subd. 2. **Prior authorization of ~~emergency~~ certain services prohibited.** No utilization
69.28 review organization, health plan company, or claims administrator may conduct or require
69.29 prior authorization of:

69.30 (1) emergency confinement or an emergency service. The enrollee or the enrollee's
69.31 authorized representative may be required to notify the health plan company, claims
69.32 administrator, or utilization review organization as soon as reasonably possible after the
69.33 beginning of the emergency confinement or emergency service;₂

70.1 (2) oral buprenorphine to treat a substance use disorder;

70.2 (3) outpatient mental health treatment or outpatient substance use disorder treatment,
70.3 except for treatment which is: (i) a medication; and (ii) not otherwise listed in this
70.4 subdivision. Prior authorizations required for medications used for outpatient mental health
70.5 treatment or outpatient substance use disorder treatment, and not otherwise listed in this
70.6 subdivision, must be processed according to section 62M.05, subdivision 3b, for initial
70.7 determinations, and according to section 62M.06, subdivision 2, for appeals;

70.8 (4) antineoplastic cancer treatment that is consistent with guidelines of the National
70.9 Comprehensive Cancer Network, except for treatment which is: (i) a medication; and (ii)
70.10 not otherwise listed in this subdivision. Prior authorizations required for medications used
70.11 for antineoplastic cancer treatment, and not otherwise listed in this subdivision, must be
70.12 processed according to section 62M.05, subdivision 3b, for initial determinations, and
70.13 according to section 62M.06, subdivision 2, for appeals;

70.14 (5) services that currently have a rating of A or B from the United States Preventive
70.15 Services Task Force, immunizations recommended by the Advisory Committee on
70.16 Immunization Practices of the Centers for Disease Control and Prevention, or preventive
70.17 services and screenings provided to women as described in Code of Federal Regulations,
70.18 title 45, section 147.130;

70.19 (6) pediatric hospice services provided by a hospice provider licensed under sections
70.20 144A.75 to 144A.755; and

70.21 (7) treatment delivered through a neonatal abstinence program operated by pediatric
70.22 pain or palliative care subspecialists.

70.23 Clauses (2) to (7) are effective January 1, 2026, and apply to health benefit plans offered,
70.24 sold, issued, or renewed on or after that date.

70.25 Sec. 27. Minnesota Statutes 2022, section 62M.07, subdivision 4, is amended to read:

70.26 Subd. 4. **Submission of prior authorization requests.** (a) If prior authorization for a
70.27 health care service is required, the utilization review organization, health plan company, or
70.28 claim administrator must allow providers to submit requests for prior authorization of the
70.29 health care services without unreasonable delay by telephone, facsimile, or voice mail or
70.30 through an electronic mechanism 24 hours a day, seven days a week. This subdivision does
70.31 not apply to dental service covered under MinnesotaCare or medical assistance.

70.32 (b) Effective January 1, 2027, for health benefit plans offered, sold, issued, or renewed
70.33 on or after that date, utilization review organizations, health plan companies, and claims

71.1 administrators must have and maintain a prior authorization application programming
71.2 interface (API) that automates the prior authorization process for health care services,
71.3 excluding prescription drugs and medications. The API must allow providers to determine
71.4 whether a prior authorization is required for health care services, identify prior authorization
71.5 information and documentation requirements, and facilitate the exchange of prior
71.6 authorization requests and determinations from provider electronic health records or practice
71.7 management systems. The API must use the Health Level Seven (HL7) Fast Healthcare
71.8 Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations,
71.9 title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the
71.10 United States Department of Health and Human Services to implement that section. Prior
71.11 authorization submission requests for prescription drugs and medications must comply with
71.12 the requirements of section 62J.497.

71.13 Sec. 28. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision
71.14 to read:

71.15 Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1,
71.16 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that
71.17 date. An authorization for treatment of a chronic health condition does not expire unless
71.18 the standard of treatment for that health condition changes. A chronic health condition is a
71.19 condition that is expected to last one year or more and:

71.20 (1) requires ongoing medical attention to effectively manage the condition or prevent
71.21 an adverse health event; or

71.22 (2) limits one or more activities of daily living.

71.23 Sec. 29. Minnesota Statutes 2022, section 62M.10, subdivision 7, is amended to read:

71.24 **Subd. 7. Availability of criteria.** (a) For utilization review determinations other than
71.25 prior authorization, a utilization review organization shall, upon request, provide to an
71.26 enrollee, a provider, and the commissioner of commerce the criteria used to determine the
71.27 medical necessity, appropriateness, and efficacy of a procedure or service and identify the
71.28 database, professional treatment guideline, or other basis for the criteria.

71.29 (b) For prior authorization determinations, a utilization review organization must submit
71.30 the organization's current prior authorization requirements and restrictions, including written,
71.31 evidence-based, clinical criteria used to make an authorization or adverse determination, to
71.32 all health plan companies for which the organization performs utilization review. A health
71.33 plan company must post on its public website the prior authorization requirements and

72.1 restrictions of any utilization review organization that performs utilization review for the
72.2 health plan company. These prior authorization requirements and restrictions must be detailed
72.3 and written in language that is easily understandable to providers. This paragraph does not
72.4 apply to the commissioner of human services when delivering services through fee-for-service
72.5 under chapters 256B and 256L.

72.6 (c) Effective January 1, 2026, the commissioner of human services must post on the
72.7 department's public website the prior authorization requirements and restrictions, including
72.8 written, evidence-based, clinical criteria used to make an authorization or adverse
72.9 determination, that apply to prior authorization determinations for fee-for-service under
72.10 chapters 256B and 256L. These prior authorization requirements and restrictions must be
72.11 detailed and written in language that is easily understandable to providers.

72.12 Sec. 30. Minnesota Statutes 2022, section 62M.10, subdivision 8, is amended to read:

72.13 Subd. 8. **Notice; new prior authorization requirements or restrictions; change to**
72.14 **existing requirement or restriction.** (a) Before a utilization review organization may
72.15 implement a new prior authorization requirement or restriction or amend an existing prior
72.16 authorization requirement or restriction, the utilization review organization must submit the
72.17 new or amended requirement or restriction to all health plan companies for which the
72.18 organization performs utilization review. A health plan company must post on its website
72.19 the new or amended requirement or restriction. This paragraph does not apply to the
72.20 commissioner of human services when delivering services through fee-for-service under
72.21 chapters 256B and 256L.

72.22 (b) At least 45 days before a new prior authorization requirement or restriction or an
72.23 amended existing prior authorization requirement or restriction is implemented, the utilization
72.24 review organization, health plan company, or claims administrator must provide written or
72.25 electronic notice of the new or amended requirement or restriction to all Minnesota-based,
72.26 in-network attending health care professionals who are subject to the prior authorization
72.27 requirements and restrictions. This paragraph does not apply to the commissioner of human
72.28 services when delivering services through fee-for-service under chapters 256B and 256L.

72.29 (c) Effective January 1, 2026, before the commissioner of human services may implement
72.30 a new prior authorization requirement or restriction or amend an existing prior authorization
72.31 requirement or restriction, the commissioner, at least 45 days before the new or amended
72.32 requirement or restriction takes effect, must provide written or electronic notice of the new
72.33 or amended requirement or restriction, to all health care professionals participating as

73.1 fee-for-service providers under chapters 256B and 256L who are subject to the prior
73.2 authorization requirements and restrictions.

73.3 Sec. 31. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

73.4 Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan
73.5 year, a utilization review organization changes coverage terms for a health care service or
73.6 the clinical criteria used to conduct prior authorizations for a health care service, the change
73.7 in coverage terms or change in clinical criteria shall not apply until the next plan year for
73.8 any enrollee who received prior authorization for a health care service using the coverage
73.9 terms or clinical criteria in effect before the effective date of the change.

73.10 (b) Paragraph (a) does not apply if a utilization review organization changes coverage
73.11 terms for a drug or device that has been deemed unsafe by the United States Food and Drug
73.12 Administration (FDA); that has been withdrawn by either the FDA or the product
73.13 manufacturer; or when an independent source of research, clinical guidelines, or
73.14 evidence-based standards has issued drug- or device-specific warnings or recommended
73.15 changes in drug or device usage.

73.16 (c) Paragraph (a) does not apply if a utilization review organization changes coverage
73.17 terms for a service or the clinical criteria used to conduct prior authorizations for a service
73.18 when an independent source of research, clinical guidelines, or evidence-based standards
73.19 has recommended changes in usage of the service for reasons related to patient harm. This
73.20 paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or
73.21 renewed on or after that date.

73.22 (d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued,
73.23 or renewed on or after that date, paragraph (a) does not apply if a utilization review
73.24 organization changes coverage terms for a service or the clinical criteria used to conduct
73.25 prior authorizations for a service when an independent source of research, clinical guidelines,
73.26 or evidence-based standards has recommended changes in usage of the service for reasons
73.27 related to previously unknown and imminent patient harm.

73.28 ~~(d)~~ (e) Paragraph (a) does not apply if a utilization review organization removes a brand
73.29 name drug from its formulary or places a brand name drug in a benefit category that increases
73.30 the enrollee's cost, provided the utilization review organization (1) adds to its formulary a
73.31 generic or multisource brand name drug rated as therapeutically equivalent according to
73.32 the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA
73.33 Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to
73.34 prescribers, pharmacists, and affected enrollees.

74.1 Sec. 32. [62M.19] ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR
74.2 AUTHORIZATIONS.

74.3 On or before September 1 each year, each utilization review organization must report
74.4 to the commissioner of health, in a form and manner specified by the commissioner,
74.5 information on prior authorization requests for the previous calendar year. The report
74.6 submitted under this subdivision must include the following data:

74.7 (1) the total number of prior authorization requests received;

74.8 (2) the number of prior authorization requests for which an authorization was issued;

74.9 (3) the number of prior authorization requests for which an adverse determination was
74.10 issued;

74.11 (4) the number of adverse determinations reversed on appeal;

74.12 (5) the 25 codes with the highest number of prior authorization requests and the
74.13 percentage of authorizations for each of these codes;

74.14 (6) the 25 codes with the highest percentage of prior authorization requests for which
74.15 an authorization was issued and the total number of the requests;

74.16 (7) the 25 codes with the highest percentage of prior authorization requests for which
74.17 an adverse determination was issued but which was reversed on appeal and the total number
74.18 of the requests;

74.19 (8) the 25 codes with the highest percentage of prior authorization requests for which
74.20 an adverse determination was issued and the total number of the requests; and

74.21 (9) the reasons an adverse determination to a prior authorization request was issued,
74.22 expressed as a percentage of all adverse determinations. The reasons listed may include but
74.23 are not limited to:

74.24 (i) the patient did not meet prior authorization criteria;

74.25 (ii) incomplete information was submitted by the provider to the utilization review
74.26 organization;

74.27 (iii) the treatment program changed; and

74.28 (iv) the patient is no longer covered by the health benefit plan.

75.1 Sec. 33. Minnesota Statutes 2022, section 62Q.14, is amended to read:

75.2 **62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.**

75.3 No health plan company may restrict the choice of an enrollee as to where the enrollee
75.4 receives services related to:

75.5 (1) the voluntary planning of the conception and bearing of children, ~~provided that this~~
75.6 ~~clause does not refer to abortion services;~~

75.7 (2) the diagnosis of infertility;

75.8 (3) the testing and treatment of a sexually transmitted disease; and

75.9 (4) the testing for AIDS or other HIV-related conditions.

75.10 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
75.11 plans offered, sold, issued, or renewed on or after that date.

75.12 Sec. 34. Minnesota Statutes 2022, section 62Q.1841, subdivision 2, is amended to read:

75.13 Subd. 2. **Prohibition on use of prior authorization or step therapy protocols.** A health
75.14 plan that provides coverage for the treatment of stage four advanced metastatic cancer or
75.15 associated conditions must not limit or exclude coverage for a drug approved by the United
75.16 States Food and Drug Administration ~~that is on the health plan's prescription drug formulary~~
75.17 by mandating that an enrollee with stage four advanced metastatic cancer or associated
75.18 conditions obtain a prior authorization or follow a step therapy protocol if the use of the
75.19 approved drug is consistent with:

75.20 (1) a United States Food and Drug Administration-approved indication; and

75.21 (2) a clinical practice guideline published by the National Comprehensive Care Network.

75.22 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
75.23 plans offered, sold, issued, or renewed on or after that date.

75.24 Sec. 35. Minnesota Statutes 2022, section 62Q.19, subdivision 3, is amended to read:

75.25 Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider
75.26 contract to ~~any~~ all designated essential community ~~provider~~ providers located within the
75.27 area served by the health plan company. A health plan company must include all essential
75.28 community providers that have accepted a contract in each of the company's provider
75.29 networks. A health plan company shall not restrict enrollee access to services designated
75.30 to be provided by the essential community provider for the population that the essential

76.1 community provider is certified to serve. A health plan company may also make other
76.2 providers available for these services. A health plan company may require an essential
76.3 community provider to meet all data requirements, utilization review, and quality assurance
76.4 requirements on the same basis as other health plan providers.

76.5 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
76.6 plans offered, issued, or renewed on or after that date.

76.7 Sec. 36. Minnesota Statutes 2022, section 62Q.19, is amended by adding a subdivision to
76.8 read:

76.9 Subd. 4a. **Contract payment rates; private.** An essential community provider and a
76.10 health plan company may negotiate the payment rate for covered services provided by the
76.11 essential community provider. This rate must be at least the same rate per unit of service
76.12 as is paid by the health plan company to the essential community provider under the provider
76.13 contract between the two with the highest number of enrollees receiving health care services
76.14 from the provider or, if there is no provider contract between the health plan company and
76.15 the essential community provider, the rate must be at least the same rate per unit of service
76.16 as is paid to other plan providers for the same or similar services. The provider contract
76.17 used to set the rate under this subdivision must be in relation to an individual, small group,
76.18 or large group health plan. This subdivision applies only to provider contracts in relation
76.19 to individual, small employer, and large group health plans.

76.20 Sec. 37. Minnesota Statutes 2022, section 62Q.19, subdivision 5, is amended to read:

76.21 Subd. 5. **Contract payment rates; public.** An essential community provider and a
76.22 health plan company may negotiate the payment rate for covered services provided by the
76.23 essential community provider. This rate must be at least the same rate per unit of service
76.24 as is paid to other health plan providers for the same or similar services. This subdivision
76.25 applies only to provider contracts in relation to health plans offered through the State
76.26 Employee Group Insurance Program, medical assistance, and MinnesotaCare.

76.27 Sec. 38. Minnesota Statutes 2023 Supplement, section 62Q.522, subdivision 1, is amended
76.28 to read:

76.29 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

76.30 ~~(b) "Closely held for-profit entity" means an entity that:~~

76.31 ~~(1) is not a nonprofit entity;~~

77.1 ~~(2) has more than 50 percent of the value of its ownership interest owned directly or~~
77.2 ~~indirectly by five or fewer owners; and~~

77.3 ~~(3) has no publicly traded ownership interest.~~

77.4 ~~For purposes of this paragraph:~~

77.5 ~~(i) ownership interests owned by a corporation, partnership, limited liability company,~~
77.6 ~~estate, trust, or similar entity are considered owned by that entity's shareholders, partners,~~
77.7 ~~members, or beneficiaries in proportion to their interest held in the corporation, partnership,~~
77.8 ~~limited liability company, estate, trust, or similar entity;~~

77.9 ~~(ii) ownership interests owned by a nonprofit entity are considered owned by a single~~
77.10 ~~owner;~~

77.11 ~~(iii) ownership interests owned by all individuals in a family are considered held by a~~
77.12 ~~single owner. For purposes of this item, "family" means brothers and sisters, including~~
77.13 ~~half brothers and half sisters, a spouse, ancestors, and lineal descendants; and~~

77.14 ~~(iv) if an individual or entity holds an option, warrant, or similar right to purchase an~~
77.15 ~~ownership interest, the individual or entity is considered to be the owner of those ownership~~
77.16 ~~interests.~~

77.17 ~~(e) (b) "Contraceptive method" means a drug, device, or other product approved by the~~
77.18 ~~Food and Drug Administration to prevent unintended pregnancy.~~

77.19 ~~(d) (c) "Contraceptive service" means consultation, examination, procedures, and medical~~
77.20 ~~services related to the prevention of unintended pregnancy, excluding vasectomies. This~~
77.21 ~~includes but is not limited to voluntary sterilization procedures, patient education, counseling~~
77.22 ~~on contraceptives, and follow-up services related to contraceptive methods or services,~~
77.23 ~~management of side effects, counseling for continued adherence, and device insertion or~~
77.24 ~~removal.~~

77.25 ~~(e) "Eligible organization" means an organization that opposes providing coverage for~~
77.26 ~~some or all contraceptive methods or services on account of religious objections and that~~
77.27 ~~is:~~

77.28 ~~(1) organized as a nonprofit entity and holds itself out to be religious; or~~

77.29 ~~(2) organized and operates as a closely held for-profit entity, and the organization's~~
77.30 ~~owners or highest governing body has adopted, under the organization's applicable rules of~~
77.31 ~~governance and consistent with state law, a resolution or similar action establishing that the~~

78.1 ~~organization objects to covering some or all contraceptive methods or services on account~~
78.2 ~~of the owners' sincerely held religious beliefs.~~

78.3 ~~(f) "Exempt organization" means an organization that is organized and operates as a~~
78.4 ~~nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal~~
78.5 ~~Revenue Code of 1986, as amended.~~

78.6 ~~(g)~~ (d) "Medical necessity" includes but is not limited to considerations such as severity
78.7 of side effects, difference in permanence and reversibility of a contraceptive method or
78.8 service, and ability to adhere to the appropriate use of the contraceptive method or service,
78.9 as determined by the attending provider.

78.10 ~~(h)~~ (e) "Therapeutic equivalent version" means a drug, device, or product that can be
78.11 expected to have the same clinical effect and safety profile when administered to a patient
78.12 under the conditions specified in the labeling, and that:

78.13 (1) is approved as safe and effective;

78.14 (2) is a pharmaceutical equivalent: (i) containing identical amounts of the same active
78.15 drug ingredient in the same dosage form and route of administration; and (ii) meeting
78.16 compendial or other applicable standards of strength, quality, purity, and identity;

78.17 (3) is bioequivalent in that:

78.18 (i) the drug, device, or product does not present a known or potential bioequivalence
78.19 problem and meets an acceptable in vitro standard; or

78.20 (ii) if the drug, device, or product does present a known or potential bioequivalence
78.21 problem, it is shown to meet an appropriate bioequivalence standard;

78.22 (4) is adequately labeled; and

78.23 (5) is manufactured in compliance with current manufacturing practice regulations.

78.24 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
78.25 plans offered, sold, issued, or renewed on or after that date.

78.26 Sec. 39. Minnesota Statutes 2023 Supplement, section 62Q.523, subdivision 1, is amended
78.27 to read:

78.28 Subdivision 1. **Scope of coverage.** Except as otherwise provided in section ~~62Q.522~~
78.29 62Q.679, subdivisions 2 and 3 ~~and 4~~, all health plans that provide prescription coverage
78.30 must comply with the requirements of this section.

79.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
79.2 plans offered, sold, issued, or renewed on or after that date.

79.3 Sec. 40. **[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED**
79.4 **SERVICES.**

79.5 Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical
79.6 treatment intended to induce the termination of a pregnancy with a purpose other than
79.7 producing a live birth.

79.8 Subd. 2. **Required coverage; cost-sharing.** (a) A health plan must provide coverage
79.9 for abortions and abortion-related services, including preabortion services and follow-up
79.10 services.

79.11 (b) A health plan must not impose on the coverage under this section any co-payment,
79.12 coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing
79.13 that applies to similar services covered under the health plan.

79.14 (c) A health plan must not impose any limitation on the coverage under this section,
79.15 including but not limited to any utilization review, prior authorization, referral requirements,
79.16 restrictions, or delays, that is not generally applicable to other coverages under the plan.

79.17 Subd. 3. **Exclusion.** This section does not apply to managed care organizations or
79.18 county-based purchasing plans when the plan provides coverage to public health care
79.19 program enrollees under chapter 256B or 256L.

79.20 Subd. 4. **Reimbursement.** The commissioner of commerce must reimburse health plan
79.21 companies for coverage under this section. Reimbursement is available only for coverage
79.22 that would not have been provided by the health plan company without the requirements
79.23 of this section. Each fiscal year, an amount necessary to make payments to health plan
79.24 companies to defray the cost of providing coverage under this section is appropriated to the
79.25 commissioner of commerce. Health plan companies must report to the commissioner
79.26 quantified costs attributable to the additional benefit under this section in a format developed
79.27 by the commissioner. The commissioner must evaluate submissions and make payments to
79.28 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

79.29 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
79.30 plans offered, sold, issued, or renewed on or after that date.

80.1 Sec. 41. **[62Q.531] AMINO ACID-BASED FORMULA COVERAGE.**

80.2 Subdivision 1. **Definition.** (a) For purposes of this section, the following term has the
80.3 meaning given.

80.4 (b) "Formula" means an amino acid-based elemental formula.

80.5 Subd. 2. **Required coverage.** A health plan company must provide coverage for formula
80.6 when formula is medically necessary.

80.7 Subd. 3. **Covered conditions.** Conditions for which formula is medically necessary
80.8 include but are not limited to:

80.9 (1) cystic fibrosis;

80.10 (2) amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;

80.11 (3) IgE mediated allergies to food proteins;

80.12 (4) food protein-induced enterocolitis syndrome;

80.13 (5) eosinophilic esophagitis;

80.14 (6) eosinophilic gastroenteritis;

80.15 (7) eosinophilic colitis; and

80.16 (8) mast cell activation syndrome.

80.17 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
80.18 plans offered, issued, or sold on or after that date.

80.19 Sec. 42. **[62Q.585] GENDER-AFFIRMING CARE COVERAGE; MEDICALLY**
80.20 **NECESSARY CARE.**

80.21 Subdivision 1. **Requirement.** No health plan that covers physical or mental health
80.22 services may be offered, sold, issued, or renewed in this state that:

80.23 (1) excludes coverage for medically necessary gender-affirming care; or

80.24 (2) requires gender-affirming treatments to satisfy a definition of "medically necessary
80.25 care," "medical necessity," or any similar term that is more restrictive than the definition
80.26 provided in subdivision 2.

80.27 Subd. 2. **Minimum definition.** "Medically necessary care" means health care services
80.28 appropriate in terms of type, frequency, level, setting, and duration to the enrollee's diagnosis
80.29 or condition and diagnostic testing and preventive services. Medically necessary care must
80.30 be consistent with generally accepted practice parameters as determined by health care

81.1 providers in the same or similar general specialty as typically manages the condition,
81.2 procedure, or treatment at issue and must:

81.3 (1) help restore or maintain the enrollee's health; or

81.4 (2) prevent deterioration of the enrollee's condition.

81.5 Subd. 3. **Definitions.** (a) For purposes of this section, the following terms have the
81.6 meanings given.

81.7 (b) "Gender-affirming care" means all medical, surgical, counseling, or referral services,
81.8 including telehealth services, that an individual may receive to support and affirm the
81.9 individual's gender identity or gender expression and that are legal under the laws of this
81.10 state.

81.11 (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes
81.12 the coverages listed in section 62A.011, subdivision 3, clauses (7) and (10).

81.13 **Sec. 43. [62Q.665] COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.**

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

81.16 (b) "Accredited facility" means any entity that is accredited to provide comprehensive
81.17 orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services
81.18 approved accrediting agency.

81.19 (c) "Orthosis" means:

81.20 (1) an external medical device that is:

81.21 (i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique
81.22 physical condition;

81.23 (ii) applied to a part of the body to correct a deformity, provide support and protection,
81.24 restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or
81.25 postoperative condition; and

81.26 (iii) deemed medically necessary by a prescribing physician or licensed health care
81.27 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,
81.28 and services; and

81.29 (2) any provision, repair, or replacement of a device that is furnished or performed by:

81.30 (i) an accredited facility in comprehensive orthotic services; or

82.1 (ii) a health care provider licensed in Minnesota and operating within the provider's
82.2 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,
82.3 or services.

82.4 (d) "Orthotics" means:

82.5 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,
82.6 fitting, adjusting, or servicing and providing the initial training necessary to accomplish the
82.7 fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular
82.8 or musculoskeletal dysfunction, disease, injury, or deformity;

82.9 (2) evaluation, treatment, and consultation related to an orthotic device;

82.10 (3) basic observation of gait and postural analysis;

82.11 (4) assessing and designing orthosis to maximize function and provide support and
82.12 alignment necessary to prevent or correct a deformity or to improve the safety and efficiency
82.13 of mobility and locomotion;

82.14 (5) continuing patient care to assess the effect of an orthotic device on the patient's
82.15 tissues; and

82.16 (6) proper fit and function of the orthotic device by periodic evaluation.

82.17 (e) "Prosthesis" means:

82.18 (1) an external medical device that is:

82.19 (i) used to replace or restore a missing limb, appendage, or other external human body
82.20 part; and

82.21 (ii) deemed medically necessary by a prescribing physician or licensed health care
82.22 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,
82.23 and services; and

82.24 (2) any provision, repair, or replacement of a device that is furnished or performed by:

82.25 (i) an accredited facility in comprehensive prosthetic services; or

82.26 (ii) a health care provider licensed in Minnesota and operating within the provider's
82.27 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,
82.28 or services.

82.29 (f) "Prosthetics" means:

82.30 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,
82.31 fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary

83.1 to accomplish the fitting of, a prosthesis through the replacement of external parts of a
83.2 human body lost due to amputation or congenital deformities or absences;

83.3 (2) the generation of an image, form, or mold that replicates the patient's body segment
83.4 and that requires rectification of dimensions, contours, and volumes for use in the design
83.5 and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial
83.6 appendage that is designed either to support body weight or to improve or restore function
83.7 or anatomical appearance, or both;

83.8 (3) observational gait analysis and clinical assessment of the requirements necessary to
83.9 refine and mechanically fix the relative position of various parts of the prosthesis to maximize
83.10 function, stability, and safety of the patient;

83.11 (4) providing and continuing patient care in order to assess the prosthetic device's effect
83.12 on the patient's tissues; and

83.13 (5) assuring proper fit and function of the prosthetic device by periodic evaluation.

83.14 Subd. 2. Coverage. (a) A health plan must provide coverage for orthotic and prosthetic
83.15 devices, supplies, and services, including repair and replacement, at least equal to the
83.16 coverage provided under federal law for health insurance for the aged and disabled under
83.17 sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42,
83.18 sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

83.19 (b) A health plan must not subject orthotic and prosthetic benefits to separate financial
83.20 requirements that apply only with respect to those benefits. A health plan may impose
83.21 co-payment and coinsurance amounts on those benefits, except that any financial
83.22 requirements that apply to such benefits must not be more restrictive than the financial
83.23 requirements that apply to the health plan's medical and surgical benefits, including those
83.24 for internal restorative devices.

83.25 (c) A health plan may limit the benefits for, or alter the financial requirements for,
83.26 out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and
83.27 requirements that apply to those benefits must not be more restrictive than the financial
83.28 requirements that apply to the out-of-network coverage for the health plan's medical and
83.29 surgical benefits.

83.30 (d) A health plan must cover orthoses and prostheses when furnished under an order by
83.31 a prescribing physician or licensed health care prescriber who has authority in Minnesota
83.32 to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices,

84.1 supplies, accessories, and services must include those devices or device systems, supplies,
84.2 accessories, and services that are customized to the covered individual's needs.

84.3 (e) A health plan must cover orthoses and prostheses determined by the enrollee's provider
84.4 to be the most appropriate model that meets the medical needs of the enrollee for purposes
84.5 of performing physical activities, as applicable, including but not limited to running, biking,
84.6 and swimming, and maximizing the enrollee's limb function.

84.7 (f) A health plan must cover orthoses and prostheses for showering or bathing.

84.8 Subd. 3. **Prior authorization.** A health plan may require prior authorization for orthotic
84.9 and prosthetic devices, supplies, and services in the same manner and to the same extent as
84.10 prior authorization is required for any other covered benefit.

84.11 Subd. 4. **Reimbursement.** The commissioner of commerce must reimburse health plan
84.12 companies for coverage under this section. Reimbursement is available only for coverage
84.13 that would not have been provided by the health plan company without the requirements
84.14 of this section. Each fiscal year, an amount necessary to make payments to health plan
84.15 companies to defray the cost of providing coverage under this section is appropriated to the
84.16 commissioner of commerce. Health plan companies must report to the commissioner
84.17 quantified costs attributable to the additional benefit under this section in a format developed
84.18 by the commissioner. The commissioner must evaluate submissions and make payments to
84.19 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

84.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health
84.21 plans offered, issued, or renewed on or after that date.

84.22 Sec. 44. **[62Q.666] MEDICAL NECESSITY AND NONDISCRIMINATION**
84.23 **STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.**

84.24 (a) When performing a utilization review for a request for coverage of prosthetic or
84.25 orthotic benefits, a health plan company shall apply the most recent version of evidence-based
84.26 treatment and fit criteria as recognized by relevant clinical specialists.

84.27 (b) A health plan company shall render utilization review determinations in a
84.28 nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative
84.29 benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or
84.30 perceived disability.

84.31 (c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual
84.32 with limb loss or absence that would otherwise be covered for a nondisabled person seeking

85.1 medical or surgical intervention to restore or maintain the ability to perform the same
85.2 physical activity.

85.3 (d) A health plan offered, issued, or renewed in Minnesota that offers coverage for
85.4 prosthetics and custom orthotic devices shall include language describing an enrollee's rights
85.5 pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

85.6 (e) A health plan that provides coverage for prosthetic or orthotic services shall ensure
85.7 access to medically necessary clinical care and to prosthetic and custom orthotic devices
85.8 and technology from not less than two distinct prosthetic and custom orthotic providers in
85.9 the plan's provider network located in Minnesota. In the event that medically necessary
85.10 covered orthotics and prosthetics are not available from an in-network provider, the health
85.11 plan company shall provide processes to refer a member to an out-of-network provider and
85.12 shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member
85.13 cost sharing determined on an in-network basis.

85.14 (f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be
85.15 made for the replacement of a prosthetic or custom orthotic device or for the replacement
85.16 of any part of the devices, without regard to continuous use or useful lifetime restrictions,
85.17 if an ordering health care provider determines that the provision of a replacement device,
85.18 or a replacement part of a device, is necessary because:

85.19 (1) of a change in the physiological condition of the patient;

85.20 (2) of an irreparable change in the condition of the device or in a part of the device; or

85.21 (3) the condition of the device, or the part of the device, requires repairs and the cost of
85.22 the repairs would be more than 60 percent of the cost of a replacement device or of the part
85.23 being replaced.

85.24 (g) Confirmation from a prescribing health care provider may be required if the prosthetic
85.25 or custom orthotic device or part being replaced is less than three years old.

85.26 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health
85.27 plans offered, issued, or renewed on or after that date.

85.28 **Sec. 45. [62Q.679] RELIGIOUS OBJECTIONS.**

85.29 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

85.30 (b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has
85.31 more than 50 percent of the value of its ownership interest owned directly or indirectly by

86.1 five or fewer owners, and has no publicly traded ownership interest. For purposes of this
86.2 paragraph:

86.3 (1) ownership interests owned by a corporation, partnership, limited liability company,
86.4 estate, trust, or similar entity are considered owned by that entity's shareholders, partners,
86.5 members, or beneficiaries in proportion to their interest held in the corporation, partnership,
86.6 limited liability company, estate, trust, or similar entity;

86.7 (2) ownership interests owned by a nonprofit entity are considered owned by a single
86.8 owner;

86.9 (3) ownership interests owned by all individuals in a family are considered held by a
86.10 single owner. For purposes of this clause, "family" means brothers and sisters, including
86.11 half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

86.12 (4) if an individual or entity holds an option, warrant, or similar right to purchase an
86.13 ownership interest, the individual or entity is considered to be the owner of those ownership
86.14 interests.

86.15 (c) "Eligible organization" means an organization that opposes covering some or all
86.16 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of religious
86.17 objections and that is:

86.18 (1) organized as a nonprofit entity and holds itself out to be religious; or

86.19 (2) organized and operates as a closely held for-profit entity, and the organization's
86.20 owners or highest governing body has adopted, under the organization's applicable rules of
86.21 governance and consistent with state law, a resolution or similar action establishing that the
86.22 organization objects to covering some or all health benefits under section 62Q.522, 62Q.524,
86.23 or 62Q.585 on account of the owners' sincerely held religious beliefs.

86.24 (d) "Exempt organization" means an organization that is organized and operates as a
86.25 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal
86.26 Revenue Code of 1986, as amended.

86.27 Subd. 2. **Exemption.** (a) An exempt organization is not required to provide coverage
86.28 under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious
86.29 objections to the coverage. An exempt organization that chooses to not provide coverage
86.30 pursuant to this paragraph must notify employees as part of the hiring process and must
86.31 notify all employees at least 30 days before:

86.32 (1) an employee enrolls in the health plan; or

87.1 (2) the effective date of the health plan, whichever occurs first.

87.2 (b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524,
87.3 or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of
87.4 such coverage which the organization refuses to cover.

87.5 Subd. 3. Accommodation for eligible organizations. (a) A health plan established or
87.6 maintained by an eligible organization complies with the coverage requirements of section
87.7 62Q.522, 62Q.524, or 62Q.585, with respect to the health benefits identified in the notice
87.8 under this paragraph, if the eligible organization provides notice to any health plan company
87.9 with which the eligible organization contracts that it is an eligible organization and that the
87.10 eligible organization has a religious objection to coverage for all or a subset of the health
87.11 benefits under section 62Q.522, 62Q.524, or 62Q.585.

87.12 (b) The notice from an eligible organization to a health plan company under paragraph
87.13 (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to
87.14 coverage for some or all of the health benefits under section 62Q.522, 62Q.524, or 62Q.585,
87.15 including a list of the health benefits to which the eligible organization objects, if applicable;
87.16 and (3) the health plan name. The notice must be executed by a person authorized to provide
87.17 notice on behalf of the eligible organization.

87.18 (c) An eligible organization must provide a copy of the notice under paragraph (a) to
87.19 prospective employees as part of the hiring process and to all employees at least 30 days
87.20 before:

87.21 (1) an employee enrolls in the health plan; or

87.22 (2) the effective date of the health plan, whichever occurs first.

87.23 (d) A health plan company that receives a copy of the notice under paragraph (a) with
87.24 respect to a health plan established or maintained by an eligible organization must, for all
87.25 future enrollments in the health plan:

87.26 (1) expressly exclude coverage for those health benefits identified in the notice under
87.27 paragraph (a) from the health plan; and

87.28 (2) provide separate payments for any health benefits required to be covered under
87.29 section 62Q.522, 62Q.524, or 62Q.585 for enrollees as long as the enrollee remains enrolled
87.30 in the health plan.

87.31 (e) The health plan company must not impose any cost-sharing requirements, including
87.32 co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or
87.33 other charge for the health benefits under section 62Q.522 on the enrollee. The health plan

88.1 company must not directly or indirectly impose any premium, fee, or other charge for the
88.2 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization
88.3 or health plan.

88.4 (f) On January 1, 2024, and every year thereafter a health plan company must notify the
88.5 commissioner, in a manner determined by the commissioner, of the number of eligible
88.6 organizations granted an accommodation under this subdivision.

88.7 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
88.8 plans offered, sold, issued, or renewed on or after that date.

88.9 Sec. 46. Minnesota Statutes 2022, section 62Q.73, subdivision 2, is amended to read:

88.10 Subd. 2. **Exception.** (a) This section does not apply to governmental programs except
88.11 as permitted under paragraph (b). For purposes of this subdivision, "governmental programs"
88.12 means the prepaid medical assistance program; effective January 1, 2026, the medical
88.13 assistance fee-for-service program; the MinnesotaCare program; the demonstration project
88.14 for people with disabilities; and the federal Medicare program.

88.15 (b) In the course of a recipient's appeal of a medical determination to the commissioner
88.16 of human services under section 256.045, the recipient may request an expert medical
88.17 opinion be arranged by the external review entity under contract to provide independent
88.18 external reviews under this section. If such a request is made, the cost of the review shall
88.19 be paid by the commissioner of human services. Any medical opinion obtained under this
88.20 paragraph shall only be used by a state human services judge as evidence in the recipient's
88.21 appeal to the commissioner of human services under section 256.045.

88.22 (c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights
88.23 provided in section 256.045 for governmental program recipients.

88.24 Sec. 47. Minnesota Statutes 2022, section 62V.05, subdivision 12, is amended to read:

88.25 Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The
88.26 MNSure Board shall provide ~~quarterly reports to the chairs and ranking minority members~~
88.27 ~~of the legislative committees with jurisdiction over health and human services policy and~~
88.28 ~~finance on:~~ legislative reports on interagency agreements and intra-agency transfers according
88.29 to section 15.0395.

88.30 ~~(1) interagency agreements or service-level agreements and any renewals or extensions~~
88.31 ~~of existing interagency or service-level agreements with a state department under section~~
88.32 ~~15.01, state agency under section 15.012, or the Department of Information Technology~~

89.1 ~~Services, with a value of more than \$100,000, or related agreements with the same department~~
89.2 ~~or agency with a cumulative value of more than \$100,000; and~~

89.3 ~~(2) transfers of appropriations of more than \$100,000 between accounts within or between~~
89.4 ~~agencies.~~

89.5 ~~The report must include the statutory citation authorizing the agreement, transfer or dollar~~
89.6 ~~amount, purpose, and effective date of the agreement, the duration of the agreement, and a~~
89.7 ~~copy of the agreement.~~

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

89.9 Sec. 48. Minnesota Statutes 2022, section 62V.08, is amended to read:

89.10 **62V.08 REPORTS.**

89.11 (a) MNsure shall submit a report to the legislature by ~~January 15, 2015~~ March 31, 2025,
89.12 and each ~~January 15~~ March 31 thereafter, on: (1) the performance of MNsure operations;
89.13 (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4)
89.14 practices and procedures that have been implemented to ensure compliance with data
89.15 practices laws, and a description of any violations of data practices laws or procedures; and
89.16 (5) the effectiveness of the outreach and implementation activities of MNsure in reducing
89.17 the rate of uninsurance.

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

89.25 Sec. 49. Minnesota Statutes 2022, section 62V.11, subdivision 4, is amended to read:

89.26 Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure
89.27 for the next fiscal year by ~~March 15~~ 31 of each year, beginning ~~March 15, 2014~~ 31, 2025.

89.28 Sec. 50. Minnesota Statutes 2023 Supplement, section 145D.01, subdivision 1, is amended
89.29 to read:

89.30 Subdivision 1. **Definitions.** (a) For purposes of this ~~chapter~~ section and section 145D.02,
89.31 the following terms have the meanings given.

90.1 (b) "Captive professional entity" means a professional corporation, limited liability
90.2 company, or other entity formed to render professional services in which a beneficial owner
90.3 is a health care provider employed by, controlled by, or subject to the direction of a hospital
90.4 or hospital system.

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

90.6 (d) "Control," including the terms "controlling," "controlled by," and "under common
90.7 control with," means the possession, direct or indirect, of the power to direct or cause the
90.8 direction of the management and policies of a health care entity, whether through the
90.9 ownership of voting securities, membership in an entity formed under chapter 317A, by
90.10 contract other than a commercial contract for goods or nonmanagement services, or otherwise,
90.11 unless the power is the result of an official position with, corporate office held by, or court
90.12 appointment of, the person. Control is presumed to exist if any person, directly or indirectly,
90.13 owns, controls, holds with the power to vote, or holds proxies representing 40 percent or
90.14 more of the voting securities of any other person, or if any person, directly or indirectly,
90.15 constitutes 40 percent or more of the membership of an entity formed under chapter 317A.
90.16 The attorney general may determine that control exists in fact, notwithstanding the absence
90.17 of a presumption to that effect.

90.18 (e) "Health care entity" means:

90.19 (1) a hospital;

90.20 (2) a hospital system;

90.21 (3) a captive professional entity;

90.22 (4) a medical foundation;

90.23 (5) a health care provider group practice;

90.24 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

90.25 (7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

90.26 (f) "Health care provider" means a physician licensed under chapter 147, a physician
90.27 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined
90.28 in section 148.171, subdivision 3, who provides health care services, including but not
90.29 limited to medical care, consultation, diagnosis, or treatment.

90.30 (g) "Health care provider group practice" means two or more health care providers legally
90.31 organized in a partnership, professional corporation, limited liability company, medical
90.32 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

91.1 (1) in which each health care provider who is a member of the group provides services
91.2 that a health care provider routinely provides, including but not limited to medical care,
91.3 consultation, diagnosis, and treatment, through the joint use of shared office space, facilities,
91.4 equipment, or personnel;

91.5 (2) for which substantially all services of the health care providers who are group
91.6 members are provided through the group and are billed in the name of the group practice
91.7 and amounts so received are treated as receipts of the group; or

91.8 (3) in which the overhead expenses of, and the income from, the group are distributed
91.9 in accordance with methods previously determined by members of the group.

91.10 An entity that otherwise meets the definition of health care provider group practice in this
91.11 paragraph shall be considered a health care provider group practice even if its shareholders,
91.12 partners, members, or owners include a professional corporation, limited liability company,
91.13 or other entity in which any beneficial owner is a health care provider and that is formed to
91.14 render professional services.

91.15 (h) "Hospital" means a health care facility licensed as a hospital under sections 144.50
91.16 to 144.56.

91.17 (i) "Medical foundation" means a nonprofit legal entity through which health care
91.18 providers perform research or provide medical services.

91.19 (j) "Transaction" means a single action, or a series of actions within a five-year period,
91.20 which occurs in part within the state of Minnesota or involves a health care entity formed
91.21 or licensed in Minnesota, that constitutes:

91.22 (1) a merger or exchange of a health care entity with another entity;

91.23 (2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity
91.24 to another entity;

91.25 (3) the granting of a security interest of 40 percent or more of the property and assets
91.26 of a health care entity to another entity;

91.27 (4) the transfer of 40 percent or more of the shares or other ownership of a health care
91.28 entity to another entity;

91.29 (5) an addition, removal, withdrawal, substitution, or other modification of one or more
91.30 members of the health care entity's governing body that transfers control, responsibility for,
91.31 or governance of the health care entity to another entity;

91.32 (6) the creation of a new health care entity;

92.1 (7) an agreement or series of agreements that results in the sharing of 40 percent or more
92.2 of the health care entity's revenues with another entity, including affiliates of such other
92.3 entity;

92.4 (8) an addition, removal, withdrawal, substitution, or other modification of the members
92.5 of a health care entity formed under chapter 317A that results in a change of 40 percent or
92.6 more of the membership of the health care entity; or

92.7 (9) any other transfer of control of a health care entity to, or acquisition of control of a
92.8 health care entity by, another entity.

92.9 (k) A transaction as defined in paragraph (j) does not include:

92.10 (1) an action or series of actions that meets one or more of the criteria set forth in
92.11 paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care
92.12 entity directly, or indirectly through one or more intermediaries, controls, is controlled by,
92.13 or is under common control with, all other parties to the action or series of actions;

92.14 (2) a mortgage or other secured loan for business improvement purposes entered into
92.15 by a health care entity that does not directly affect delivery of health care or governance of
92.16 the health care entity;

92.17 (3) a clinical affiliation of health care entities formed solely for the purpose of
92.18 collaborating on clinical trials or providing graduate medical education;

92.19 (4) the mere offer of employment to, or hiring of, a health care provider by a health care
92.20 entity;

92.21 (5) contracts between a health care entity and a health care provider primarily for clinical
92.22 services; or

92.23 (6) a single action or series of actions within a five-year period involving only entities
92.24 that operate solely as a nursing home licensed under chapter 144A; a boarding care home
92.25 licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections
92.26 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting
92.27 licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that
92.28 is not the primary residence of the license holder; a community residential setting as defined
92.29 in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471
92.30 to 144A.483.

93.1 Sec. 51. **[145D.30] DEFINITIONS.**

93.2 **Subdivision 1. Application.** For purposes of sections 145D.30 to 145D.37, the following
93.3 terms have the meanings given unless the context clearly indicates otherwise.

93.4 **Subd. 2. Commissioner** "Commissioner" means the commissioner of commerce for a
93.5 nonprofit health coverage entity that is a nonprofit health service plan corporation operating
93.6 under chapter 62C or the commissioner of health for a nonprofit health coverage entity that
93.7 is a nonprofit health maintenance organization operating under chapter 62D.

93.8 **Subd. 3. Control.** "Control," including the terms "controlling," "controlled by," and
93.9 "under common control with," means the possession, direct or indirect, of the power to
93.10 direct or cause the direction of the management and policies of a nonprofit health coverage
93.11 entity, whether through the ownership of voting securities, through membership in an entity
93.12 formed under chapter 317A, by contract other than a commercial contract for goods or
93.13 nonmanagement services, or otherwise, unless the power is the result of an official position
93.14 with, corporate office held by, or court appointment of the person. Control is presumed to
93.15 exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or
93.16 holds proxies representing 40 percent or more of the voting securities of any other person
93.17 or if any person, directly or indirectly, constitutes 40 percent or more of the membership
93.18 of an entity formed under chapter 317A. The attorney general may determine that control
93.19 exists in fact, notwithstanding the absence of a presumption to that effect.

93.20 **Subd. 4. Conversion benefit entity.** "Conversion benefit entity" means a foundation,
93.21 corporation, limited liability company, trust, partnership, or other entity that receives, in
93.22 connection with a conversion transaction, the value of any public benefit asset in accordance
93.23 with section 145D.32, subdivision 5.

93.24 **Subd. 5. Conversion transaction.** "Conversion transaction" means a transaction otherwise
93.25 permitted under applicable law in which a nonprofit health coverage entity:

93.26 (1) merges, consolidates, converts, or transfers all or substantially all of its assets to any
93.27 entity except a corporation that is exempt under United States Code, title 26, section
93.28 501(c)(3);

93.29 (2) makes a series of separate transfers within a 60-month period that in the aggregate
93.30 constitute a transfer of all or substantially all of the nonprofit health coverage entity's assets
93.31 to any entity except a corporation that is exempt under United States Code, title 26, section
93.32 501(c)(3); or

94.1 (3) adds or substitutes one or more directors or officers that effectively transfer the
94.2 control of, responsibility for, or governance of the nonprofit health coverage entity to any
94.3 entity except a corporation that is exempt under United States Code, title 26, section
94.4 501(c)(3).

94.5 Subd. 6. **Corporation.** "Corporation" has the meaning given in section 317A.011,
94.6 subdivision 6, and also includes a nonprofit limited liability company organized under
94.7 section 322C.1101.

94.8 Subd. 7. **Director.** "Director" has the meaning given in section 317A.011, subdivision
94.9 7.

94.10 Subd. 8. **Family member.** "Family member" means a spouse, parent, child, spouse of
94.11 a child, brother, sister, or spouse of a brother or sister.

94.12 Subd. 9. **Full and fair value.** "Full and fair value" means at least the amount that the
94.13 public benefit assets of the nonprofit health coverage entity would be worth if the assets
94.14 were equal to stock in the nonprofit health coverage entity, if the nonprofit health coverage
94.15 entity was a for-profit corporation and if the nonprofit health coverage entity had 100 percent
94.16 of its stock authorized by the corporation and available for purchase without transfer
94.17 restrictions. The valuation shall consider market value, investment or earning value, net
94.18 asset value, goodwill, amount of donations received, and control premium, if any.

94.19 Subd. 10. **Key employee.** "Key employee" means an individual, regardless of title, who:
94.20 (1) has responsibilities, power, or influence over an organization similar to those of an
94.21 officer or director;

94.22 (2) manages a discrete segment or activity of the organization that represents ten percent
94.23 or more of the activities, assets, income, or expenses of the organization, as compared to
94.24 the organization as a whole; or

94.25 (3) has or shares authority to control or determine ten percent or more of the organization's
94.26 capital expenditures, operating budget, or compensation for employees.

94.27 Subd. 11. **Nonprofit health coverage entity.** "Nonprofit health coverage entity" means
94.28 a nonprofit health service plan corporation operating under chapter 62C or a nonprofit health
94.29 maintenance organization operating under chapter 62D.

94.30 Subd. 12. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision
94.31 15.

95.1 Subd. 13. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit
95.2 health coverage entity's assets, whether tangible or intangible, including but not limited to
95.3 its goodwill and anticipated future revenue.

95.4 Subd. 14. **Related organization.** "Related organization" has the meaning given in section
95.5 317A.011, subdivision 18.

95.6 **Sec. 52. [145D.31] CERTAIN CONVERSION TRANSACTIONS PROHIBITED.**

95.7 A nonprofit health coverage entity must not enter into a conversion transaction if:

95.8 (1) doing so would result in less than the full and fair market value of all public benefit
95.9 assets remaining dedicated to the public benefit; or

95.10 (2) an individual who has been an officer, director, or other executive of the nonprofit
95.11 health coverage entity or of a related organization, or a family member of such an individual:

95.12 (i) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
95.13 securities, investment, or other financial interest in an entity to which the nonprofit health
95.14 coverage entity transfers public benefit assets in connection with the conversion transaction;

95.15 (ii) has received or will receive any type of compensation or other financial benefit from
95.16 an entity to which the nonprofit health coverage entity transfers public benefit assets in
95.17 connection with the conversion transaction;

95.18 (iii) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,
95.19 securities, investment, or other financial interest in an entity that has or will have a business
95.20 relationship with an entity to which the nonprofit health coverage entity transfers public
95.21 benefit assets in connection with the conversion transaction; or

95.22 (iv) has received or will receive any type of compensation or other financial benefit from
95.23 an entity that has or will have a business relationship with an entity to which the nonprofit
95.24 health coverage entity transfers public benefit assets in connection with the conversion
95.25 transaction.

95.26 **Sec. 53. [145D.32] REQUIREMENTS FOR NONPROFIT HEALTH COVERAGE**
95.27 **ENTITY CONVERSION TRANSACTIONS.**

95.28 Subdivision 1. **Notice.** (a) Before entering into a conversion transaction, a nonprofit
95.29 health coverage entity must notify the attorney general according to section 317A.811. In
95.30 addition to the elements listed in section 317A.811, subdivision 1, the notice required by
95.31 this subdivision must also include: (1) an itemization of the nonprofit health coverage entity's

96.1 public benefit assets and an independent third-party valuation of the nonprofit health coverage
96.2 entity's public benefit assets; (2) a proposed plan to distribute the value of those public
96.3 benefit assets to a conversion benefit entity that meets the requirements of section 145D.33;
96.4 and (3) other information contained in forms provided by the attorney general.

96.5 (b) When the nonprofit health coverage entity provides the attorney general with the
96.6 notice and other information required under paragraph (a), the nonprofit health coverage
96.7 entity must also provide a copy of this notice and other information to the applicable
96.8 commissioner.

96.9 Subd. 2. **Nonprofit health coverage entity requirements.** Before entering into a
96.10 conversion transaction, a nonprofit health coverage entity must ensure that:

96.11 (1) the proposed conversion transaction complies with chapters 317A and 501B and
96.12 other applicable laws;

96.13 (2) the proposed conversion transaction does not involve or constitute a breach of
96.14 charitable trust;

96.15 (3) the nonprofit health coverage entity shall receive full and fair value for its public
96.16 benefit assets;

96.17 (4) the value of the public benefit assets to be transferred has not been manipulated in
96.18 a manner that causes or caused the value of the assets to decrease;

96.19 (5) the proceeds of the proposed conversion transaction shall be used in a manner
96.20 consistent with the public benefit for which the assets are held by the nonprofit health
96.21 coverage entity;

96.22 (6) the proposed conversion transaction shall not result in a breach of fiduciary duty;
96.23 and

96.24 (7) the conversion benefit entity that receives the value of the nonprofit health coverage
96.25 entity's public benefit assets meets the requirements in section 145D.33.

96.26 Subd. 3. **Listening sessions and public comment.** The attorney general or the
96.27 commissioner may hold public listening sessions or forums and may solicit public comments
96.28 regarding the proposed conversion transaction, including on the formation of a conversion
96.29 benefit entity under section 145D.33.

96.30 Subd. 4. **Waiting period.** (a) Subject to paragraphs (b) and (c), a nonprofit health
96.31 coverage entity must not enter into a conversion transaction until 90 days after the nonprofit
96.32 health coverage entity has given written notice as required in subdivision 1.

97.1 (b) The attorney general may waive all or part of the waiting period or may extend the
97.2 waiting period for an additional 90 days by notifying the nonprofit health coverage entity
97.3 of the extension in writing.

97.4 (c) The time periods specified in this subdivision shall be suspended while an
97.5 investigation into the conversion transaction is pending or while a request from the attorney
97.6 general for additional information is outstanding.

97.7 Subd. 5. **Transfer of value of assets required.** As part of a conversion transaction for
97.8 which notice is provided under subdivision 1, the nonprofit health coverage entity must
97.9 transfer the entirety of the full and fair value of its public benefit assets to one or more
97.10 conversion benefit entities that meet the requirements in section 145D.33.

97.11 Subd. 6. **Funds restricted for a particular purpose.** Nothing in this section relieves a
97.12 nonprofit health coverage entity from complying with requirements for funds that are
97.13 restricted for a particular purpose. Funds restricted for a particular purpose must continue
97.14 to be used in accordance with the purpose for which they were restricted under sections
97.15 317A.671 and 501B.31. A nonprofit health coverage entity may not convert assets that
97.16 would conflict with their restricted purpose.

97.17 Sec. 54. **[145D.33] CONVERSION BENEFIT ENTITY REQUIREMENTS.**

97.18 Subdivision 1. **Requirements.** In order to receive the value of a nonprofit health coverage
97.19 entity's public benefit assets as part of a conversion transaction, a conversion benefit entity
97.20 must:

97.21 (1) be: (i) an existing or new domestic, nonprofit corporation operating under chapter
97.22 317A, a nonprofit limited liability company operating under chapter 322C, or a wholly
97.23 owned subsidiary thereof; and (ii) exempt under United States Code, title 26, section
97.24 501(c)(3);

97.25 (2) have in place procedures and policies to prohibit conflicts of interest, including but
97.26 not limited to conflicts of interest relating to any grant-making activities that may benefit:

97.27 (i) the officers, directors, or key employees of the conversion benefit entity;

97.28 (ii) any entity to which the nonprofit health coverage entity transfers public benefit assets
97.29 in connection with a conversion transaction; or

97.30 (iii) any officers, directors, or key employees of an entity to which the nonprofit health
97.31 coverage entity transfers public benefit assets in connection with a conversion transaction;

97.32 (3) operate to benefit the health of the people in this state;

98.1 (4) have in place procedures and policies that prohibit:

98.2 (i) an officer, director, or key employee of the nonprofit health coverage entity from
98.3 -serving as an officer, director, or key employee of the conversion benefit entity for the
98.4 five-year period following the conversion transaction;

98.5 (ii) an officer, director, or key employee of the nonprofit health coverage entity or of
98.6 the conversion benefit entity from directly or indirectly benefiting from the conversion
98.7 transaction; and

98.8 (iii) elected or appointed public officials from serving as an officer, director, or key
98.9 employee of the conversion benefit entity;

98.10 (5) not make grants or payments or otherwise provide financial benefit to an entity to
98.11 which a nonprofit health coverage entity transfers public benefit assets as part of a conversion
98.12 transaction or to a related organization of the entity to which the nonprofit health coverage
98.13 entity transfers public benefit assets as part of a conversion transaction; and

98.14 (6) not have as an officer director, or key employee any individual who has been an
98.15 officer, director, or key employee of an entity that receives public benefit assets as part of
98.16 a conversion transaction.

98.17 Subd. 2. **Review and approval.** The commissioner must review and approve a conversion
98.18 benefit entity before the conversion benefit entity receives the value of public benefit assets
98.19 from a nonprofit health coverage entity. In order to be approved under this subdivision, the
98.20 conversion benefit entity's governance must be broadly based in the community served by
98.21 the nonprofit health coverage entity and must be independent of the entity to which the
98.22 nonprofit health coverage entity transfers public benefit assets as part of the conversion
98.23 transaction. As part of the review of the conversion benefit entity's governance, the
98.24 commissioner may hold a public hearing. The public hearing, if held by the commissioner
98.25 of health, may be held concurrently with the hearing authorized under section 62D.31. If
98.26 the commissioner finds it necessary, a portion of the value of the public benefit assets must
98.27 be used to develop a community-based plan for use by the conversion benefit entity.

98.28 Subd. 3. **Community advisory committee.** The commissioner must establish a
98.29 community advisory committee for a conversion benefit entity receiving the value of public
98.30 benefit assets. The members of the community advisory committee must be selected to
98.31 represent the diversity of the community previously served by the nonprofit health coverage
98.32 entity. The community advisory committee must:

99.1 (1) provide a slate of three nominees for each vacancy on the governing board of the
99.2 conversion benefit entity, from which the remaining board members must select new
99.3 members to the board;

99.4 (2) provide the conversion benefit entity's governing board with guidance on the health
99.5 needs of the community previously served by the nonprofit health coverage entity; and

99.6 (3) promote dialogue and information sharing between the conversion benefit entity and
99.7 the community previously served by the nonprofit health coverage entity.

99.8 **Sec. 55. [145D.34] ENFORCEMENT AND REMEDIES.**

99.9 Subdivision 1. **Investigation.** The attorney general has the powers in section 8.31.
99.10 Nothing in this subdivision limits the powers, remedies, or responsibilities of the attorney
99.11 general under this chapter; chapter 8, 309, 317A, or 501B; or any other chapter. For purposes
99.12 of this section, an approval by the commissioner for regulatory purposes does not impair
99.13 or inform the attorney general's authority.

99.14 Subd. 2. **Enforcement and penalties.** (a) The attorney general may bring an action in
99.15 district court to enjoin or unwind a conversion transaction or seek other equitable relief
99.16 necessary to protect the public interest if:

99.17 (1) a nonprofit health coverage entity or conversion transaction violates sections 145D.30
99.18 to 145D.33; or

99.19 (2) the conversion transaction is contrary to the public interest.

99.20 In seeking injunctive relief, the attorney general must not be required to establish irreparable
99.21 harm but must instead establish that a violation of sections 145D.30 to 145D.33 occurred
99.22 or that the requested order promotes the public interest.

99.23 (b) Factors informing whether a conversion transaction is contrary to the public interest
99.24 include but are not limited to whether:

99.25 (1) the conversion transaction shall result in increased health care costs for patients; and

99.26 (2) the conversion transaction shall adversely impact provider cost trends and containment
99.27 of total health care spending.

99.28 (c) The attorney general may enforce sections 145D.30 to 145D.33 under section 8.31.

99.29 (d) Failure of the entities involved in a conversion transaction to provide timely
99.30 information as required by the attorney general or the commissioner shall be an independent
99.31 and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable

100.1 relief, provided the attorney general notifies the entities of the inadequacy of the information
100.2 provided and provides the entities with a reasonable opportunity to remedy the inadequacy.

100.3 (e) An officer, director, or other executive found to have violated sections 145D.30 to
100.4 145D.33 shall be subject to a civil penalty of up to \$100,000 for each violation. A corporation
100.5 or other entity which is a party to or materially participated in a conversion transaction
100.6 found to have violated sections 145D.30 to 145D.33 shall be subject to a civil penalty of
100.7 up to \$1,000,000. A court may also award reasonable attorney fees and costs of investigation
100.8 and litigation.

100.9 Subd. 3. **Commissioner of health; data and research.** The commissioner of health
100.10 must provide the attorney general, upon request, with data and research on broader market
100.11 trends, impacts on prices and outcomes, public health and population health considerations,
100.12 and health care access, for the attorney general to use when evaluating whether a conversion
100.13 transaction is contrary to public interest. The commissioner may share with the attorney
100.14 general, according to section 13.05, subdivision 9, any not public data, as defined in section
100.15 13.02, subdivision 8a, held by the commissioner to aid in the investigation and review of
100.16 the conversion transaction, and the attorney general must maintain this data with the same
100.17 classification according to section 13.03, subdivision 4, paragraph (c).

100.18 Subd. 4. **Failure to take action.** Failure by the attorney general to take action with
100.19 respect to a conversion transaction under this section does not constitute approval of the
100.20 conversion transaction or waiver, nor shall failure prevent the attorney general from taking
100.21 action in the same, similar, or subsequent circumstances.

100.22 Sec. 56. **[145D.35] DATA PRACTICES.**

100.23 Section 13.65 applies to data provided by a nonprofit health coverage entity or the
100.24 commissioner to the attorney general under sections 145D.30 to 145D.33. Section 13.39
100.25 applies to data provided by a nonprofit health coverage entity to the commissioner under
100.26 sections 145D.30 to 145D.33. The attorney general or the commissioner may make any
100.27 data classified as confidential or protected nonpublic under this section accessible to any
100.28 civil or criminal law enforcement agency if the attorney general or commissioner determines
100.29 that the access aids the law enforcement process.

100.30 Sec. 57. **[145D.36] COMMISSIONER OF HEALTH; REPORTS AND ANALYSIS.**

100.31 Notwithstanding any law to the contrary, the commissioner of health may use data or
100.32 information submitted under sections 60A.135 to 60A.137, 60A.17, 60D.18, 60D.20,
100.33 62D.221, and 145D.32 to conduct analyses of the aggregate impact of transactions within

101.1 nonprofit health coverage entities and organizations which include nonprofit health coverage
101.2 entities or their affiliates on access to or the cost of health care services, health care market
101.3 consolidation, and health care quality. The commissioner of health must issue periodic
101.4 public reports on the number and types of conversion transactions subject to sections 145D.30
101.5 to 145D.35 and on the aggregate impact of conversion transactions on health care costs,
101.6 quality, and competition in Minnesota.

101.7 Sec. 58. **145D.37] RELATION TO OTHER LAW.**

101.8 (a) Sections 145D.30 to 145D.36 are in addition to and do not affect or limit any power,
101.9 remedy, or responsibility of a health maintenance organization, a service plan corporation,
101.10 a conversion benefit entity, the attorney general, the commissioner of health, or the
101.11 commissioner of commerce under this chapter; chapter 8, 62C, 62D, 309, 317A, or 501B;
101.12 or other law.

101.13 (b) Nothing in sections 145D.03 to 145D.36 authorizes a nonprofit health coverage entity
101.14 to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B
101.15 or other law.

101.16 Sec. 59. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

101.17 Subd. 12. ~~**Eyeglasses, dentures, and prosthetic and orthotic devices.**~~ (a) Medical
101.18 assistance covers eyeglasses, ~~dentures, and prosthetic and orthotic devices~~ if prescribed by
101.19 a licensed practitioner.

101.20 ~~(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"~~
101.21 ~~includes a physician, an advanced practice registered nurse, a physician assistant, or a~~
101.22 ~~podiatrist.~~

101.23 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
101.24 whichever is later. The commissioner of human services shall notify the revisor of statutes
101.25 when federal approval is obtained.

101.26 Sec. 60. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 16, is
101.27 amended to read:

101.28 Subd. 16. **Abortion services.** Medical assistance covers ~~abortion services determined~~
101.29 ~~to be medically necessary by the treating provider and delivered in accordance with all~~
101.30 ~~applicable Minnesota laws~~ abortions and abortion-related services, including preabortion
101.31 services and follow-up services.

102.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
102.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
102.3 when federal approval is obtained.

102.4 Sec. 61. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
102.5 to read:

102.6 Subd. 25c. **Applicability of utilization review provisions.** Effective January 1, 2026,
102.7 the following provisions of chapter 62M apply to the commissioner when delivering services
102.8 through fee-for-service under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to
102.9 12, 13, 14 to 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to
102.10 3; 62M.07; 62M.072; 62M.09; 62M.10; 62M.12; and 62M.17, subdivision 2.

102.11 Sec. 62. Minnesota Statutes 2022, section 256B.0625, subdivision 32, is amended to read:

102.12 Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed
102.13 for nutritional supplementation because solid food or nutrients thereof cannot be properly
102.14 absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple
102.15 syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or
102.16 any other childhood or adult diseases, conditions, or disorders identified by the commissioner
102.17 as requiring a similarly necessary nutritional product. Medical assistance covers amino
102.18 acid-based elemental formulas in the same manner as is required under section 62Q.531.
102.19 Nutritional products needed for the treatment of a combined allergy to human milk, cow's
102.20 milk, and soy formula require prior authorization. Separate payment shall not be made for
102.21 nutritional products for residents of long-term care facilities. Payment for dietary
102.22 requirements is a component of the per diem rate paid to these facilities.

102.23 **EFFECTIVE DATE.** This section is effective January 1, 2025.

102.24 Sec. 63. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
102.25 to read:

102.26 Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and
102.27 prosthetic devices, supplies, and services according to section 256B.066.

102.28 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
102.29 whichever is later. The commissioner of human services shall notify the revisor of statutes
102.30 when federal approval is obtained.

103.1 Sec. 64. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
103.2 to read:

103.3 Subd. 73. **Rapid whole genome sequencing.** Medical assistance covers rapid whole
103.4 genome sequencing (rWGS) testing. Coverage and eligibility for rWGS testing, and the use
103.5 of genetic data, must meet the requirements specified in section 62A.3098, subdivisions 1
103.6 to 3 and 6.

103.7 **EFFECTIVE DATE.** This section is effective January 1, 2025.

103.8 Sec. 65. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
103.9 to read:

103.10 Subd. 74. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses
103.11 prescribed for hair loss suffered as a result of treatment for cancer. Medical assistance must
103.12 meet the requirements that would otherwise apply to a health plan under section 62A.28,
103.13 except for the limitation on coverage required per benefit year set forth in section 62A.28,
103.14 subdivision 2, paragraph (c).

103.15 **EFFECTIVE DATE.** This section is effective January 1, 2025.

103.16 Sec. 66. **[256B.066] ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND**
103.17 **SERVICES.**

103.18 Subdivision 1. **Definitions.** All terms used in this section have the meanings given them
103.19 in section 62Q.665, subdivision 1.

103.20 Subd. 2. **Coverage requirements.** (a) Medical assistance covers orthotic and prosthetic
103.21 devices, supplies, and services:

103.22 (1) furnished under an order by a prescribing physician or licensed health care prescriber
103.23 who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic
103.24 and prosthetic devices, supplies, accessories, and services under this clause includes those
103.25 devices or device systems, supplies, accessories, and services that are customized to the
103.26 enrollee's needs;

103.27 (2) determined by the enrollee's provider to be the most appropriate model that meets
103.28 the medical needs of the enrollee for purposes of performing physical activities, as applicable,
103.29 including but not limited to running, biking, and swimming, and maximizing the enrollee's
103.30 limb function; or

103.31 (3) for showering or bathing.

104.1 (b) The coverage set forth in paragraph (a) includes the repair and replacement of those
104.2 orthotic and prosthetic devices, supplies, and services described therein.

104.3 (c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with
104.4 limb loss or absence that would otherwise be covered for a nondisabled person seeking
104.5 medical or surgical intervention to restore or maintain the ability to perform the same
104.6 physical activity.

104.7 (d) If coverage for prosthetic or custom orthotic devices is provided, payment must be
104.8 made for the replacement of a prosthetic or custom orthotic device or for the replacement
104.9 of any part of the devices, without regard to useful lifetime restrictions, if an ordering health
104.10 care provider determines that the provision of a replacement device, or a replacement part
104.11 of a device, is necessary because:

104.12 (1) of a change in the physiological condition of the enrollee;

104.13 (2) of an irreparable change in the condition of the device or in a part of the device; or

104.14 (3) the condition of the device, or the part of the device, requires repairs and the cost of
104.15 the repairs would be more than 60 percent of the cost of a replacement device or of the part
104.16 being replaced.

104.17 Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic
104.18 and prosthetic devices, supplies, and services.

104.19 (b) A utilization review for a request for coverage of prosthetic or orthotic benefits must
104.20 apply the most recent version of evidence-based treatment and fit criteria as recognized by
104.21 relevant clinical specialists.

104.22 (c) Utilization review determinations must be rendered in a nondiscriminatory manner
104.23 and must not deny coverage for habilitative or rehabilitative benefits, including prosthetics
104.24 or orthotics, solely on the basis of an enrollee's actual or perceived disability.

104.25 (d) Evidence of coverage and any benefit denial letters must include language describing
104.26 an enrollee's rights pursuant to paragraphs (b) and (c).

104.27 (e) Confirmation from a prescribing health care provider may be required if the prosthetic
104.28 or custom orthotic device or part being replaced is less than three years old.

104.29 Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based
104.30 purchasing plans subject to this section must ensure access to medically necessary clinical
104.31 care and to prosthetic and custom orthotic devices and technology from at least two distinct
104.32 prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

105.1 (b) In the event that medically necessary covered orthotics and prosthetics are not
105.2 available from an in-network provider, the plan must provide processes to refer an enrollee
105.3 to an out-of-network provider and must fully reimburse the out-of-network provider at a
105.4 mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

105.5 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
105.6 whichever is later. The commissioner of human services shall notify the revisor of statutes
105.7 when federal approval is obtained.

105.8 Sec. 67. Minnesota Statutes 2022, section 317A.811, subdivision 1, is amended to read:

105.9 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following
105.10 corporations shall notify the attorney general of their intent to dissolve, merge, consolidate,
105.11 or convert, or to transfer all or substantially all of their assets:

105.12 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,
105.13 subdivision 2; ~~or~~

105.14 (2) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code
105.15 of 1986, or any successor section; or

105.16 (3) a nonprofit health coverage entity as defined in section 145D.30.

105.17 (b) The notice must include:

105.18 (1) the purpose of the corporation that is giving the notice;

105.19 (2) a list of assets owned or held by the corporation for charitable purposes;

105.20 (3) a description of restricted assets and purposes for which the assets were received;

105.21 (4) a description of debts, obligations, and liabilities of the corporation;

105.22 (5) a description of tangible assets being converted to cash and the manner in which
105.23 they will be sold;

105.24 (6) anticipated expenses of the transaction, including attorney fees;

105.25 (7) a list of persons to whom assets will be transferred, if known, or the name of the
105.26 converted organization;

105.27 (8) the purposes of persons receiving the assets or of the converted organization; and

105.28 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred or
105.29 converted assets.

105.30 The notice must be signed on behalf of the corporation by an authorized person.

106.1 Sec. 68. **COMMISSIONER OF HEALTH; ANALYSIS AND REPORT TO THE**
106.2 **LEGISLATURE.**

106.3 (a) The commissioner of health must use the data submitted by utilization review
106.4 organizations under Minnesota Statutes, section 62M.19, and other data available to the
106.5 commissioner to analyze the use of utilization management tools, including prior
106.6 authorization, in health care. The analysis must evaluate the effect utilization management
106.7 tools have on patient access to care, the administrative burden the use of utilization
106.8 management tools places on health care providers, and system costs. The commissioner
106.9 must also develop recommendations on how to simplify health insurance prior authorization
106.10 standards and processes to improve health care access, reduce delays in care, reduce the
106.11 administrative burden on health care providers, and maximize quality of care, including
106.12 recommendations for a prior authorization exemption process for providers and group
106.13 practices that have an authorization rate for all submitted requests for authorization at or
106.14 above a level determined by the commissioner as qualifying for the exemption. When
106.15 conducting the analysis and developing recommendations, the commissioner must consult,
106.16 as appropriate, with physicians, other providers, health plan companies, consumers, and
106.17 other health care experts.

106.18 (b) The commissioner must issue a report to the legislature by December 15, 2026,
106.19 containing the commissioner's analysis and recommendations under paragraph (a).

106.20 Sec. 69. **INITIAL REPORTS TO COMMISSIONER OF HEALTH; UTILIZATION**
106.21 **MANAGEMENT TOOLS.**

106.22 Utilization review organizations must submit initial reports to the commissioner of health
106.23 under Minnesota Statutes, section 62M.19, by September 1, 2025.

106.24 Sec. 70. **TRANSITION.**

106.25 (a) A health maintenance organization that has a certificate of authority under Minnesota
106.26 Statutes, chapter 62D, but that is not a nonprofit corporation organized under Minnesota
106.27 Statutes, chapter 317A, or a local governmental unit, as defined in Minnesota Statutes,
106.28 section 62D.02, subdivision 11:

106.29 (1) must not offer, sell, issue, or renew any health maintenance contracts on or after
106.30 August 1, 2024;

106.31 (2) may otherwise continue to operate as a health maintenance organization until
106.32 December 31, 2025; and

107.1 (3) must provide notice to the health maintenance organization's enrollees as of August
107.2 1, 2024, of the date the health maintenance organization will cease to operate in this state
107.3 and any plans to transition enrollee coverage to another insurer. This notice must be provided
107.4 by October 1, 2024.

107.5 (b) The commissioner of health must not issue or renew a certificate of authority to
107.6 operate as a health maintenance organization on or after August 1, 2024, unless the entity
107.7 seeking the certificate of authority meets the requirements for a health maintenance
107.8 organization under Minnesota Statutes, chapter 62D, in effect on or after August 1, 2024.

107.9 Sec. 71. **REPEALER.**

107.10 (a) Minnesota Statutes 2022, section 62A.041, subdivision 3, is repealed.

107.11 (b) Minnesota Statutes 2023 Supplement, section 62Q.522, subdivisions 3 and 4, are
107.12 repealed.

107.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health
107.14 plans offered, sold, issued, or renewed on or after that date.

107.15

ARTICLE 5

107.16

DEPARTMENT OF HEALTH FINANCE

107.17 Section 1. Minnesota Statutes 2022, section 62D.14, subdivision 1, is amended to read:

107.18 Subdivision 1. **Examination authority.** The commissioner of health may make an
107.19 examination of the affairs of any health maintenance organization and its contracts,
107.20 agreements, or other arrangements with any participating entity as often as the commissioner
107.21 of health deems necessary for the protection of the interests of the people of this state, but
107.22 not less frequently than once every ~~three~~ five years. Examinations of participating entities
107.23 pursuant to this subdivision shall be limited to their dealings with the health maintenance
107.24 organization and its enrollees, except that examinations of major participating entities may
107.25 include inspection of the entity's financial statements kept in the ordinary course of business.
107.26 The commissioner may require major participating entities to submit the financial statements
107.27 directly to the commissioner. Financial statements of major participating entities are subject
107.28 to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major
107.29 participating entity or the health maintenance organization with which it contracts.

108.1 Sec. 2. Minnesota Statutes 2022, section 103I.621, subdivision 1, is amended to read:

108.2 Subdivision 1. **Permit.** (a) Notwithstanding any department or agency rule to the contrary,
108.3 the commissioner shall issue, on request by the owner of the property and payment of the
108.4 permit fee, permits for the reinjection of water by a properly constructed well into the same
108.5 aquifer from which the water was drawn for the operation of a groundwater thermal exchange
108.6 device.

108.7 (b) As a condition of the permit, an applicant must agree to allow inspection by the
108.8 commissioner during regular working hours for department inspectors.

108.9 (c) Not more than 200 permits may be issued for small systems having maximum
108.10 capacities of 20 gallons per minute or less and that are compliant with the natural resource
108.11 water-use requirements under subdivision 2. ~~The small systems are subject to inspection~~
108.12 ~~twice a year.~~

108.13 (d) Not more than ~~ten~~ 100 permits may be issued for larger systems having maximum
108.14 capacities ~~from over 20 to 50~~ gallons per minute and are compliant with the natural resource
108.15 water-use requirements under subdivision 2. ~~The larger systems are subject to inspection~~
108.16 ~~four times a year.~~

108.17 (e) A person issued a permit must comply with this section and permit conditions deemed
108.18 necessary to protect public health and safety of groundwater ~~for the permit to be valid.~~ The
108.19 permit conditions may include but are not limited to requirements for:

108.20 (1) notification to the commissioner at intervals specified in the permit conditions;

108.21 (2) system operation and maintenance;

108.22 (3) system location and construction;

108.23 (4) well location and construction;

108.24 (5) signage;

108.25 (6) reports of system construction, performance, operation, and maintenance;

108.26 (7) removal of the system upon termination of its use or system failure;

108.27 (8) disclosure of the system at the time of property transfer;

108.28 (9) obtaining approval from the commissioner prior to deviation from the approval plan
108.29 and conditions;

108.30 (10) groundwater level monitoring; or

108.31 (11) groundwater quality monitoring.

109.1 (f) The property owner or the property owner's agent must submit to the commissioner
109.2 a permit application on a form provided by the commissioner, or in a format approved by
109.3 the commissioner, that provides any information necessary to protect public health and
109.4 safety of groundwater.

109.5 (g) A permit granted under this section is not valid if a water-use permit is required for
109.6 the project and is not approved by the commissioner of natural resources.

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

109.8 Sec. 3. Minnesota Statutes 2022, section 103I.621, subdivision 2, is amended to read:

109.9 Subd. 2. **Water-use requirements apply.** Water-use permit requirements and penalties
109.10 under chapter ~~103F~~ 103G and related rules adopted and enforced by the commissioner of
109.11 natural resources apply to groundwater thermal exchange permit recipients. A person who
109.12 violates a provision of this section is subject to enforcement or penalties for the noncomplying
109.13 activity that are available to the commissioner and the Pollution Control Agency.

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

109.15 Sec. 4. Minnesota Statutes 2022, section 144.05, subdivision 6, is amended to read:

109.16 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The
109.17 commissioner of health shall provide ~~quarterly reports to the chairs and ranking minority~~
109.18 ~~members of the legislative committees with jurisdiction over health and human services~~
109.19 ~~policy and finance on:~~ the interagency agreements and intra-agency transfers report per
109.20 section 15.0395.

109.21 ~~(1) interagency agreements or service-level agreements and any renewals or extensions~~
109.22 ~~of existing interagency or service-level agreements with a state department under section~~
109.23 ~~15.01, state agency under section 15.012, or the Department of Information Technology~~
109.24 ~~Services, with a value of more than \$100,000, or related agreements with the same department~~
109.25 ~~or agency with a cumulative value of more than \$100,000; and~~

109.26 ~~(2) transfers of appropriations of more than \$100,000 between accounts within or between~~
109.27 ~~agencies.~~

109.28 ~~The report must include the statutory citation authorizing the agreement, transfer or dollar~~
109.29 ~~amount, purpose, and effective date of the agreement, duration of the agreement, and a copy~~
109.30 ~~of the agreement.~~

110.1 Sec. 5. Minnesota Statutes 2023 Supplement, section 144.1501, subdivision 2, is amended
110.2 to read:

110.3 Subd. 2. ~~Creation of account~~ Availability. (a) ~~A health professional education loan~~
110.4 ~~forgiveness program account is established.~~ The commissioner of health shall use money
110.5 ~~from the account to establish a~~ appropriated for health professional education loan forgiveness
110.6 program in this section:

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

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

110.13 (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate
110.14 care facility for persons with developmental disability; in a hospital if the hospital owns
110.15 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked
110.16 by the nurse is in the nursing home; in an assisted living facility as defined in section
110.17 144G.08, subdivision 7; or for a home care provider as defined in section 144A.43,
110.18 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing
110.19 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
110.20 level;

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

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

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

111.1 (7) for nurses employed as a hospital nurse by a nonprofit hospital and providing direct
111.2 care to patients at the nonprofit hospital.

111.3 (b) Appropriations made ~~to the account~~ for health professional education loan forgiveness
111.4 in this section do not cancel and are available until expended, except that at the end of each
111.5 biennium, any remaining balance in the account that is not committed by contract and not
111.6 needed to fulfill existing commitments shall cancel to the fund.

111.7 Sec. 6. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

111.8 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required
111.9 minimum commitment of service according to subdivision 3, the commissioner of health
111.10 shall collect from the participant the total amount paid to the participant under the loan
111.11 forgiveness program plus interest at a rate established according to section 270C.40. The
111.12 commissioner shall deposit the money collected in ~~the health care access fund to be credited~~
111.13 ~~to a dedicated account in the special revenue fund.~~ The balance of the account is appropriated
111.14 annually to the commissioner for the health professional education loan forgiveness program
111.15 ~~account~~ established in subdivision 2. The commissioner shall allow waivers of all or part
111.16 of the money owed the commissioner as a result of a nonfulfillment penalty if emergency
111.17 circumstances prevented fulfillment of the minimum service commitment.

111.18 Sec. 7. Minnesota Statutes 2023 Supplement, section 144.1505, subdivision 2, is amended
111.19 to read:

111.20 Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants,
111.21 the commissioner of health shall award health professional training site grants to eligible
111.22 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental
111.23 health professional programs to plan and implement expanded clinical training. A planning
111.24 grant shall not exceed \$75,000, and a three-year training grant shall not exceed ~~\$150,000~~
111.25 ~~for the first year, \$100,000 for the second year, and \$50,000 for the third year~~ \$300,000 per
111.26 program project. The commissioner may provide a one-year, no-cost extension for grants.

111.27 (b) For health professional rural and underserved clinical rotations grants, the
111.28 commissioner of health shall award health professional training site grants to eligible
111.29 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,
111.30 dental therapy, and mental health professional programs to augment existing clinical training
111.31 programs to add rural and underserved rotations or clinical training experiences, such as
111.32 credential or certificate rural tracks or other specialized training. For physician and dentist
111.33 training, the expanded training must include rotations in primary care settings such as

112.1 community clinics, hospitals, health maintenance organizations, or practices in rural
112.2 communities.

112.3 (c) Funds may be used for:

112.4 (1) establishing or expanding rotations and clinical training;

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

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

112.8 (4) travel and lodging for students;

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

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

112.11 (7) evaluations;

112.12 (8) training site improvements, fees, equipment, and supplies required to establish,
112.13 maintain, or expand a training program; and

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

112.15 Sec. 8. Minnesota Statutes 2022, section 144.555, subdivision 1a, is amended to read:

112.16 Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to**
112.17 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under
112.18 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health ~~and~~₂
112.19 the public, and others at least ~~120~~ 182 days before the hospital or hospital campus voluntarily
112.20 plans to implement one of the following scheduled actions:

112.21 (1) cease operations;

112.22 (2) curtail operations to the extent that patients must be relocated;

112.23 (3) relocate the provision of health services to another hospital or another hospital
112.24 campus; or

112.25 (4) cease offering maternity care and newborn care services, intensive care unit services,
112.26 inpatient mental health services, or inpatient substance use disorder treatment services.

112.27 (b) A notice required under this subdivision must comply with the requirements in
112.28 subdivision 1d.

112.29 ~~(b)~~ (c) The commissioner shall cooperate with the controlling persons and advise them
112.30 about relocating the patients.

113.1 Sec. 9. Minnesota Statutes 2022, section 144.555, subdivision 1b, is amended to read:

113.2 Subd. 1b. **Public hearing.** Within ~~45~~ 30 days after receiving notice under subdivision
113.3 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations,
113.4 curtailment of operations, relocation of health services, or cessation in offering health
113.5 services. The commissioner must provide adequate public notice of the hearing in a time
113.6 and manner determined by the commissioner. The controlling persons of the hospital or
113.7 hospital campus must participate in the public hearing. The public hearing must be held at
113.8 a location that is within 30 miles of the hospital or hospital campus and that is provided or
113.9 arranged by the hospital or hospital campus. A hospital or hospital campus is encouraged
113.10 to hold the public hearing at a location that is within ten miles of the hospital or hospital
113.11 campus. Video conferencing technology must be used to allow members of the public to
113.12 view and participate in the hearing. The public hearing must include:

113.13 (1) an explanation by the controlling persons of the reasons for ceasing or curtailing
113.14 operations, relocating health services, or ceasing to offer any of the listed health services;

113.15 (2) a description of the actions that controlling persons will take to ensure that residents
113.16 in the hospital's or campus's service area have continued access to the health services being
113.17 eliminated, curtailed, or relocated;

113.18 (3) an opportunity for public testimony on the scheduled cessation or curtailment of
113.19 operations, relocation of health services, or cessation in offering any of the listed health
113.20 services, and on the hospital's or campus's plan to ensure continued access to those health
113.21 services being eliminated, curtailed, or relocated; and

113.22 (4) an opportunity for the controlling persons to respond to questions from interested
113.23 persons.

113.24 Sec. 10. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision
113.25 to read:

113.26 Subd. 1d. **Methods of providing notice; content of notice.** (a) A notice required under
113.27 subdivision 1a must be provided to patients, hospital personnel, the public, local units of
113.28 government, and the commissioner of health using at least the following methods:

113.29 (1) posting a notice of the proposed cessation of operations, curtailment, relocation of
113.30 health services, or cessation in offering health services at the main public entrance of the
113.31 hospital or hospital campus;

114.1 (2) providing written notice to the commissioner of health, to the city council in the city
114.2 where the hospital or hospital campus is located, and to the county board in the county
114.3 where the hospital or hospital campus is located;

114.4 (3) providing written notice to the local health department as defined in section 145A.02,
114.5 subdivision 8b, for the community where the hospital or hospital campus is located;

114.6 (4) providing notice to the public through a written public announcement which must
114.7 be distributed to local media outlets;

114.8 (5) providing written notice to existing patients of the hospital or hospital campus; and

114.9 (6) notifying all personnel currently employed in the unit, hospital, or hospital campus
114.10 impacted by the proposed cessation, curtailment, or relocation.

114.11 (b) A notice required under subdivision 1a must include:

114.12 (1) a description of the proposed cessation of operations, curtailment, relocation of health
114.13 services, or cessation in offering health services. The description must include:

114.14 (i) the number of beds, if any, that will be eliminated, repurposed, reassigned, or otherwise
114.15 reconfigured to serve populations or patients other than those currently served;

114.16 (ii) the current number of beds in the impacted unit, hospital, or hospital campus, and
114.17 the number of beds in the impacted unit, hospital, or hospital campus after the proposed
114.18 cessation, curtailment, or relocation takes place;

114.19 (iii) the number of existing patients who will be impacted by the proposed cessation,
114.20 curtailment, or relocation;

114.21 (iv) any decrease in personnel, or relocation of personnel to a different unit, hospital, or
114.22 hospital campus, caused by the proposed cessation, curtailment, or relocation;

114.23 (v) a description of the health services provided by the unit, hospital, or hospital campus
114.24 impacted by the proposed cessation, curtailment, or relocation; and

114.25 (vi) identification of the three nearest available health care facilities where patients may
114.26 obtain the health services provided by the unit, hospital, or hospital campus impacted by
114.27 the proposed cessation, curtailment, or relocation, and any potential barriers to seamlessly
114.28 transition patients to receive services at one of these facilities. If the unit, hospital, or hospital
114.29 campus impacted by the proposed cessation, curtailment, or relocation serves medical
114.30 assistance or Medicare enrollees, the information required under this item must specify
114.31 whether any of the three nearest available facilities serves medical assistance or Medicare
114.32 enrollees; and

115.1 (2) a telephone number, email address, and address for each of the following, to which
115.2 interested parties may offer comments on the proposed cessation, curtailment, or relocation:

115.3 (i) the hospital or hospital campus; and

115.4 (ii) the parent entity, if any, or the entity under contract, if any, that acts as the corporate
115.5 administrator of the hospital or hospital campus.

115.6 Sec. 11. Minnesota Statutes 2022, section 144.555, subdivision 2, is amended to read:

115.7 Subd. 2. **Penalty; facilities other than hospitals.** Failure to notify the commissioner
115.8 under subdivision 1, ~~1a, or 1c or failure to participate in a public hearing under subdivision~~
115.9 ~~H~~ may result in issuance of a correction order under section 144.653, subdivision 5.

115.10 Sec. 12. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision
115.11 to read:

115.12 Subd. 3. **Penalties; hospitals.** (a) Failure to participate in a public hearing under
115.13 subdivision 1b or failure to notify the commissioner under subdivision 1c may result in
115.14 issuance of a correction order under section 144.653, subdivision 5.

115.15 (b) Notwithstanding any law to the contrary, the commissioner must impose on the
115.16 controlling persons of a hospital or hospital campus a fine of \$20,000 for each failure to
115.17 provide notice to an individual or entity or at a location required under subdivision 1d,
115.18 paragraph (a), with the total fine amount imposed not to exceed \$60,000 for failures to
115.19 comply with the notice requirements for a single scheduled action. The commissioner is
115.20 not required to issue a correction order before imposing a fine under this paragraph. Section
115.21 144.653, subdivision 8, applies to fines imposed under this paragraph.

115.22 Sec. 13. **[144.556] RIGHT OF FIRST REFUSAL; SALE OF HOSPITAL OR**
115.23 **HOSPITAL CAMPUS.**

115.24 (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a
115.25 hospital campus must not sell or convey the hospital or hospital campus, offer to sell or
115.26 convey the hospital or hospital campus to a person other than a local unit of government
115.27 listed in this paragraph, or voluntarily cease operations of the hospital or hospital campus
115.28 unless the controlling persons have first made a good faith offer to sell or convey the hospital
115.29 or hospital campus to the home rule charter or statutory city, county, town, or hospital
115.30 district in which the hospital or hospital campus is located.

116.1 (b) The offer to sell or convey the hospital or hospital campus to a local unit of
116.2 government under paragraph (a) must be at a price that does not exceed the current fair
116.3 market value of the hospital or hospital campus. A party to whom an offer is made under
116.4 paragraph (a) must accept or decline the offer within 60 days of receipt. If the party to whom
116.5 the offer is made fails to respond within 60 days of receipt, the offer is deemed declined.

116.6 Sec. 14. Minnesota Statutes 2022, section 144A.70, subdivision 3, is amended to read:

116.7 Subd. 3. **Controlling person.** "Controlling person" means a business entity or entities,
116.8 officer, program administrator, or director, whose responsibilities include ~~the direction of~~
116.9 ~~the management or policies of a supplemental nursing services agency~~ the management and
116.10 decision-making authority to establish or control business policy and all other policies of a
116.11 supplemental nursing services agency. Controlling person also means an individual who,
116.12 directly or indirectly, beneficially owns an interest in a corporation, partnership, or other
116.13 business association that is a controlling person.

116.14 Sec. 15. Minnesota Statutes 2022, section 144A.70, subdivision 5, is amended to read:

116.15 Subd. 5. **Person.** "Person" includes an individual, ~~firm,~~ corporation, partnership, limited
116.16 liability company, or association.

116.17 Sec. 16. Minnesota Statutes 2022, section 144A.70, subdivision 6, is amended to read:

116.18 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
116.19 agency" means a person, ~~firm,~~ corporation, partnership, limited liability company, or
116.20 association engaged for hire in the business of providing or procuring temporary employment
116.21 in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental
116.22 nursing services agency does not include an individual who only engages in providing the
116.23 individual's services on a temporary basis to health care facilities. Supplemental nursing
116.24 services agency does not include a professional home care agency licensed under section
116.25 144A.471 that only provides staff to other home care providers.

116.26 Sec. 17. Minnesota Statutes 2022, section 144A.70, subdivision 7, is amended to read:

116.27 Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental
116.28 nursing services agencies through ~~annual~~ semiannual unannounced surveys and follow-up
116.29 surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions
116.30 necessary to ensure compliance with sections 144A.70 to 144A.74.

117.1 Sec. 18. Minnesota Statutes 2022, section 144A.71, subdivision 2, is amended to read:

117.2 Subd. 2. **Application information and fee.** The commissioner shall establish forms and
117.3 procedures for processing each supplemental nursing services agency registration application.
117.4 An application for a supplemental nursing services agency registration must include at least
117.5 the following:

117.6 (1) the names and addresses of ~~the owner or owners~~ all owners and controlling persons
117.7 of the supplemental nursing services agency;

117.8 (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws,
117.9 together with the names and addresses of its officers and directors;

117.10 (3) ~~satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to~~
117.11 ~~(7)~~ if the owner is a limited liability company, copies of its articles of organization and
117.12 operating agreement, together with the names and addresses of its officers and directors;

117.13 (4) documentation that the supplemental nursing services agency has medical malpractice
117.14 insurance to insure against the loss, damage, or expense of a claim arising out of the death
117.15 or injury of any person as the result of negligence or malpractice in the provision of health
117.16 care services by the supplemental nursing services agency or by any employee of the agency;

117.17 (5) documentation that the supplemental nursing services agency has an employee
117.18 dishonesty bond in the amount of \$10,000;

117.19 (6) documentation that the supplemental nursing services agency has insurance coverage
117.20 for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies
117.21 provided or procured by the agency;

117.22 (7) documentation that the supplemental nursing services agency filed with the
117.23 commissioner of revenue: (i) the name and address of the bank, savings bank, or savings
117.24 association in which the supplemental nursing services agency deposits all employee income
117.25 tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide,
117.26 or orderly whose income is derived from placement by the agency, if the agency purports
117.27 the income is not subject to withholding;

117.28 ~~(4)~~ (8) any other relevant information that the commissioner determines is necessary to
117.29 properly evaluate an application for registration;

117.30 ~~(5)~~ (9) a policy and procedure that describes how the supplemental nursing services
117.31 agency's records will be immediately available at all times to the commissioner and facility;
117.32 and

118.1 ~~(6)~~ (10) a nonrefundable registration fee of \$2,035.

118.2 If a supplemental nursing services agency fails to provide the items in this subdivision
118.3 to the department, the commissioner shall immediately suspend or refuse to issue the
118.4 supplemental nursing services agency registration. The supplemental nursing services agency
118.5 may appeal the commissioner's findings according to section 144A.475, subdivisions 3a
118.6 and 7, except that the hearing must be conducted by an administrative law judge within 60
118.7 calendar days of the request for hearing assignment.

118.8 Sec. 19. Minnesota Statutes 2022, section 144A.71, is amended by adding a subdivision
118.9 to read:

118.10 Subd. 2a. **Renewal applications.** An applicant for registration renewal must complete
118.11 the registration application form supplied by the department. An application must be
118.12 submitted at least 60 days before the expiration of the current registration.

118.13 Sec. 20. [144A.715] PENALTIES.

118.14 Subdivision 1. **Authority.** The fines imposed under this section are in accordance with
118.15 section 144.653, subdivision 6.

118.16 Subd. 2. **Fines.** Each violation of sections 144A.70 to 144A.74, not corrected at the time
118.17 of a follow-up survey, is subject to a fine. A fine must be assessed according to the schedules
118.18 established in the sections violated.

118.19 Subd. 3. **Failure to correct.** If, upon a subsequent follow-up survey after a fine has been
118.20 imposed under subdivision 2, a violation is still not corrected, another fine shall be assessed.
118.21 The fine shall be double the amount of the previous fine.

118.22 Subd. 4. **Payment of fines.** Payment of fines is due 15 business days from the registrant's
118.23 receipt of notice of the fine from the department.

118.24 Sec. 21. Minnesota Statutes 2022, section 144A.72, subdivision 1, is amended to read:

118.25 Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition
118.26 of registration:

118.27 (1) all owners and controlling persons must complete a background study under section
118.28 144.057 and receive a clearance or set aside of any disqualification;

118.29 ~~(1)~~ (2) the supplemental nursing services agency shall document that each temporary
118.30 employee provided to health care facilities currently meets the minimum licensing, training,
118.31 and continuing education standards for the position in which the employee will be working

119.1 and verifies competency for the position. A violation of this provision may be subject to a
119.2 fine of \$3,000;

119.3 ~~(2)~~ (3) the supplemental nursing services agency shall comply with all pertinent
119.4 requirements relating to the health and other qualifications of personnel employed in health
119.5 care facilities;

119.6 ~~(3)~~ (4) the supplemental nursing services agency must not restrict in any manner the
119.7 employment opportunities of its employees; A violation of this provision may be subject
119.8 to a fine of \$3,000;

119.9 ~~(4)~~ the supplemental nursing services agency shall carry medical malpractice insurance
119.10 to insure against the loss, damage, or expense incident to a claim arising out of the death
119.11 or injury of any person as the result of negligence or malpractice in the provision of health
119.12 care services by the supplemental nursing services agency or by any employee of the agency;

119.13 ~~(5)~~ the supplemental nursing services agency shall carry an employee dishonesty bond
119.14 in the amount of \$10,000;

119.15 ~~(6)~~ the supplemental nursing services agency shall maintain insurance coverage for
119.16 workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided
119.17 or procured by the agency;

119.18 ~~(7)~~ the supplemental nursing services agency shall file with the commissioner of revenue:
119.19 (i) the name and address of the bank, savings bank, or savings association in which the
119.20 supplemental nursing services agency deposits all employee income tax withholdings; and
119.21 (ii) the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income
119.22 is derived from placement by the agency, if the agency purports the income is not subject
119.23 to withholding;

119.24 ~~(8)~~ (5) the supplemental nursing services agency must not, in any contract with any
119.25 employee or health care facility, require the payment of liquidated damages, employment
119.26 fees, or other compensation should the employee be hired as a permanent employee of a
119.27 health care facility; A violation of this provision may be subject to a fine of \$3,000;

119.28 ~~(9)~~ (6) the supplemental nursing services agency shall document that each temporary
119.29 employee provided to health care facilities is an employee of the agency and is not an
119.30 independent contractor; and

119.31 ~~(10)~~ (7) the supplemental nursing services agency shall retain all records for five calendar
119.32 years. All records of the supplemental nursing services agency must be immediately available
119.33 to the department.

120.1 (b) In order to retain registration, the supplemental nursing services agency must provide
120.2 services to a health care facility ~~during the year~~ in Minnesota within the past 12 months
120.3 preceding the supplemental nursing services agency's registration renewal date.

120.4 Sec. 22. Minnesota Statutes 2022, section 144A.73, is amended to read:

120.5 **144A.73 COMPLAINT SYSTEM.**

120.6 The commissioner shall establish a system for reporting complaints against a supplemental
120.7 nursing services agency or its employees. Complaints may be made by any member of the
120.8 public. Complaints against a supplemental nursing services agency shall be investigated by
120.9 the ~~Office of Health Facility Complaints~~ commissioner of health under sections 144A.51
120.10 to 144A.53.

120.11 Sec. 23. Minnesota Statutes 2023 Supplement, section 145.561, subdivision 4, is amended
120.12 to read:

120.13 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide
120.14 Hotline Designation Act of 2020, ~~the commissioner shall impose a monthly statewide fee~~
120.15 ~~on~~ each subscriber of a wireline, wireless, or IP-enabled voice service ~~at a rate that provides~~
120.16 must pay a monthly fee to provide for the robust creation, operation, and maintenance of a
120.17 statewide 988 suicide prevention and crisis system.

120.18 ~~(b) The commissioner shall annually recommend to the Public Utilities Commission an~~
120.19 ~~adequate and appropriate fee to implement this section. The amount of the fee must comply~~
120.20 ~~with the limits in paragraph (c). The commissioner shall provide telecommunication service~~
120.21 ~~providers and carriers a minimum of 45 days' notice of each fee change.~~

120.22 ~~(e)~~ (b) The amount of the 988 telecommunications fee ~~must not be more than 25~~ is 12
120.23 cents per month ~~on or after January 1, 2024,~~ for each consumer access line, including trunk
120.24 equivalents as designated by the ~~commission~~ Public Utilities Commission pursuant to section
120.25 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

120.26 ~~(d)~~ (c) Each wireline, wireless, and IP-enabled voice telecommunication service provider
120.27 shall collect the 988 telecommunications fee and transfer the amounts collected to the
120.28 commissioner of public safety in the same manner as provided in section 403.11, subdivision
120.29 1, paragraph (d).

120.30 ~~(e)~~ (d) The commissioner of public safety shall deposit the money collected from the
120.31 988 telecommunications fee to the 988 special revenue account established in subdivision
120.32 3.

121.1 ~~(f)~~ (e) All 988 telecommunications fee revenue must be used to supplement, and not
121.2 supplant, federal, state, and local funding for suicide prevention.

121.3 ~~(g)~~ (f) The 988 telecommunications fee amount shall be adjusted as needed to provide
121.4 for continuous operation of the lifeline centers and 988 hotline, volume increases, and
121.5 maintenance.

121.6 ~~(h)~~ (g) The commissioner shall annually report to the Federal Communications
121.7 Commission on revenue generated by the 988 telecommunications fee.

121.8 **EFFECTIVE DATE.** This section is effective September 1, 2024.

121.9 Sec. 24. Minnesota Statutes 2022, section 149A.02, subdivision 3, is amended to read:

121.10 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means any
121.11 action normally taken by a funeral provider in anticipation of or preparation for the
121.12 entombment, burial in a cemetery, alkaline hydrolysis, ~~or~~ cremation, or, effective July 1,
121.13 2025, natural organic reduction of a dead human body.

121.14 Sec. 25. Minnesota Statutes 2022, section 149A.02, subdivision 16, is amended to read:

121.15 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
121.16 entombment, burial in a cemetery, alkaline hydrolysis, ~~or~~ cremation, or, effective July 1,
121.17 2025, natural organic reduction of a dead human body.

121.18 Sec. 26. Minnesota Statutes 2022, section 149A.02, subdivision 26a, is amended to read:

121.19 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains in
121.20 a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.
121.21 Effective July 1, 2025, inurnment also includes placing naturally reduced remains in a
121.22 naturally reduced remains container suitable for placement, burial, or shipment.

121.23 Sec. 27. Minnesota Statutes 2022, section 149A.02, subdivision 27, is amended to read:

121.24 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued a license
121.25 to practice mortuary science, to operate a funeral establishment, to operate an alkaline
121.26 hydrolysis facility, ~~or~~ to operate a crematory, or, effective July 1, 2025, to operate a natural
121.27 organic reduction facility by the Minnesota commissioner of health.

122.1 Sec. 28. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
122.2 to read:

122.3 Subd. 30b. **Natural organic reduction or naturally reduce.** "Natural organic reduction"
122.4 or "naturally reduce" means the contained, accelerated conversion of a dead human body
122.5 to soil. This subdivision is effective July 1, 2025.

122.6 Sec. 29. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
122.7 to read:

122.8 Subd. 30c. **Natural organic reduction facility.** "Natural organic reduction facility"
122.9 means a structure, room, or other space in a building or real property where natural organic
122.10 reduction of a dead human body occurs. This subdivision is effective July 1, 2025.

122.11 Sec. 30. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
122.12 to read:

122.13 Subd. 30d. **Natural organic reduction vessel.** "Natural organic reduction vessel" means
122.14 the enclosed container in which natural organic reduction takes place. This subdivision is
122.15 effective July 1, 2025.

122.16 Sec. 31. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
122.17 to read:

122.18 Subd. 30e. **Naturally reduced remains.** "Naturally reduced remains" means the soil
122.19 remains following the natural organic reduction of a dead human body and the accompanying
122.20 plant material. This subdivision is effective July 1, 2025.

122.21 Sec. 32. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision
122.22 to read:

122.23 Subd. 30f. **Naturally reduced remains container.** "Naturally reduced remains container"
122.24 means a receptacle in which naturally reduced remains are placed. This subdivision is
122.25 effective July 1, 2025.

122.26 Sec. 33. Minnesota Statutes 2022, section 149A.02, subdivision 35, is amended to read:

122.27 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
122.28 cooling, and the reduction of the hydrolyzed ~~or~~ remains, cremated remains, or, effective
122.29 July 1, 2025, naturally reduced remains by mechanical means including, but not limited to,

123.1 grinding, crushing, or pulverizing, to a granulated appearance appropriate for final
123.2 disposition.

123.3 Sec. 34. Minnesota Statutes 2022, section 149A.02, subdivision 37c, is amended to read:

123.4 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed ~~or~~
123.5 remains, cremated remains, or, effective July 1, 2025, naturally reduced remains in a defined
123.6 area of a dedicated cemetery or in areas where no local prohibition exists provided that the
123.7 hydrolyzed ~~or~~, cremated, or naturally reduced remains are not distinguishable to the public,
123.8 are not in a container, and that the person who has control over disposition of the hydrolyzed
123.9 ~~or~~, cremated, or naturally reduced remains has obtained written permission of the property
123.10 owner or governing agency to scatter on the property.

123.11 Sec. 35. Minnesota Statutes 2022, section 149A.03, is amended to read:

123.12 **149A.03 DUTIES OF COMMISSIONER.**

123.13 The commissioner shall:

123.14 (1) enforce all laws and adopt and enforce rules relating to the:

123.15 (i) removal, preparation, transportation, arrangements for disposition, and final disposition
123.16 of dead human bodies;

123.17 (ii) licensure and professional conduct of funeral directors, morticians, interns, practicum
123.18 students, and clinical students;

123.19 (iii) licensing and operation of a funeral establishment;

123.20 (iv) licensing and operation of an alkaline hydrolysis facility; ~~and~~

123.21 (v) licensing and operation of a crematory; and

123.22 (vi) effective July 1, 2025, licensing and operation of a natural organic reduction facility;

123.23 (2) provide copies of the requirements for licensure and permits to all applicants;

123.24 (3) administer examinations and issue licenses and permits to qualified persons and other
123.25 legal entities;

123.26 (4) maintain a record of the name and location of all current licensees and interns;

123.27 (5) perform periodic compliance reviews and premise inspections of licensees;

123.28 (6) accept and investigate complaints relating to conduct governed by this chapter;

123.29 (7) maintain a record of all current preneed arrangement trust accounts;

124.1 (8) maintain a schedule of application, examination, permit, and licensure fees, initial
124.2 and renewal, sufficient to cover all necessary operating expenses;

124.3 (9) educate the public about the existence and content of the laws and rules for mortuary
124.4 science licensing and the removal, preparation, transportation, arrangements for disposition,
124.5 and final disposition of dead human bodies to enable consumers to file complaints against
124.6 licensees and others who may have violated those laws or rules;

124.7 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary science
124.8 in order to refine the standards for licensing and to improve the regulatory and enforcement
124.9 methods used; and

124.10 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in the
124.11 laws, rules, or procedures governing the practice of mortuary science and the removal,
124.12 preparation, transportation, arrangements for disposition, and final disposition of dead
124.13 human bodies.

124.14 Sec. 36. **[149A.56] LICENSE TO OPERATE A NATURAL ORGANIC REDUCTION**
124.15 **FACILITY.**

124.16 Subdivision 1. License requirement. This section is effective July 1, 2025. Except as
124.17 provided in section 149A.01, subdivision 3, no person shall maintain, manage, or operate
124.18 a place or premises devoted to or used in the holding and natural organic reduction of a
124.19 dead human body without possessing a valid license to operate a natural organic reduction
124.20 facility issued by the commissioner of health.

124.21 Subd. 2. Requirements for natural organic reduction facility. (a) A natural organic
124.22 reduction facility licensed under this section must consist of:

124.23 (1) a building or structure that complies with applicable local and state building codes,
124.24 zoning laws and ordinances, and environmental standards, and that contains one or more
124.25 natural organic reduction vessels for the natural organic reduction of dead human bodies;

124.26 (2) a motorized mechanical device for processing naturally reduced remains; and

124.27 (3) an appropriate refrigerated holding facility for dead human bodies awaiting natural
124.28 organic reduction.

124.29 (b) A natural organic reduction facility licensed under this section may also contain a
124.30 display room for funeral goods.

125.1 Subd. 3. **Application procedure; documentation; initial inspection.** (a) An applicant
125.2 for a license to operate a natural organic reduction facility shall submit a completed
125.3 application to the commissioner. A completed application includes:

125.4 (1) a completed application form, as provided by the commissioner;

125.5 (2) proof of business form and ownership; and

125.6 (3) proof of liability insurance coverage or other financial documentation, as determined
125.7 by the commissioner, that demonstrates the applicant's ability to respond in damages for
125.8 liability arising from the ownership, maintenance, management, or operation of a natural
125.9 organic reduction facility.

125.10 (b) Upon receipt of the application and appropriate fee, the commissioner shall review
125.11 and verify all information. Upon completion of the verification process and resolution of
125.12 any deficiencies in the application information, the commissioner shall conduct an initial
125.13 inspection of the premises to be licensed. After the inspection and resolution of any
125.14 deficiencies found and any reinspections as may be necessary, the commissioner shall make
125.15 a determination, based on all the information available, to grant or deny licensure. If the
125.16 commissioner's determination is to grant the license, the applicant shall be notified and the
125.17 license shall issue and remain valid for a period prescribed on the license, but not to exceed
125.18 one calendar year from the date of issuance of the license. If the commissioner's determination
125.19 is to deny the license, the commissioner must notify the applicant, in writing, of the denial
125.20 and provide the specific reason for denial.

125.21 Subd. 4. **Nontransferability of license.** A license to operate a natural organic reduction
125.22 facility is not assignable or transferable and shall not be valid for any entity other than the
125.23 one named. Each license issued to operate a natural organic reduction facility is valid only
125.24 for the location identified on the license. A 50 percent or more change in ownership or
125.25 location of the natural organic reduction facility automatically terminates the license. Separate
125.26 licenses shall be required of two or more persons or other legal entities operating from the
125.27 same location.

125.28 Subd. 5. **Display of license.** Each license to operate a natural organic reduction facility
125.29 must be conspicuously displayed in the natural organic reduction facility at all times.
125.30 Conspicuous display means in a location where a member of the general public within the
125.31 natural organic reduction facility is able to observe and read the license.

125.32 Subd. 6. **Period of licensure.** All licenses to operate a natural organic reduction facility
125.33 issued by the commissioner are valid for a period of one calendar year beginning on July 1
125.34 and ending on June 30, regardless of the date of issuance.

126.1 Subd. 7. **Reporting changes in license information.** Any change of license information
126.2 must be reported to the commissioner, on forms provided by the commissioner, no later
126.3 than 30 calendar days after the change occurs. Failure to report changes is grounds for
126.4 disciplinary action.

126.5 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained
126.6 by the commissioner pursuant to this section.

126.7 Sec. 37. **[149A.57] RENEWAL OF LICENSE TO OPERATE A NATURAL**
126.8 **ORGANIC REDUCTION FACILITY.**

126.9 Subdivision 1. **Renewal required.** This section is effective July 1, 2025. All licenses
126.10 to operate a natural organic reduction facility issued by the commissioner expire on June
126.11 30 following the date of issuance of the license and must be renewed to remain valid.

126.12 Subd. 2. **Renewal procedure and documentation.** (a) Licensees who wish to renew
126.13 their licenses must submit to the commissioner a completed renewal application no later
126.14 than June 30 following the date the license was issued. A completed renewal application
126.15 includes:

126.16 (1) a completed renewal application form, as provided by the commissioner; and

126.17 (2) proof of liability insurance coverage or other financial documentation, as determined
126.18 by the commissioner, that demonstrates the applicant's ability to respond in damages for
126.19 liability arising from the ownership, maintenance, management, or operation of a natural
126.20 organic reduction facility.

126.21 (b) Upon receipt of the completed renewal application, the commissioner shall review
126.22 and verify the information. Upon completion of the verification process and resolution of
126.23 any deficiencies in the renewal application information, the commissioner shall make a
126.24 determination, based on all the information available, to reissue or refuse to reissue the
126.25 license. If the commissioner's determination is to reissue the license, the applicant shall be
126.26 notified and the license shall issue and remain valid for a period prescribed on the license,
126.27 but not to exceed one calendar year from the date of issuance of the license. If the
126.28 commissioner's determination is to refuse to reissue the license, section 149A.09, subdivision
126.29 2, applies.

126.30 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration date
126.31 of a license will result in the assessment of a late filing penalty. The late filing penalty must
126.32 be paid before the reissuance of the license and received by the commissioner no later than
126.33 31 calendar days after the expiration date of the license.

127.1 Subd. 4. **Lapse of license.** A license to operate a natural organic reduction facility shall
127.2 automatically lapse when a completed renewal application is not received by the
127.3 commissioner within 31 calendar days after the expiration date of a license, or a late filing
127.4 penalty assessed under subdivision 3 is not received by the commissioner within 31 calendar
127.5 days after the expiration of a license.

127.6 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom the
127.7 license was issued is no longer licensed to operate a natural organic reduction facility in
127.8 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
127.9 license holder from operating a natural organic reduction facility in Minnesota and may
127.10 pursue any additional lawful remedies as justified by the case.

127.11 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed license
127.12 upon receipt and review of a completed renewal application, receipt of the late filing penalty,
127.13 and reinspection of the premises, provided that the receipt is made within one calendar year
127.14 from the expiration date of the lapsed license and the cease and desist order issued by the
127.15 commissioner has not been violated. If a lapsed license is not restored within one calendar
127.16 year from the expiration date of the lapsed license, the holder of the lapsed license cannot
127.17 be relicensed until the requirements in section 149A.56 are met.

127.18 Subd. 7. **Reporting changes in license information.** Any change of license information
127.19 must be reported to the commissioner, on forms provided by the commissioner, no later
127.20 than 30 calendar days after the change occurs. Failure to report changes is grounds for
127.21 disciplinary action.

127.22 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained
127.23 by the commissioner pursuant to this section.

127.24 Sec. 38. Minnesota Statutes 2022, section 149A.65, is amended by adding a subdivision
127.25 to read:

127.26 Subd. 6a. **Natural organic reduction facilities.** This subdivision is effective July 1,
127.27 2025. The initial and renewal fee for a natural organic reduction facility is \$425. The late
127.28 fee charge for a license renewal is \$100.

127.29 Sec. 39. Minnesota Statutes 2022, section 149A.70, subdivision 1, is amended to read:

127.30 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice mortuary
127.31 science issued by the commissioner may use the title of mortician, funeral director, or any
127.32 other title implying that the licensee is engaged in the business or practice of mortuary

128.1 science. Only the holder of a valid license to operate an alkaline hydrolysis facility issued
128.2 by the commissioner may use the title of alkaline hydrolysis facility, water cremation,
128.3 water-reduction, biocremation, green-cremation, resomation, dissolution, or any other title,
128.4 word, or term implying that the licensee operates an alkaline hydrolysis facility. Only the
128.5 holder of a valid license to operate a funeral establishment issued by the commissioner may
128.6 use the title of funeral home, funeral chapel, funeral service, or any other title, word, or
128.7 term implying that the licensee is engaged in the business or practice of mortuary science.
128.8 Only the holder of a valid license to operate a crematory issued by the commissioner may
128.9 use the title of crematory, crematorium, green-cremation, or any other title, word, or term
128.10 implying that the licensee operates a crematory or crematorium. Effective July 1, 2025,
128.11 only the holder of a valid license to operate a natural organic reduction facility issued by
128.12 the commissioner may use the title of natural organic reduction facility, human composting,
128.13 or any other title, word, or term implying that the licensee operates a natural organic reduction
128.14 facility.

128.15 Sec. 40. Minnesota Statutes 2022, section 149A.70, subdivision 2, is amended to read:

128.16 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, ~~or~~
128.17 crematory, or, effective July 1, 2025, natural organic reduction facility shall not do business
128.18 in a location that is not licensed as a funeral establishment, alkaline hydrolysis facility, ~~or~~
128.19 crematory, or natural organic reduction facility and shall not advertise a service that is
128.20 available from an unlicensed location.

128.21 Sec. 41. Minnesota Statutes 2022, section 149A.70, subdivision 3, is amended to read:

128.22 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern shall
128.23 publish or disseminate false, misleading, or deceptive advertising. False, misleading, or
128.24 deceptive advertising includes, but is not limited to:

128.25 (1) identifying, by using the names or pictures of, persons who are not licensed to practice
128.26 mortuary science in a way that leads the public to believe that those persons will provide
128.27 mortuary science services;

128.28 (2) using any name other than the names under which the funeral establishment, alkaline
128.29 hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural organic reduction facility
128.30 is known to or licensed by the commissioner;

128.31 (3) using a surname not directly, actively, or presently associated with a licensed funeral
128.32 establishment, alkaline hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural
128.33 organic reduction facility, unless the surname had been previously and continuously used

129.1 by the licensed funeral establishment, alkaline hydrolysis facility, ~~or crematory~~, or natural
129.2 organic reduction facility; and

129.3 (4) using a founding or establishing date or total years of service not directly or
129.4 continuously related to a name under which the funeral establishment, alkaline hydrolysis
129.5 facility, ~~or crematory~~, or, effective July 1, 2025, natural organic reduction facility is currently
129.6 or was previously licensed.

129.7 Any advertising or other printed material that contains the names or pictures of persons
129.8 affiliated with a funeral establishment, alkaline hydrolysis facility, ~~or crematory~~, or, effective
129.9 July 1, 2025, natural organic reduction facility shall state the position held by the persons
129.10 and shall identify each person who is licensed or unlicensed under this chapter.

129.11 Sec. 42. Minnesota Statutes 2022, section 149A.70, subdivision 5, is amended to read:

129.12 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,
129.13 or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
129.14 reimbursement in consideration for recommending or causing a dead human body to be
129.15 disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis
129.16 facility, crematory, mausoleum, ~~or cemetery~~, or, effective July 1, 2025, natural organic
129.17 reduction facility.

129.18 Sec. 43. Minnesota Statutes 2022, section 149A.71, subdivision 2, is amended to read:

129.19 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices,
129.20 the requirements of this subdivision must be met. This subdivision applies to natural organic
129.21 reduction and naturally reduced remains goods and services effective July 1, 2025.

129.22 (b) Funeral providers must tell persons who ask by telephone about the funeral provider's
129.23 offerings or prices any accurate information from the price lists described in paragraphs (c)
129.24 to (e) and any other readily available information that reasonably answers the questions
129.25 asked.

129.26 (c) Funeral providers must make available for viewing to people who inquire in person
129.27 about the offerings or prices of funeral goods or burial site goods, separate printed or
129.28 typewritten price lists using a ten-point font or larger. Each funeral provider must have a
129.29 separate price list for each of the following types of goods that are sold or offered for sale:

129.30 (1) caskets;

129.31 (2) alternative containers;

- 130.1 (3) outer burial containers;
- 130.2 (4) alkaline hydrolysis containers;
- 130.3 (5) cremation containers;
- 130.4 (6) hydrolyzed remains containers;
- 130.5 (7) cremated remains containers;
- 130.6 (8) markers; ~~and~~
- 130.7 (9) headstones; and
- 130.8 (10) naturally reduced remains containers.

130.9 (d) Each separate price list must contain the name of the funeral provider's place of
130.10 business, address, and telephone number and a caption describing the list as a price list for
130.11 one of the types of funeral goods or burial site goods described in paragraph (c), clauses
130.12 (1) to ~~(9)~~ (10). The funeral provider must offer the list upon beginning discussion of, but
130.13 in any event before showing, the specific funeral goods or burial site goods and must provide
130.14 a photocopy of the price list, for retention, if so asked by the consumer. The list must contain,
130.15 at least, the retail prices of all the specific funeral goods and burial site goods offered which
130.16 do not require special ordering, enough information to identify each, and the effective date
130.17 for the price list. However, funeral providers are not required to make a specific price list
130.18 available if the funeral providers place the information required by this paragraph on the
130.19 general price list described in paragraph (e).

130.20 (e) Funeral providers must give a printed price list, for retention, to persons who inquire
130.21 in person about the funeral goods, funeral services, burial site goods, or burial site services
130.22 or prices offered by the funeral provider. The funeral provider must give the list upon
130.23 beginning discussion of either the prices of or the overall type of funeral service or disposition
130.24 or specific funeral goods, funeral services, burial site goods, or burial site services offered
130.25 by the provider. This requirement applies whether the discussion takes place in the funeral
130.26 establishment or elsewhere. However, when the deceased is removed for transportation to
130.27 the funeral establishment, an in-person request for authorization to embalm does not, by
130.28 itself, trigger the requirement to offer the general price list. If the provider, in making an
130.29 in-person request for authorization to embalm, discloses that embalming is not required by
130.30 law except in certain special cases, the provider is not required to offer the general price
130.31 list. Any other discussion during that time about prices or the selection of funeral goods,
130.32 funeral services, burial site goods, or burial site services triggers the requirement to give

131.1 the consumer a general price list. The general price list must contain the following
131.2 information:

131.3 (1) the name, address, and telephone number of the funeral provider's place of business;

131.4 (2) a caption describing the list as a "general price list";

131.5 (3) the effective date for the price list;

131.6 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per hour,
131.7 mile, or other unit of computation, and other information described as follows:

131.8 (i) forwarding of remains to another funeral establishment, together with a list of the
131.9 services provided for any quoted price;

131.10 (ii) receiving remains from another funeral establishment, together with a list of the
131.11 services provided for any quoted price;

131.12 (iii) separate prices for each alkaline hydrolysis, natural organic reduction, or cremation
131.13 offered by the funeral provider, with the price including an alternative container or shroud
131.14 or alkaline hydrolysis facility or cremation container; any alkaline hydrolysis, natural
131.15 organic reduction facility, or crematory charges; and a description of the services and
131.16 container included in the price, where applicable, and the price of alkaline hydrolysis or
131.17 cremation where the purchaser provides the container;

131.18 (iv) separate prices for each immediate burial offered by the funeral provider, including
131.19 a casket or alternative container, and a description of the services and container included
131.20 in that price, and the price of immediate burial where the purchaser provides the casket or
131.21 alternative container;

131.22 (v) transfer of remains to the funeral establishment or other location;

131.23 (vi) embalming;

131.24 (vii) other preparation of the body;

131.25 (viii) use of facilities, equipment, or staff for viewing;

131.26 (ix) use of facilities, equipment, or staff for funeral ceremony;

131.27 (x) use of facilities, equipment, or staff for memorial service;

131.28 (xi) use of equipment or staff for graveside service;

131.29 (xii) hearse or funeral coach;

131.30 (xiii) limousine; and

132.1 (xiv) separate prices for all cemetery-specific goods and services, including all goods
132.2 and services associated with interment and burial site goods and services and excluding
132.3 markers and headstones;

132.4 (5) the price range for the caskets offered by the funeral provider, together with the
132.5 statement "A complete price list will be provided at the funeral establishment or casket sale
132.6 location." or the prices of individual caskets, as disclosed in the manner described in
132.7 paragraphs (c) and (d);

132.8 (6) the price range for the alternative containers or shrouds offered by the funeral provider,
132.9 together with the statement "A complete price list will be provided at the funeral
132.10 establishment or alternative container sale location." or the prices of individual alternative
132.11 containers, as disclosed in the manner described in paragraphs (c) and (d);

132.12 (7) the price range for the outer burial containers offered by the funeral provider, together
132.13 with the statement "A complete price list will be provided at the funeral establishment or
132.14 outer burial container sale location." or the prices of individual outer burial containers, as
132.15 disclosed in the manner described in paragraphs (c) and (d);

132.16 (8) the price range for the alkaline hydrolysis container offered by the funeral provider,
132.17 together with the statement "A complete price list will be provided at the funeral
132.18 establishment or alkaline hydrolysis container sale location." or the prices of individual
132.19 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c) and
132.20 (d);

132.21 (9) the price range for the hydrolyzed remains container offered by the funeral provider,
132.22 together with the statement "A complete price list will be provided at the funeral
132.23 establishment or hydrolyzed remains container sale location." or the prices of individual
132.24 hydrolyzed remains container, as disclosed in the manner described in paragraphs (c) and
132.25 (d);

132.26 (10) the price range for the cremation containers offered by the funeral provider, together
132.27 with the statement "A complete price list will be provided at the funeral establishment or
132.28 cremation container sale location." or the prices of individual cremation containers, as
132.29 disclosed in the manner described in paragraphs (c) and (d);

132.30 (11) the price range for the cremated remains containers offered by the funeral provider,
132.31 together with the statement, "A complete price list will be provided at the funeral
132.32 establishment or cremated remains container sale location," or the prices of individual
132.33 cremation containers as disclosed in the manner described in paragraphs (c) and (d);

133.1 (12) the price range for the naturally reduced remains containers offered by the funeral
133.2 provider, together with the statement, "A complete price list will be provided at the funeral
133.3 establishment or naturally reduced remains container sale location," or the prices of individual
133.4 naturally reduced remains containers as disclosed in the manner described in paragraphs
133.5 (c) and (d);

133.6 ~~(12)~~ (13) the price for the basic services of funeral provider and staff, together with a
133.7 list of the principal basic services provided for any quoted price and, if the charge cannot
133.8 be declined by the purchaser, the statement "This fee for our basic services will be added
133.9 to the total cost of the funeral arrangements you select. (This fee is already included in our
133.10 charges for alkaline hydrolysis, natural organic reduction, direct cremations, immediate
133.11 burials, and forwarding or receiving remains.)" If the charge cannot be declined by the
133.12 purchaser, the quoted price shall include all charges for the recovery of unallocated funeral
133.13 provider overhead, and funeral providers may include in the required disclosure the phrase
133.14 "and overhead" after the word "services." This services fee is the only funeral provider fee
133.15 for services, facilities, or unallocated overhead permitted by this subdivision to be
133.16 nondeclinable, unless otherwise required by law;

133.17 ~~(13)~~ (14) the price range for the markers and headstones offered by the funeral provider,
133.18 together with the statement "A complete price list will be provided at the funeral
133.19 establishment or marker or headstone sale location." or the prices of individual markers and
133.20 headstones, as disclosed in the manner described in paragraphs (c) and (d); and

133.21 ~~(14)~~ (15) any package priced funerals offered must be listed in addition to and following
133.22 the information required in paragraph (e) and must clearly state the funeral goods and
133.23 services being offered, the price being charged for those goods and services, and the
133.24 discounted savings.

133.25 (f) Funeral providers must give an itemized written statement, for retention, to each
133.26 consumer who arranges an at-need funeral or other disposition of human remains at the
133.27 conclusion of the discussion of the arrangements. The itemized written statement must be
133.28 signed by the consumer selecting the goods and services as required in section 149A.80. If
133.29 the statement is provided by a funeral establishment, the statement must be signed by the
133.30 licensed funeral director or mortician planning the arrangements. If the statement is provided
133.31 by any other funeral provider, the statement must be signed by an authorized agent of the
133.32 funeral provider. The statement must list the funeral goods, funeral services, burial site
133.33 goods, or burial site services selected by that consumer and the prices to be paid for each
133.34 item, specifically itemized cash advance items (these prices must be given to the extent then
133.35 known or reasonably ascertainable if the prices are not known or reasonably ascertainable,

134.1 a good faith estimate shall be given and a written statement of the actual charges shall be
134.2 provided before the final bill is paid), and the total cost of goods and services selected. At
134.3 the conclusion of an at-need arrangement, the funeral provider is required to give the
134.4 consumer a copy of the signed itemized written contract that must contain the information
134.5 required in this paragraph.

134.6 (g) Upon receiving actual notice of the death of an individual with whom a funeral
134.7 provider has entered a preneed funeral agreement, the funeral provider must provide a copy
134.8 of all preneed funeral agreement documents to the person who controls final disposition of
134.9 the human remains or to the designee of the person controlling disposition. The person
134.10 controlling final disposition shall be provided with these documents at the time of the
134.11 person's first in-person contact with the funeral provider, if the first contact occurs in person
134.12 at a funeral establishment, alkaline hydrolysis facility, crematory, natural organic reduction
134.13 facility, or other place of business of the funeral provider. If the contact occurs by other
134.14 means or at another location, the documents must be provided within 24 hours of the first
134.15 contact.

134.16 Sec. 44. Minnesota Statutes 2022, section 149A.71, subdivision 4, is amended to read:

134.17 Subd. 4. **Casket, alternate container, alkaline hydrolysis container, naturally reduced**
134.18 **remains container, and cremation container sales; records; required disclosures.** Any
134.19 funeral provider who sells or offers to sell a casket, alternate container, alkaline hydrolysis
134.20 container, hydrolyzed remains container, cremation container, ~~or~~ cremated remains container,
134.21 or, effective July 1, 2025, naturally reduced remains container to the public must maintain
134.22 a record of each sale that includes the name of the purchaser, the purchaser's mailing address,
134.23 the name of the decedent, the date of the decedent's death, and the place of death. These
134.24 records shall be open to inspection by the regulatory agency. Any funeral provider selling
134.25 a casket, alternate container, or cremation container to the public, and not having charge of
134.26 the final disposition of the dead human body, shall provide a copy of the statutes and rules
134.27 controlling the removal, preparation, transportation, arrangements for disposition, and final
134.28 disposition of a dead human body. This subdivision does not apply to morticians, funeral
134.29 directors, funeral establishments, crematories, or wholesale distributors of caskets, alternate
134.30 containers, alkaline hydrolysis containers, or cremation containers.

134.31 Sec. 45. Minnesota Statutes 2022, section 149A.72, subdivision 3, is amended to read:

134.32 Subd. 3. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**
134.33 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods or

135.1 funeral services to the public, it is a deceptive act or practice for a funeral provider to
135.2 represent that a casket is required for alkaline hydrolysis ~~or~~, cremations, or, effective July
135.3 1, 2025, natural organic reduction by state or local law or otherwise.

135.4 Sec. 46. Minnesota Statutes 2022, section 149A.72, subdivision 9, is amended to read:

135.5 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods, funeral
135.6 services, burial site goods, or burial site services to the public, it is a deceptive act or practice
135.7 for a funeral provider to represent that federal, state, or local laws, or particular cemeteries,
135.8 alkaline hydrolysis facilities, ~~or~~ crematories, or, effective July 1, 2025, natural organic
135.9 reduction facilities require the purchase of any funeral goods, funeral services, burial site
135.10 goods, or burial site services when that is not the case.

135.11 Sec. 47. Minnesota Statutes 2022, section 149A.73, subdivision 1, is amended to read:

135.12 Subdivision 1. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**
135.13 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods, funeral
135.14 services, burial site goods, or burial site services to the public, it is a deceptive act or practice
135.15 for a funeral provider to require that a casket be purchased for alkaline hydrolysis ~~or~~,
135.16 cremation, or, effective July 1, 2025, natural organic reduction.

135.17 Sec. 48. Minnesota Statutes 2022, section 149A.74, subdivision 1, is amended to read:

135.18 Subdivision 1. **Services provided without prior approval; deceptive acts or**
135.19 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it is
135.20 a deceptive act or practice for any funeral provider to embalm a dead human body unless
135.21 state or local law or regulation requires embalming in the particular circumstances regardless
135.22 of any funeral choice which might be made, or prior approval for embalming has been
135.23 obtained from an individual legally authorized to make such a decision. In seeking approval
135.24 to embalm, the funeral provider must disclose that embalming is not required by law except
135.25 in certain circumstances; that a fee will be charged if a funeral is selected which requires
135.26 embalming, such as a funeral with viewing; and that no embalming fee will be charged if
135.27 the family selects a service which does not require embalming, such as direct alkaline
135.28 hydrolysis, direct cremation, ~~or~~ immediate burial, or, effective July 1, 2025, natural organic
135.29 reduction.

136.1 Sec. 49. Minnesota Statutes 2022, section 149A.93, subdivision 3, is amended to read:

136.2 Subd. 3. **Disposition permit.** A disposition permit is required before a body can be
136.3 buried, entombed, alkaline hydrolyzed, ~~or cremated,~~ or, effective July 1, 2025, naturally
136.4 reduced. No disposition permit shall be issued until a fact of death record has been completed
136.5 and filed with the state registrar of vital records.

136.6 Sec. 50. Minnesota Statutes 2022, section 149A.94, subdivision 1, is amended to read:

136.7 Subdivision 1. **Generally.** Every dead human body lying within the state, except
136.8 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
136.9 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
136.10 the state for the purpose of disposition elsewhere; and the remains of any dead human body
136.11 after dissection or anatomical study, shall be decently buried or entombed in a public or
136.12 private cemetery, alkaline hydrolyzed, ~~or cremated,~~ or, effective July 1, 2025, naturally
136.13 reduced within a reasonable time after death. Where final disposition of a body will not be
136.14 accomplished, or, effective July 1, 2025, when natural organic reduction will not be initiated,
136.15 within 72 hours following death or release of the body by a competent authority with
136.16 jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed
136.17 with dry ice. A body may not be kept in refrigeration for a period exceeding six calendar
136.18 days, or packed in dry ice for a period that exceeds four calendar days, from the time of
136.19 death or release of the body from the coroner or medical examiner.

136.20 Sec. 51. Minnesota Statutes 2022, section 149A.94, subdivision 3, is amended to read:

136.21 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, ~~or cremated,~~
136.22 alkaline hydrolyzed, or, effective July 1, 2025, naturally reduced without a disposition
136.23 permit. The disposition permit must be filed with the person in charge of the place of final
136.24 disposition. Where a dead human body will be transported out of this state for final
136.25 disposition, the body must be accompanied by a certificate of removal.

136.26 Sec. 52. Minnesota Statutes 2022, section 149A.94, subdivision 4, is amended to read:

136.27 Subd. 4. **Alkaline hydrolysis ~~or~~, cremation, or natural organic reduction.** Inurnment
136.28 of alkaline hydrolyzed ~~or~~ remains, cremated remains, or, effective July 1, 2025, naturally
136.29 reduced remains and release to an appropriate party is considered final disposition and no
136.30 further permits or authorizations are required for transportation, interment, entombment, or
136.31 placement of the ~~cremated~~ remains, except as provided in section 149A.95, subdivision 16.

137.1 Sec. 53. [149A.955] NATURAL ORGANIC REDUCTION FACILITIES AND
137.2 NATURAL ORGANIC REDUCTION.

137.3 Subdivision 1. License required. This section is effective July 1, 2025. A dead human
137.4 body may only undergo natural organic reduction in this state at a natural organic reduction
137.5 facility licensed by the commissioner of health.

137.6 Subd. 2. General requirements. Any building to be used as a natural organic reduction
137.7 facility must comply with all applicable local and state building codes, zoning laws and
137.8 ordinances, and environmental standards. A natural organic reduction facility must have,
137.9 on site, a natural organic reduction system approved by the commissioner and a motorized
137.10 mechanical device for processing naturally reduced remains and must have, in the building,
137.11 a refrigerated holding facility for the retention of dead human bodies awaiting natural organic
137.12 reduction. The holding facility must be secure from access by anyone except the authorized
137.13 personnel of the natural organic reduction facility, preserve the dignity of the remains, and
137.14 protect the health and safety of the natural organic reduction facility personnel.

137.15 Subd. 3. Aerobic reduction vessel. A natural organic reduction facility must use as a
137.16 natural organic reduction vessel, a contained reduction vessel that is designed to promote
137.17 aerobic reduction and that minimizes odors.

137.18 Subd. 4. Unlicensed personnel. A licensed natural organic reduction facility may employ
137.19 unlicensed personnel, provided that all applicable provisions of this chapter are followed.
137.20 It is the duty of the licensed natural organic reduction facility to provide proper training for
137.21 all unlicensed personnel, and the licensed natural organic reduction facility shall be strictly
137.22 accountable for compliance with this chapter and other applicable state and federal regulations
137.23 regarding occupational and workplace health and safety.

137.24 Subd. 5. Authorization to naturally reduce. No natural organic reduction facility shall
137.25 naturally reduce or cause to be naturally reduced any dead human body or identifiable body
137.26 part without receiving written authorization to do so from the person or persons who have
137.27 the legal right to control disposition as described in section 149A.80 or the person's legal
137.28 designee. The written authorization must include:

137.29 (1) the name of the deceased and the date of death of the deceased;

137.30 (2) a statement authorizing the natural organic reduction facility to naturally reduce the
137.31 body;

137.32 (3) the name, address, phone number, relationship to the deceased, and signature of the
137.33 person or persons with the legal right to control final disposition or a legal designee;

138.1 (4) directions for the disposition of any non-naturally reduced materials or items recovered
138.2 from the natural organic reduction vessel;

138.3 (5) acknowledgment that some of the naturally reduced remains will be mechanically
138.4 reduced to a granulated appearance and included in the appropriate containers with the
138.5 naturally reduced remains; and

138.6 (6) directions for the ultimate disposition of the naturally reduced remains.

138.7 Subd. 6. **Limitation of liability.** The limitations in section 149A.95, subdivision 5, apply
138.8 to natural organic reduction facilities.

138.9 Subd. 7. **Acceptance of delivery of body.** (a) No dead human body shall be accepted
138.10 for final disposition by natural organic reduction unless:

138.11 (1) a licensed mortician is present;

138.12 (2) the body is wrapped in a container, such as a pouch or shroud, that is impermeable
138.13 or leak-resistant;

138.14 (3) the body is accompanied by a disposition permit issued pursuant to section 149A.93,
138.15 subdivision 3, including a photocopy of the complete death record or a signed release
138.16 authorizing natural organic reduction received from a coroner or medical examiner; and

138.17 (4) the body is accompanied by a natural organic reduction authorization that complies
138.18 with subdivision 5.

138.19 (b) A natural organic reduction facility shall refuse to accept delivery of the dead human
138.20 body:

138.21 (1) where there is a known dispute concerning natural organic reduction of the body
138.22 delivered;

138.23 (2) where there is a reasonable basis for questioning any of the representations made on
138.24 the written authorization to naturally reduce; or

138.25 (3) for any other lawful reason.

138.26 (c) When a container, pouch, or shroud containing a dead human body shows evidence
138.27 of leaking bodily fluid, the container, pouch, or shroud and the body must be returned to
138.28 the contracting funeral establishment, or the body must be transferred to a new container,
138.29 pouch, or shroud by a licensed mortician.

139.1 (d) If a dead human body is delivered to a natural organic reduction facility in a container,
139.2 pouch, or shroud that is not suitable for placement in a natural organic reduction vessel, the
139.3 transfer of the body to the vessel must be performed by a licensed mortician.

139.4 Subd. 8. **Bodies awaiting natural organic reduction.** A dead human body must be
139.5 placed in the natural organic reduction vessel to initiate the natural reduction process within
139.6 24 hours after the natural organic reduction facility accepts legal and physical custody of
139.7 the body.

139.8 Subd. 9. **Handling of dead human bodies.** All natural organic reduction facility
139.9 employees handling the containers, pouches, or shrouds for dead human bodies shall use
139.10 universal precautions and otherwise exercise all reasonable precautions to minimize the
139.11 risk of transmitting any communicable disease from the body. No dead human body shall
139.12 be removed from the container, pouch, or shroud in which it is delivered to the natural
139.13 organic reduction facility without express written authorization of the person or persons
139.14 with legal right to control the disposition and only by a licensed mortician. The remains
139.15 shall be considered a dead human body until after the processing and curing of the remains
139.16 are completed.

139.17 Subd. 10. **Identification of the body.** All licensed natural organic reduction facilities
139.18 shall develop, implement, and maintain an identification procedure whereby dead human
139.19 bodies can be identified from the time the natural organic reduction facility accepts delivery
139.20 of the body until the naturally reduced remains are released to an authorized party. After
139.21 natural organic reduction, an identifying disk, tab, or other permanent label shall be placed
139.22 within the naturally reduced remains container or containers before the remains are released
139.23 from the natural organic reduction facility. Each identification disk, tab, or label shall have
139.24 a number that shall be recorded on all paperwork regarding the decedent. This procedure
139.25 shall be designed to reasonably ensure that the proper body is naturally reduced and that
139.26 the remains are returned to the appropriate party. Loss of all or part of the remains or the
139.27 inability to individually identify the remains is a violation of this subdivision.

139.28 Subd. 11. **Natural organic reduction vessel for human remains.** A licensed natural
139.29 organic reduction facility shall knowingly naturally reduce only dead human bodies or
139.30 human remains in a natural organic reduction vessel.

139.31 Subd. 12. **Natural organic reduction procedures; privacy.** The final disposition of
139.32 dead human bodies by natural organic reduction shall be done in privacy. Unless there is
139.33 written authorization from the person with the legal right to control the final disposition,
139.34 only authorized natural organic reduction facility personnel shall be permitted in the natural

140.1 organic reduction area while any human body is awaiting placement in a natural organic
140.2 reduction vessel, being removed from the vessel, or being processed for placement in a
140.3 naturally reduced remains container. This does not prohibit an in-person laying-in ceremony
140.4 to honor the deceased and the transition prior to the placement.

140.5 **Subd. 13. Natural organic reduction procedures; commingling of bodies**
140.6 **prohibited.** Except with the express written permission of the person with the legal right
140.7 to control the final disposition, no natural organic reduction facility shall naturally reduce
140.8 more than one dead human body at the same time and in the same natural organic reduction
140.9 vessel or introduce a second dead human body into same natural organic reduction vessel
140.10 until reasonable efforts have been employed to remove all fragments of remains from the
140.11 preceding natural organic reduction. This subdivision does not apply where commingling
140.12 of human remains during natural organic reduction is otherwise provided by law. The fact
140.13 that there is incidental and unavoidable residue in the natural organic reduction vessel used
140.14 in a prior natural organic reduction is not a violation of this subdivision.

140.15 **Subd. 14. Natural organic reduction procedures; removal from natural organic**
140.16 **reduction vessel.** Upon completion of the natural organic reduction process, reasonable
140.17 efforts shall be made to remove from the natural organic reduction vessel all the recoverable
140.18 naturally reduced remains. The naturally reduced remains shall be transported to the
140.19 processing area, and any non-naturally reducible materials or items shall be separated from
140.20 the naturally reduced remains and disposed of, in any lawful manner, by the natural organic
140.21 reduction facility.

140.22 **Subd. 15. Natural organic reduction procedures; processing naturally reduced**
140.23 **remains.** The remaining intact naturally reduced remains shall be reduced by a motorized
140.24 mechanical processor to a granulated appearance. The granulated remains and the rest of
140.25 the naturally reduced remains shall be returned to a natural organic reduction vessel for
140.26 final reduction.

140.27 **Subd. 16. Natural organic reduction procedures; commingling of naturally reduced**
140.28 **remains prohibited.** Except with the express written permission of the person with the
140.29 legal right to control the final deposition or as otherwise provided by law, no natural organic
140.30 reduction facility shall mechanically process the naturally reduced remains of more than
140.31 one body at a time in the same mechanical processor, or introduce the naturally reduced
140.32 remains of a second body into a mechanical processor until reasonable efforts have been
140.33 employed to remove all fragments of naturally reduced remains already in the processor.
140.34 The presence of incidental and unavoidable residue in the mechanical processor does not
140.35 violate this subdivision.

141.1 Subd. 17. Natural organic reduction procedures; testing naturally reduced

141.2 remains. A natural organic reduction facility must:

141.3 (1) ensure that the material in the natural organic reduction vessel naturally reaches and
 141.4 maintains a minimum temperature of 131 degrees Fahrenheit for a minimum of 72
 141.5 consecutive hours during the process of natural organic reduction;

141.6 (2) analyze each instance of the naturally reduced remains for physical contaminants,
 141.7 including but are not limited to intact bone, dental fillings, and medical implants, and ensure
 141.8 naturally reduced remains have less than 0.01 mg/kg dry weight of any physical contaminants;

141.9 (3) collect material samples for analysis that are representative of each instance of natural
 141.10 organic reduction, using a sampling method such as that described in the U.S. Composting
 141.11 Council 2002 Test Methods for the Examination of Composting and Compost, method
 141.12 02.01-A through E;

141.13 (4) develop and use a natural organic reduction process in which the naturally reduced
 141.14 remains from the process do not exceed the following limits:

<u>Metals and other testing</u>	<u>Limit (mg/kg dry weight), unless otherwise</u>
<u>parameters</u>	<u>specified</u>
141.17 <u>Fecal coliform</u>	<u>Less than 1,000 most probable number per gram</u>
141.18 <u>Salmonella</u>	<u>of total solids (dry weight)</u>
141.19 <u>Arsenic</u>	<u>Less than 3 most probable number per 4 grams</u>
141.20 <u>Cadmium</u>	<u>of total solids (dry weight)</u>
141.21 <u>Lead</u>	<u>Less than or equal to 11 ppm</u>
141.22 <u>Mercury</u>	<u>Less than or equal to 7.1 ppm</u>
141.23 <u>Selenium</u>	<u>Less than or equal to 150 ppm</u>
141.24 <u></u>	<u>Less than or equal to 8 ppm</u>
141.25 <u></u>	<u>Less than or equal to 18 ppm;</u>

141.26 (5) analyze, using a third-party laboratory, the natural organic reduction facility's material
 141.27 samples of naturally reduced remains according to the following schedule:

141.28 (i) the natural organic reduction facility must analyze each of the first 20 instances of
 141.29 naturally reduced remains for the parameters in clause (4);

141.30 (ii) if any of the first 20 instances of naturally reduced remains yield results exceeding
 141.31 the limits in clause (4), the natural organic reduction facility must conduct appropriate
 141.32 processes to correct the levels of the substances in clause (4) and have the resultant remains
 141.33 tested to ensure they fall within the identified limits;

141.34 (iii) if any of the first 20 instances of naturally reduced remains yield results exceeding
 141.35 the limits in clause (4), the natural organic reduction facility must analyze each additional

142.1 instance of naturally reduced remains for the parameters in clause (4) until a total of 20
142.2 samples, not including those from remains that were reprocessed as required in item (ii),
142.3 have yielded results within the limits in clause (4) on initial testing;

142.4 (iv) after 20 material samples of naturally reduced remains have met the limits in clause
142.5 (4), the natural organic reduction facility must analyze at least 25 percent of the natural
142.6 organic reduction facility's monthly instances of naturally reduced remains for the parameters
142.7 in clause (4) until 80 total material samples of naturally reduced remains are found to meet
142.8 the limits in clause (4), not including any samples that required reprocessing to meet those
142.9 limits; and

142.10 (v) after 80 material samples of naturally reduced remains are found to meet the limits
142.11 in clause (4), the natural organic reduction facility must analyze at least one instance of
142.12 naturally reduced remains each month for the parameters in clause (4);

142.13 (6) comply with any testing requirements established by the commissioner for content
142.14 parameters in addition to those specified in clause (4);

142.15 (7) not release any naturally reduced remains that exceed the limits in clause (4); and

142.16 (8) prepare, maintain, and provide to the commissioner upon request, a report for each
142.17 calendar year detailing the natural organic reduction facility's activities during the previous
142.18 calendar year. The report must include the following information:

142.19 (i) the name and address of the natural organic reduction facility;

142.20 (ii) the calendar year covered by the report;

142.21 (iii) the annual quantity of naturally reduced remains;

142.22 (iv) the results of any laboratory analyses of naturally reduced remains; and

142.23 (v) any additional information required by the commissioner.

142.24 **Subd. 18. Natural organic reduction procedures; use of more than one naturally**
142.25 **reduced remains container.** If the naturally reduced remains are to be separated into two
142.26 or more naturally reduced remains containers according to the directives provided in the
142.27 written authorization for natural organic reduction, all of the containers shall contain duplicate
142.28 identification disks, tabs, or permanent labels and all paperwork regarding the given body
142.29 shall include a notation of the number of and disposition of each container, as provided in
142.30 the written authorization.

142.31 **Subd. 19. Natural organic reduction procedures; disposition of accumulated**
142.32 **residue.** Every natural organic reduction facility shall provide for the removal and disposition

143.1 of any accumulated residue from any natural organic reduction vessel, mechanical processor,
143.2 or other equipment used in natural organic reduction. Disposition of accumulated residue
143.3 shall be by any lawful manner deemed appropriate.

143.4 Subd. 20. **Natural organic reduction procedures; release of naturally reduced**
143.5 **remains.** Following completion of the natural organic reduction process, the inurned naturally
143.6 reduced remains shall be released according to the instructions given on the written
143.7 authorization for natural organic reduction. If the remains are to be shipped, they must be
143.8 securely packaged and transported by a method which has an internal tracing system available
143.9 and which provides a receipt signed by the person accepting delivery. Where there is a
143.10 dispute over release or disposition of the naturally reduced remains, a natural organic
143.11 reduction facility may deposit the naturally reduced remains in accordance with the directives
143.12 of a court of competent jurisdiction pending resolution of the dispute or retain the naturally
143.13 reduced remains until the person with the legal right to control disposition presents
143.14 satisfactory indication that the dispute is resolved. A natural organic reduction facility must
143.15 not sell naturally reduced remains and must make every effort to not release naturally reduced
143.16 remains for sale or for use for commercial purposes.

143.17 Subd. 21. **Unclaimed naturally reduced remains.** If, after 30 calendar days following
143.18 the inurnment, the naturally reduced remains are not claimed or disposed of according to
143.19 the written authorization for natural organic reduction, the natural organic reduction facility
143.20 shall give written notice, by certified mail, to the person with the legal right to control the
143.21 final disposition or a legal designee, that the naturally reduced remains are unclaimed and
143.22 requesting further release directions. Should the naturally reduced remains be unclaimed
143.23 120 calendar days following the mailing of the written notification, the natural organic
143.24 reduction facility may return the remains to the earth respectfully in any lawful manner
143.25 deemed appropriate.

143.26 Subd. 22. **Required records.** Every natural organic reduction facility shall create and
143.27 maintain on its premises or other business location in Minnesota an accurate record of every
143.28 natural organic reduction provided. The record shall include all of the following information
143.29 for each natural organic reduction:

143.30 (1) the name of the person or funeral establishment delivering the body for natural
143.31 organic reduction;

143.32 (2) the name of the deceased and the identification number assigned to the body;

143.33 (3) the date of acceptance of delivery;

144.1 (4) the names of the operator of the natural organic reduction process and mechanical
144.2 processor operator;

144.3 (5) the times and dates that the body was placed in and removed from the natural organic
144.4 reduction vessel;

144.5 (6) the time and date that processing and inurnment of the naturally reduced remains
144.6 was completed;

144.7 (7) the time, date, and manner of release of the naturally reduced remains;

144.8 (8) the name and address of the person who signed the authorization for natural organic
144.9 reduction;

144.10 (9) all supporting documentation, including any transit or disposition permits, a photocopy
144.11 of the death record, and the authorization for natural organic reduction; and

144.12 (10) the type of natural organic reduction vessel.

144.13 Subd. 23. **Retention of records.** Records required under subdivision 22 shall be
144.14 maintained for a period of three calendar years after the release of the naturally reduced
144.15 remains. Following this period and subject to any other laws requiring retention of records,
144.16 the natural organic reduction facility may then place the records in storage or reduce them
144.17 to microfilm, a digital format, or any other method that can produce an accurate reproduction
144.18 of the original record, for retention for a period of ten calendar years from the date of release
144.19 of the naturally reduced remains. At the end of this period and subject to any other laws
144.20 requiring retention of records, the natural organic reduction facility may destroy the records
144.21 by shredding, incineration, or any other manner that protects the privacy of the individuals
144.22 identified.

144.23 Sec. 54. **REQUEST FOR INFORMATION; EVALUATION OF STATEWIDE**
144.24 **HEALTH CARE NEEDS AND CAPACITY AND PROJECTIONS OF FUTURE**
144.25 **HEALTH CARE NEEDS.**

144.26 (a) By November 1, 2024, the commissioner of health must publish a request for
144.27 information to assist the commissioner in a future comprehensive evaluation of current
144.28 health care needs and capacity in the state and projections of future health care needs in the
144.29 state based on population and provider characteristics. The request for information:

144.30 (1) must provide guidance on defining the scope of the study and assist in answering
144.31 methodological questions that will inform the development of a request for proposals to
144.32 contract for performance of the study; and

145.1 (2) may address topics that include but are not limited to how to define health care
145.2 capacity, expectations for capacity by geography or service type, how to consider health
145.3 centers that have areas of particular expertise or services that generally have a higher margin,
145.4 how hospital-based services should be considered as compared with evolving
145.5 nonhospital-based services, the role of technology in service delivery, health care workforce
145.6 supply issues, and other issues related to data or methods.

145.7 (b) By February 1, 2025, the commissioner must submit a report to the chairs and ranking
145.8 minority members of the legislative committees with jurisdiction over health care, with the
145.9 results of the request for information and recommendations regarding conducting a
145.10 comprehensive evaluation of current health care needs and capacity in the state and
145.11 projections of future health care needs in the state.

145.12 Sec. 55. **REPEALER.**

145.13 Minnesota Statutes 2023 Supplement, section 144.0528, subdivision 5, is repealed.

145.14 **ARTICLE 6**
145.15 **DEPARTMENT OF HEALTH POLICY**

145.16 Section 1. **[62J.461] 340B COVERED ENTITY REPORT.**

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

145.19 (b) "340B covered entity" or "covered entity" means a covered entity as defined in United
145.20 States Code, title 42, section 256b(a)(4), with a service address in Minnesota as of January
145.21 1 of the reporting year. 340B covered entity includes all entity types and grantees. All
145.22 facilities that are identified as child sites or grantee associated sites under the federal 340B
145.23 Drug Pricing Program are considered part of the 340B covered entity.

145.24 (c) "340B Drug Pricing Program" or "340B program" means the drug discount program
145.25 established under United States Code, title 42, section 256b.

145.26 (d) "340B entity type" is the designation of the 340B covered entity according to the
145.27 entity types specified in United States Code, title 42, section 256b(a)(4).

145.28 (e) "340B ID" is the unique identification number provided by the Health Resources
145.29 and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy
145.30 Affairs Information System.

146.1 (f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an
146.2 arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

146.3 (g) "Pricing unit" means the smallest dispensable amount of a prescription drug product
146.4 that can be dispensed or administered.

146.5 Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must
146.6 maintain a current registration with the commissioner in a form and manner prescribed by
146.7 the commissioner. The registration must include the following information:

146.8 (1) the name of the 340B covered entity;

146.9 (2) the 340B ID of the 340B covered entity;

146.10 (3) the servicing address of the 340B covered entity; and

146.11 (4) the 340B entity type of the 340B covered entity.

146.12 Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered
146.13 entity shall report to the commissioner by April 1, 2024, and by April 1 of each year
146.14 thereafter, the following information for transactions conducted by the 340B covered entity
146.15 or on its behalf, and related to its participation in the federal 340B program for the previous
146.16 calendar year:

146.17 (1) the aggregated acquisition cost for prescription drugs obtained under the 340B
146.18 program;

146.19 (2) the aggregated payment amount received for drugs obtained under the 340B program
146.20 and dispensed or administered to patients;

146.21 (3) the number of pricing units dispensed or administered for prescription drugs described
146.22 in clause (2); and

146.23 (4) the aggregated payments made:

146.24 (i) to contract pharmacies to dispense drugs obtained under the 340B program;

146.25 (ii) to any other entity that is not the covered entity and is not a contract pharmacy for
146.26 managing any aspect of the covered entity's 340B program; and

146.27 (iii) for all other expenses related to administering the 340B program.

146.28 The information under clauses (2) and (3) must be reported by payer type, including but
146.29 not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in
146.30 the form and manner prescribed by the commissioner.

147.1 (b) For covered entities that are hospitals, the information required under paragraph (a),
147.2 clauses (1) to (3), must also be reported at the national drug code level for the 50 most
147.3 frequently dispensed or administered drugs by the facility under the 340B program.

147.4 (c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as
147.5 nonpublic data, as defined in section 13.02, subdivision 9.

147.6 Subd. 4. **Enforcement and exceptions.** (a) Any health care entity subject to reporting
147.7 under this section that fails to provide data in the form and manner prescribed by the
147.8 commissioner is subject to a fine paid to the commissioner of up to \$500 for each day the
147.9 data are past due. Any fine levied against the entity under this subdivision is subject to the
147.10 contested case and judicial review provisions of sections 14.57 and 14.69.

147.11 (b) The commissioner may grant an entity an extension of or exemption from the reporting
147.12 obligations under this subdivision, upon a showing of good cause by the entity.

147.13 Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of
147.14 each year thereafter, the commissioner shall submit to the chairs and ranking minority
147.15 members of the legislative committees with jurisdiction over health care finance and policy,
147.16 a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). The
147.17 following information must be included in the report for all 340B entities whose net 340B
147.18 revenue constitutes a significant share, as determined by the commissioner, of all net 340B
147.19 revenue across all 340B covered entities in Minnesota:

147.20 (1) the information submitted under subdivision 2; and

147.21 (2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as
147.22 calculated using the data submitted under subdivision 3, paragraph (a), with net revenue
147.23 being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a),
147.24 clauses (1) and (4).

147.25 For all other entities, the data in the report must be aggregated to the entity type or groupings
147.26 of entity types in a manner that prevents the identification of an individual entity and any
147.27 entity's specific data value reported for an individual data element.

147.28 Sec. 2. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

147.29 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ Opportunity for
147.30 comment. The commissioner shall ~~biennially seek comments from affected parties~~ maintain
147.31 an email address for submission of comments from interested parties to provide input about
147.32 the effectiveness of and continued need for the rulemaking procedures set out in subdivision
147.33 2 and about the quality and effectiveness of rules adopted using these procedures. The

148.1 commissioner ~~shall seek comments by holding a meeting and by publishing a notice in the~~
148.2 ~~State Register that contains the date, time, and location of the meeting and a statement that~~
148.3 ~~invites oral or written comments. The notice must be published at least 30 days before the~~
148.4 ~~meeting date. The commissioner shall write a report summarizing the comments and shall~~
148.5 ~~submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative~~
148.6 ~~Uniformity Committee by January 15 of every even-numbered year~~ may seek additional
148.7 input and provide additional opportunities for input as needed.

148.8 Sec. 3. Minnesota Statutes 2022, section 144.05, subdivision 7, is amended to read:

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

148.13 (b) If the mandate requires the submission of an annual report and the mandate was
148.14 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate
148.15 requires the submission of a biennial or less frequent report and the mandate was enacted
148.16 before January 1, 2021, the mandate shall expire on January 1, 2024.

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

148.22 (d) The commissioner shall submit a list to the chairs and ranking minority members of
148.23 the legislative committees with jurisdiction over health by February 15 of each year,
148.24 beginning February 15, 2022, of all reports set to expire during the following calendar year
148.25 in accordance with this section. The mandate to submit a report to the legislature under this
148.26 paragraph does not expire.

148.27 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2024.

148.28 Sec. 4. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended
148.29 to read:

148.30 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota
148.31 One Health Antimicrobial Stewardship Collaborative. The commissioner shall ~~appoint~~ hire
148.32 a director to execute operations, conduct health education, and provide technical assistance.

149.1 Sec. 5. Minnesota Statutes 2022, section 144.058, is amended to read:

149.2 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

149.3 (a) The commissioner of health shall establish a voluntary statewide roster; and develop
149.4 a plan for a registry and certification process for interpreters who provide high quality,
149.5 spoken language health care interpreter services. The roster, registry, and certification
149.6 process shall be based on the findings and recommendations set forth by the Interpreter
149.7 Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

149.8 (b) By January 1, 2009, the commissioner shall establish a roster of all available
149.9 interpreters to address access concerns, particularly in rural areas.

149.10 (c) By January 15, 2010, the commissioner shall:

149.11 (1) develop a plan for a registry of spoken language health care interpreters, including:

149.12 (i) development of standards for registration that set forth educational requirements,
149.13 training requirements, demonstration of language proficiency and interpreting skills,
149.14 agreement to abide by a code of ethics, and a criminal background check;

149.15 (ii) recommendations for appropriate alternate requirements in languages for which
149.16 testing and training programs do not exist;

149.17 (iii) recommendations for appropriate fees; and

149.18 (iv) recommendations for establishing and maintaining the standards for inclusion in
149.19 the registry; and

149.20 (2) develop a plan for implementing a certification process based on national testing and
149.21 certification processes for spoken language interpreters 12 months after the establishment
149.22 of a national certification process.

149.23 (d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper
149.24 Midwest Translators and Interpreters Association for advice on the standards required to
149.25 plan for the development of a registry and certification process.

149.26 (e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the
149.27 roster. Fee revenue shall be deposited in the state government special revenue fund. All fees
149.28 are nonrefundable.

149.29 Sec. 6. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

149.30 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
149.31 given.

150.1 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
 150.2 periods in the MDS assessment process. This look-back period is also called the observation
 150.3 or assessment period.

150.4 (b) "Case mix index" means the weighting factors assigned to the ~~RUG-IV~~ case mix
 150.5 reimbursement classifications determined by an assessment.

150.6 (c) "Index maximization" means classifying a resident who could be assigned to more
 150.7 than one category, to the category with the highest case mix index.

150.8 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,
 150.9 and functional status elements, that include common definitions and coding categories
 150.10 specified by the Centers for Medicare and Medicaid Services and designated by the
 150.11 Department of Health.

150.12 (e) "Representative" means a person who is the resident's guardian or conservator, the
 150.13 person authorized to pay the nursing home expenses of the resident, a representative of the
 150.14 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
 150.15 other individual designated by the resident.

150.16 ~~(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing~~
 150.17 ~~facility's residents according to their clinical and functional status identified in data supplied~~
 150.18 ~~by the facility's Minimum Data Set.~~

150.19 ~~(g)~~ (f) "Activities of daily living" includes personal hygiene, dressing, bathing,
 150.20 transferring, bed mobility, locomotion, eating, and toileting.

150.21 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that
 150.22 results in a determination of a resident's or prospective resident's need for nursing facility
 150.23 level of care as established in subdivision 11 for purposes of medical assistance payment
 150.24 of long-term care services for:

150.25 (1) nursing facility services under ~~section 256B.434~~ or chapter 256R;

150.26 (2) elderly waiver services under chapter 256S;

150.27 (3) CADI and BI waiver services under section 256B.49; and

150.28 (4) state payment of alternative care services under section 256B.0913.

150.29 Sec. 7. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

150.30 Subd. 3a. **Resident reimbursement case mix reimbursement classifications beginning**
 150.31 **January 1, 2012.** (a) Beginning January 1, 2012, Resident reimbursement case mix

151.1 reimbursement classifications shall be based on the Minimum Data Set, version 3.0
 151.2 assessment instrument, or its successor version mandated by the Centers for Medicare and
 151.3 Medicaid Services that nursing facilities are required to complete for all residents. ~~The~~
 151.4 ~~commissioner of health shall establish resident classifications according to the RUG-IV,~~
 151.5 ~~48 group, resource utilization groups. Resident classification must be established based on~~
 151.6 ~~the individual items on the Minimum Data Set, which must be completed according to the~~
 151.7 ~~Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its~~
 151.8 ~~successor issued by the Centers for Medicare and Medicaid Services. Case mix~~
 151.9 reimbursement classifications shall also be based on assessments required under subdivision
 151.10 4. Assessments must be completed according to the Long Term Care Facility Resident
 151.11 Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the
 151.12 Centers for Medicare and Medicaid Services. The optional state assessment must be
 151.13 completed according to the OSA Manual Version 1.0 v.2.

151.14 (b) Each resident must be classified based on the information from the Minimum Data
 151.15 Set according to the general categories issued by the Minnesota Department of Health,
 151.16 utilized for reimbursement purposes.

151.17 Sec. 8. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

151.18 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 151.19 submit to the federal database MDS assessments that conform with the assessment schedule
 151.20 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,
 151.21 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The
 151.22 commissioner of health may substitute successor manuals or question and answer documents
 151.23 published by the United States Department of Health and Human Services, Centers for
 151.24 Medicare and Medicaid Services, to replace or supplement the current version of the manual
 151.25 or document.

151.26 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987
 151.27 (OBRA) used to determine a case mix reimbursement classification ~~for reimbursement~~
 151.28 include:

151.29 (1) a new admission comprehensive assessment, which must have an assessment reference
 151.30 date (ARD) within 14 calendar days after admission, excluding readmissions;

151.31 (2) an annual comprehensive assessment, which must have an ARD within 92 days of
 151.32 a previous quarterly review assessment or a previous comprehensive assessment, which
 151.33 must occur at least once every 366 days;

152.1 (3) a significant change in status comprehensive assessment, which must have an ARD
 152.2 within 14 days after the facility determines, or should have determined, that there has been
 152.3 a significant change in the resident's physical or mental condition, whether an improvement
 152.4 or a decline, and regardless of the amount of time since the last comprehensive assessment
 152.5 or quarterly review assessment;

152.6 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the
 152.7 previous quarterly review assessment or a previous comprehensive assessment;

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

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

152.12 ~~(7) a required significant change in status assessment when:~~

152.13 ~~(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA~~
 152.14 ~~comprehensive or quarterly assessment completed does not result in a rehabilitation case~~
 152.15 ~~mix classification, then the significant change in status assessment is not required. The ARD~~
 152.16 ~~of this assessment must be set on day eight after all therapy services have ended; and~~

152.17 ~~(ii) isolation for an infectious disease has ended. If isolation was not coded on the most~~
 152.18 ~~recent OBRA comprehensive or quarterly assessment completed, then the significant change~~
 152.19 ~~in status assessment is not required. The ARD of this assessment must be set on day 15 after~~
 152.20 ~~isolation has ended; and~~

152.21 (8) (7) any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

152.22 (c) The optional state assessment must accompany all OBRA assessments. The optional
 152.23 state assessment is also required to determine reimbursement when:

152.24 (i) all speech, occupational, and physical therapies have ended. If the most recent optional
 152.25 state assessment completed does not result in a rehabilitation case mix reimbursement
 152.26 classification, then the optional state assessment is not required. The ARD of this assessment
 152.27 must be set on day eight after all therapy services have ended; and

152.28 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most
 152.29 recent optional state assessment completed, then the optional state assessment is not required.
 152.30 The ARD of this assessment must be set on day 15 after isolation has ended.

152.31 ~~(e)~~ (d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the
 152.32 assessments used to determine nursing facility level of care include the following:

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

153.4 (2) a nursing facility level of care determination as provided for under section 256B.0911,
 153.5 subdivision 26, as part of a face-to-face long-term care consultation assessment completed
 153.6 under section 256B.0911, by a county, tribe, or managed care organization under contract
 153.7 with the Department of Human Services.

153.8 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

153.9 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or
 153.10 submit an assessment according to subdivisions 4 and 5 for a ~~RUG-IV~~ case mix
 153.11 reimbursement classification ~~within seven days of the time requirements listed in the~~
 153.12 ~~Long-Term Care Facility Resident Assessment Instrument User's Manual~~ when the
 153.13 assessment is due is subject to a reduced rate for that resident. The reduced rate shall be the
 153.14 lowest rate for that facility. The reduced rate is effective on the day of admission for new
 153.15 admission assessments, on the ARD for significant change in status assessments, or on the
 153.16 day that the assessment was due for all other assessments and continues in effect until the
 153.17 first day of the month following the date of submission and acceptance of the resident's
 153.18 assessment.

153.19 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
 153.20 are equal to or greater than 0.1 percent of the total operating costs on the facility's most
 153.21 recent annual statistical and cost report, a facility may apply to the commissioner of human
 153.22 services for a reduction in the total penalty amount. The commissioner of human services,
 153.23 in consultation with the commissioner of health, may, at the sole discretion of the
 153.24 commissioner of human services, limit the penalty for residents covered by medical assistance
 153.25 to ten days.

153.26 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

153.27 Subd. 7. **Notice of resident ~~reimbursement~~ case mix reimbursement classification.** (a)
 153.28 The commissioner of health shall provide to a nursing facility a notice for each resident of
 153.29 the classification established under subdivision 1. The notice must inform the resident of
 153.30 the case mix reimbursement classification assigned, the opportunity to review the
 153.31 documentation supporting the classification, the opportunity to obtain clarification from the
 153.32 commissioner, ~~and~~ the opportunity to request a reconsideration of the classification, ~~and~~
 153.33 the address and telephone number of the Office of Ombudsman for Long-Term Care. The

154.1 commissioner must transmit the notice of resident classification by electronic means to the
154.2 nursing facility. The nursing facility is responsible for the distribution of the notice to each
154.3 resident or the resident's representative. This notice must be distributed within three business
154.4 days after the facility's receipt.

154.5 (b) If a facility submits a ~~modifying~~ modified assessment resulting in a change in the
154.6 case mix reimbursement classification, the facility must provide a written notice to the
154.7 resident or the resident's representative regarding the item or items that were modified and
154.8 the reason for the modifications. The written notice must be provided within three business
154.9 days after distribution of the resident case mix reimbursement classification notice.

154.10 Sec. 11. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

154.11 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, ~~or~~
154.12 the resident's representative, ~~or~~ the nursing facility, or the boarding care home may request
154.13 that the commissioner of health reconsider the assigned ~~reimbursement~~ case mix
154.14 reimbursement classification and any item or items changed during the audit process. The
154.15 request for reconsideration must be submitted in writing to the commissioner of health.

154.16 (b) For reconsideration requests initiated by the resident or the resident's representative:

154.17 (1) The resident or the resident's representative must submit in writing a reconsideration
154.18 request to the facility administrator within 30 days of receipt of the resident classification
154.19 notice. The written request must include the reasons for the reconsideration request.

154.20 (2) Within three business days of receiving the reconsideration request, the nursing
154.21 facility must submit to the commissioner of health a completed reconsideration request
154.22 form, a copy of the resident's or resident's representative's written request, and all supporting
154.23 documentation used to complete the assessment being ~~considered~~ reconsidered. If the facility
154.24 fails to provide the required information, the reconsideration will be completed with the
154.25 information submitted and the facility cannot make further reconsideration requests on this
154.26 classification.

154.27 (3) Upon written request and within three business days, the nursing facility must give
154.28 the resident or the resident's representative a copy of the assessment being reconsidered and
154.29 all supporting documentation used to complete the assessment. Notwithstanding any law
154.30 to the contrary, the facility may not charge a fee for providing copies of the requested
154.31 documentation. If a facility fails to provide the required documents within this time, it is
154.32 subject to the issuance of a correction order and penalty assessment under sections 144.653
154.33 and 144A.10. Notwithstanding those sections, any correction order issued under this

155.1 subdivision must require that the nursing facility immediately comply with the request for
155.2 information, and as of the date of the issuance of the correction order, the facility shall
155.3 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the
155.4 \$100 fine by \$50 increments for each day the noncompliance continues.

155.5 (c) For reconsideration requests initiated by the facility:

155.6 (1) The facility is required to inform the resident or the resident's representative in writing
155.7 that a reconsideration of the resident's case mix reimbursement classification is being
155.8 requested. The notice must inform the resident or the resident's representative:

155.9 (i) of the date and reason for the reconsideration request;

155.10 (ii) of the potential for a case mix reimbursement classification change and subsequent
155.11 rate change;

155.12 (iii) of the extent of the potential rate change;

155.13 (iv) that copies of the request and supporting documentation are available for review;
155.14 and

155.15 (v) that the resident or the resident's representative has the right to request a
155.16 reconsideration also.

155.17 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the
155.18 facility must submit to the commissioner of health a completed reconsideration request
155.19 form, all supporting documentation used to complete the assessment being reconsidered,
155.20 and a copy of the notice informing the resident or the resident's representative that a
155.21 reconsideration of the resident's classification is being requested.

155.22 (3) If the facility fails to provide the required information, the reconsideration request
155.23 may be denied and the facility may not make further reconsideration requests on this
155.24 classification.

155.25 (d) Reconsideration by the commissioner must be made by individuals not involved in
155.26 reviewing the assessment, audit, or reconsideration that established the disputed classification.
155.27 The reconsideration must be based upon the assessment that determined the classification
155.28 and upon the information provided to the commissioner of health under paragraphs (a) to
155.29 (c). If necessary for evaluating the reconsideration request, the commissioner may conduct
155.30 on-site reviews. Within 15 business days of receiving the request for reconsideration, the
155.31 commissioner shall affirm or modify the original resident classification. The original
155.32 classification must be modified if the commissioner determines that the assessment resulting
155.33 in the classification did not accurately reflect characteristics of the resident at the time of

156.1 the assessment. The commissioner must transmit the reconsideration classification notice
156.2 by electronic means to the nursing facility. The nursing facility is responsible for the
156.3 distribution of the notice to the resident or the resident's representative. The notice must be
156.4 distributed by the nursing facility within three business days after receipt. A decision by
156.5 the commissioner under this subdivision is the final administrative decision of the agency
156.6 for the party requesting reconsideration.

156.7 (e) The case mix reimbursement classification established by the commissioner shall be
156.8 the classification which applies to the resident while the request for reconsideration is
156.9 pending. If a request for reconsideration applies to an assessment used to determine nursing
156.10 facility level of care under subdivision 4, paragraph ~~(e)~~ (d), the resident shall continue to
156.11 be eligible for nursing facility level of care while the request for reconsideration is pending.

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

156.14 (g) Data collected as part of the reconsideration process under this section is classified
156.15 as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding
156.16 the classification of these data as private or nonpublic, the commissioner is authorized to
156.17 share these data with the U.S. Centers for Medicare and Medicaid Services and the
156.18 commissioner of human services as necessary for reimbursement purposes.

156.19 Sec. 12. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

156.20 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
156.21 assessments performed under section 256R.17 through any of the following: desk audits;
156.22 on-site review of residents and their records; and interviews with staff, residents, or residents'
156.23 families. The commissioner shall reclassify a resident if the commissioner determines that
156.24 the resident was incorrectly classified.

156.25 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

156.26 (c) A facility must grant the commissioner access to examine the medical records relating
156.27 to the resident assessments selected for audit under this subdivision. The commissioner may
156.28 also observe and speak to facility staff and residents.

156.29 (d) The commissioner shall consider documentation under the time frames for coding
156.30 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
156.31 Instrument User's Manual or OSA Manual version 1.0 v.2 published by the Centers for
156.32 Medicare and Medicaid Services.

157.1 (e) The commissioner shall develop an audit selection procedure that includes the
157.2 following factors:

157.3 (1) Each facility shall be audited annually. If a facility has two successive audits in which
157.4 the percentage of change is five percent or less and the facility has not been the subject of
157.5 a special audit in the past 36 months, the facility may be audited biannually. A stratified
157.6 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
157.7 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ case mix reimbursement
157.8 classifications are changed as a result of the audit, the audit shall be expanded to a second
157.9 15 percent sample, with a minimum of ten assessments. If the total change between the first
157.10 and second samples is 35 percent or greater, the commissioner may expand the audit to all
157.11 of the remaining assessments.

157.12 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
157.13 again within six months. If a facility has two expanded audits within a 24-month period,
157.14 that facility will be audited at least every six months for the next 18 months.

157.15 (3) The commissioner may conduct special audits if the commissioner determines that
157.16 circumstances exist that could alter or affect the validity of case mix reimbursement
157.17 classifications of residents. These circumstances include, but are not limited to, the following:

157.18 (i) frequent changes in the administration or management of the facility;

157.19 (ii) an unusually high percentage of residents in a specific case mix reimbursement
157.20 classification;

157.21 (iii) a high frequency in the number of reconsideration requests received from a facility;

157.22 (iv) frequent adjustments of case mix reimbursement classifications as the result of
157.23 reconsiderations or audits;

157.24 (v) a criminal indictment alleging provider fraud;

157.25 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

157.26 (vii) an atypical pattern of scoring minimum data set items;

157.27 (viii) nonsubmission of assessments;

157.28 (ix) late submission of assessments; or

157.29 (x) a previous history of audit changes of 35 percent or greater.

157.30 (f) If the audit results in a case mix reimbursement classification change, the
157.31 commissioner must transmit the audit classification notice by electronic means to the nursing

158.1 facility within 15 business days of completing an audit. The nursing facility is responsible
158.2 for distribution of the notice to each resident or the resident's representative. This notice
158.3 must be distributed by the nursing facility within three business days after receipt. The
158.4 notice must inform the resident of the case mix reimbursement classification assigned, the
158.5 opportunity to review the documentation supporting the classification, the opportunity to
158.6 obtain clarification from the commissioner, the opportunity to request a reconsideration of
158.7 the classification, and the address and telephone number of the Office of Ombudsman for
158.8 Long-Term Care.

158.9 Sec. 13. Minnesota Statutes 2022, section 144.0724, subdivision 11, is amended to read:

158.10 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment
158.11 of long-term care services, a recipient must be determined, using assessments defined in
158.12 subdivision 4, to meet one of the following nursing facility level of care criteria:

158.13 (1) the person requires formal clinical monitoring at least once per day;

158.14 (2) the person needs the assistance of another person or constant supervision to begin
158.15 and complete at least four of the following activities of living: bathing, bed mobility, dressing,
158.16 eating, grooming, toileting, transferring, and walking;

158.17 (3) the person needs the assistance of another person or constant supervision to begin
158.18 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

158.19 (4) the person has significant difficulty with memory, using information, daily decision
158.20 making, or behavioral needs that require intervention;

158.21 (5) the person has had a qualifying nursing facility stay of at least 90 days;

158.22 (6) the person meets the nursing facility level of care criteria determined 90 days after
158.23 admission or on the first quarterly assessment after admission, whichever is later; or

158.24 (7) the person is determined to be at risk for nursing facility admission or readmission
158.25 through a face-to-face long-term care consultation assessment as specified in section
158.26 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care
158.27 organization under contract with the Department of Human Services. The person is
158.28 considered at risk under this clause if the person currently lives alone or will live alone or
158.29 be homeless without the person's current housing and also meets one of the following criteria:

158.30 (i) the person has experienced a fall resulting in a fracture;

158.31 (ii) the person has been determined to be at risk of maltreatment or neglect, including
158.32 self-neglect; or

159.1 (iii) the person has a sensory impairment that substantially impacts functional ability
159.2 and maintenance of a community residence.

159.3 (b) The assessment used to establish medical assistance payment for nursing facility
159.4 services must be the most recent assessment performed under subdivision 4, ~~paragraph~~
159.5 paragraphs (b) and (c), that occurred no more than 90 calendar days before the effective
159.6 date of medical assistance eligibility for payment of long-term care services. In no case
159.7 shall medical assistance payment for long-term care services occur prior to the date of the
159.8 determination of nursing facility level of care.

159.9 (c) The assessment used to establish medical assistance payment for long-term care
159.10 services provided under chapter 256S and section 256B.49 and alternative care payment
159.11 for services provided under section 256B.0913 must be the most recent face-to-face
159.12 assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28,
159.13 that occurred no more than 60 calendar days before the effective date of medical assistance
159.14 eligibility for payment of long-term care services.

159.15 Sec. 14. Minnesota Statutes 2022, section 144.1464, subdivision 1, is amended to read:

159.16 Subdivision 1. **Summer internships.** The commissioner of health, through a contract
159.17 with a nonprofit organization as required by subdivision 4, shall award grants, within
159.18 available appropriations, to hospitals, clinics, nursing facilities, assisted living facilities,
159.19 and home care providers to establish a secondary and postsecondary summer health care
159.20 intern program. The purpose of the program is to expose interested secondary and
159.21 postsecondary pupils to various careers within the health care profession.

159.22 Sec. 15. Minnesota Statutes 2022, section 144.1464, subdivision 2, is amended to read:

159.23 Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall
159.24 award grants to hospitals, clinics, nursing facilities, assisted living facilities, and home care
159.25 providers that agree to:

159.26 (1) provide secondary and postsecondary summer health care interns with formal exposure
159.27 to the health care profession;

159.28 (2) provide an orientation for the secondary and postsecondary summer health care
159.29 interns;

159.30 (3) pay one-half the costs of employing the secondary and postsecondary summer health
159.31 care intern;

160.1 (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks
160.2 and a maximum of 12 weeks; and

160.3 (5) employ at least one secondary student for each postsecondary student employed, to
160.4 the extent that there are sufficient qualifying secondary student applicants.

160.5 (b) In order to be eligible to be hired as a secondary summer health intern by a hospital,
160.6 clinic, nursing facility, assisted living facility, or home care provider, a pupil must:

160.7 (1) intend to complete high school graduation requirements and be between the junior
160.8 and senior year of high school; and

160.9 (2) be from a school district in proximity to the facility.

160.10 (c) In order to be eligible to be hired as a postsecondary summer health care intern by
160.11 a hospital or clinic, a pupil must:

160.12 (1) intend to complete a health care training program or a two-year or four-year degree
160.13 program and be planning on enrolling in or be enrolled in that training program or degree
160.14 program; and

160.15 (2) be enrolled in a Minnesota educational institution or be a resident of the state of
160.16 Minnesota; priority must be given to applicants from a school district or an educational
160.17 institution in proximity to the facility.

160.18 (d) Hospitals, clinics, nursing facilities, assisted living facilities, and home care providers
160.19 awarded grants may employ pupils as secondary and postsecondary summer health care
160.20 interns ~~beginning on or after June 15, 1993~~, if they agree to pay the intern, during the period
160.21 before disbursement of state grant money, with money designated as the facility's 50 percent
160.22 contribution towards internship costs.

160.23 Sec. 16. Minnesota Statutes 2022, section 144.1464, subdivision 3, is amended to read:

160.24 Subd. 3. **Grants.** The commissioner, through the organization under contract, shall
160.25 award separate grants to hospitals, clinics, nursing facilities, assisted living facilities, and
160.26 home care providers meeting the requirements of subdivision 2. The grants must be used
160.27 to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital,
160.28 clinic, nursing facility, assisted living facility, or home care setting during the course of the
160.29 program. No more than 50 percent of the participants may be postsecondary students, unless
160.30 the program does not receive enough qualified secondary applicants per fiscal year. No
160.31 more than five pupils may be selected from any secondary or postsecondary institution to

161.1 participate in the program and no more than one-half of the number of pupils selected may
161.2 be from the seven-county metropolitan area.

161.3 Sec. 17. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

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

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

161.7 (c) "Immigrant international medical graduate" means an international medical graduate
161.8 who was born outside the United States, now resides permanently in the United States or
161.9 who has entered the United States on a temporary status based on urgent humanitarian or
161.10 significant public benefit reasons, and who did not enter the United States on a J1 or similar
161.11 nonimmigrant visa following acceptance into a United States medical residency or fellowship
161.12 program.

161.13 (d) "International medical graduate" means a physician who received a basic medical
161.14 degree or qualification from a medical school located outside the United States and Canada.

161.15 (e) "Minnesota immigrant international medical graduate" means an immigrant
161.16 international medical graduate who has lived in Minnesota for at least two years.

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

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

161.24 Sec. 18. Minnesota Statutes 2022, section 144.292, subdivision 6, is amended to read:

161.25 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of
161.26 reviewing current medical care, the provider must not charge a fee.

161.27 (b) When a provider or its representative makes copies of patient records upon a patient's
161.28 request under this section, the provider or its representative may charge the patient or the
161.29 patient's representative no more than 75 cents per page, plus \$10 for time spent retrieving
161.30 and copying the records, unless other law or a rule or contract provide for a lower maximum
161.31 charge. This limitation does not apply to x-rays. The provider may charge a patient no more

162.1 than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving
162.2 and copying the x-rays.

162.3 (c) The respective maximum charges of 75 cents per page and \$10 for time provided in
162.4 this subdivision are in effect for calendar year 1992 and may be adjusted annually each
162.5 calendar year as provided in this subdivision. The permissible maximum charges shall
162.6 change each year by an amount that reflects the change, as compared to the previous year,
162.7 in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U),
162.8 published by the Department of Labor.

162.9 (d) A provider or its representative may charge the \$10 retrieval fee, but must not charge
162.10 a per page fee, a retrieval fee, or any other fee to provide copies of records requested by a
162.11 patient or the patient's authorized representative if the request for copies of records is for
162.12 purposes of appealing a denial of Social Security disability income or Social Security
162.13 disability benefits under title II or title XVI of the Social Security Act; ~~except that no fee~~
162.14 ~~shall be charged to a patient who is receiving public assistance, or to a patient who is~~
162.15 ~~represented by an attorney on behalf of a civil legal services program or a volunteer attorney~~
162.16 ~~program based on indigency.~~ when the patient is:

162.17 (1) receiving public assistance;

162.18 (2) represented by an attorney on behalf of a civil legal services program; or

162.19 (3) represented by a volunteer attorney program based on indigency.

162.20 The patient or the patient's representative must submit one of the following to show that
162.21 they are entitled to receive records without charge under this paragraph: (1) a public
162.22 assistance statement from the county or state administering assistance; (2) a request for
162.23 records on the letterhead of the civil legal services program or volunteer attorney program
162.24 based on indigency; or (3) a benefits statement from the Social Security Administration.

162.25 For the purpose of further appeals, a patient may receive no more than two medical
162.26 record updates without charge, but only for medical record information previously not
162.27 provided.

162.28 For purposes of this paragraph, a patient's authorized representative does not include
162.29 units of state government engaged in the adjudication of Social Security disability claims.

162.30 Sec. 19. [144.2925] CONSTRUCTION.

162.31 Sections 144.291 to 144.298 shall be construed to protect the privacy of a patient's health
162.32 records in a more stringent manner than provided in Code of Federal Regulations, title 45,

163.1 part 164. For purposes of this section, "more stringent" has the meaning given to that term
163.2 in Code of Federal Regulations, title 45, section 160.202, with respect to a use or disclosure
163.3 or the need for express legal permission from an individual to disclose individually
163.4 identifiable health information.

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

163.6 Sec. 20. Minnesota Statutes 2022, section 144.293, subdivision 2, is amended to read:

163.7 Subd. 2. **Patient consent to release of records.** A provider, or a person who receives
163.8 health records from a provider, may not release a patient's health records to a person without:

163.9 (1) a signed and dated consent from the patient or the patient's legally authorized
163.10 representative authorizing the release;

163.11 (2) specific authorization in Minnesota law; or

163.12 (3) a representation from a provider that holds a signed and dated consent from the
163.13 patient authorizing the release.

163.14 **EFFECTIVE DATE.** This section is effective the day following final enactment and
163.15 applies to health records released on or after that date.

163.16 Sec. 21. Minnesota Statutes 2022, section 144.293, subdivision 4, is amended to read:

163.17 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for
163.18 one year or for a period specified in the consent or for a different period provided by
163.19 Minnesota law.

163.20 **EFFECTIVE DATE.** This section is effective the day following final enactment and
163.21 applies to health records released on or after that date.

163.22 Sec. 22. Minnesota Statutes 2022, section 144.293, subdivision 9, is amended to read:

163.23 Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records
163.24 without patient consent as authorized by Minnesota law, the release must be documented
163.25 in the patient's health record. In the case of a release under section 144.294, subdivision 2,
163.26 the documentation must include the date and circumstances under which the release was
163.27 made, the person or agency to whom the release was made, and the records that were released.

163.28 (b) When a health record is released using a representation from a provider that holds a
163.29 consent from the patient, the releasing provider shall document:

163.30 (1) the provider requesting the health records;

- 164.1 (2) the identity of the patient;
- 164.2 (3) the health records requested; and
- 164.3 (4) the date the health records were requested.

164.4 **EFFECTIVE DATE.** This section is effective the day following final enactment and
164.5 applies to health records released on or after that date.

164.6 Sec. 23. Minnesota Statutes 2022, section 144.293, subdivision 10, is amended to read:

164.7 Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When
164.8 requesting health records using consent, a person warrants that the consent:

- 164.9 (1) contains no information known to the person to be false; and
- 164.10 (2) accurately states the patient's desire to have health records disclosed or that there is
164.11 specific authorization in Minnesota law.

164.12 (b) When requesting health records using consent, or a representation of holding a
164.13 consent, a provider warrants that the request:

- 164.14 (1) contains no information known to the provider to be false;
- 164.15 (2) accurately states the patient's desire to have health records disclosed or that there is
164.16 specific authorization in Minnesota law; and
- 164.17 (3) does not exceed any limits imposed by the patient in the consent.

164.18 (c) When disclosing health records, a person releasing health records warrants that the
164.19 person:

- 164.20 (1) has complied with the requirements of this section regarding disclosure of health
164.21 records;
- 164.22 (2) knows of no information related to the request that is false; and
- 164.23 (3) has complied with the limits set by the patient in the consent.

164.24 **EFFECTIVE DATE.** This section is effective the day following final enactment and
164.25 applies to health records released on or after that date.

164.26 Sec. 24. Minnesota Statutes 2022, section 144.493, is amended by adding a subdivision
164.27 to read:

164.28 **Subd. 2a. Thrombectomy-capable stroke center.** A hospital meets the criteria for a
164.29 thrombectomy-capable stroke center if the hospital has been certified as a

165.1 thrombectomy-capable stroke center by the joint commission or another nationally recognized
165.2 accreditation entity, or is a primary stroke center that is not certified as a thrombectomy-based
165.3 capable stroke center but the hospital has attained a level of stroke care distinction by offering
165.4 mechanical endovascular therapies and has been certified by a department approved certifying
165.5 body that is a nationally recognized guidelines-based organization.

165.6 Sec. 25. Minnesota Statutes 2022, section 144.494, subdivision 2, is amended to read:

165.7 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive
165.8 stroke center, thrombectomy-capable stroke center, primary stroke center, or acute stroke
165.9 ready hospital may apply to the commissioner for designation, and upon the commissioner's
165.10 review and approval of the application, shall be designated as a comprehensive stroke center,
165.11 a thrombectomy-capable stroke center, a primary stroke center, or an acute stroke ready
165.12 hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke
165.13 center or primary stroke center from the joint commission or other nationally recognized
165.14 accreditation entity, or no longer participates in the Minnesota stroke registry program, its
165.15 Minnesota designation shall be immediately withdrawn. Prior to the expiration of the
165.16 ~~three-year~~ designation period, a hospital seeking to remain part of the voluntary acute stroke
165.17 system may reapply to the commissioner for designation.

165.18 Sec. 26. Minnesota Statutes 2022, section 144.551, subdivision 1, is amended to read:

165.19 Subdivision 1. **Restricted construction or modification.** (a) The following construction
165.20 or modification may not be commenced:

165.21 (1) any erection, building, alteration, reconstruction, modernization, improvement,
165.22 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
165.23 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
165.24 to another, or otherwise results in an increase or redistribution of hospital beds within the
165.25 state; and

165.26 (2) the establishment of a new hospital.

165.27 (b) This section does not apply to:

165.28 (1) construction or relocation within a county by a hospital, clinic, or other health care
165.29 facility that is a national referral center engaged in substantial programs of patient care,
165.30 medical research, and medical education meeting state and national needs that receives more
165.31 than 40 percent of its patients from outside the state of Minnesota;

166.1 (2) a project for construction or modification for which a health care facility held an
166.2 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
166.3 certificate;

166.4 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
166.5 appeal results in an order reversing the denial;

166.6 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
166.7 section 2;

166.8 (5) a project involving consolidation of pediatric specialty hospital services within the
166.9 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
166.10 of pediatric specialty hospital beds among the hospitals being consolidated;

166.11 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
166.12 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
166.13 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
166.14 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
166.15 hospitals must be reinstated at the capacity that existed on each site before the relocation;

166.16 (7) the relocation or redistribution of hospital beds within a hospital building or
166.17 identifiable complex of buildings provided the relocation or redistribution does not result
166.18 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
166.19 one physical site or complex to another; or (iii) redistribution of hospital beds within the
166.20 state or a region of the state;

166.21 (8) relocation or redistribution of hospital beds within a hospital corporate system that
166.22 involves the transfer of beds from a closed facility site or complex to an existing site or
166.23 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
166.24 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
166.25 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
166.26 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution
166.27 does not involve the construction of a new hospital building; and (v) the transferred beds
166.28 are used first to replace within the hospital corporate system the total number of beds
166.29 previously used in the closed facility site or complex for mental health services and substance
166.30 use disorder services. Only after the hospital corporate system has fulfilled the requirements
166.31 of this item may the remainder of the available capacity of the closed facility site or complex
166.32 be transferred for any other purpose;

167.1 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
167.2 County that primarily serves adolescents and that receives more than 70 percent of its
167.3 patients from outside the state of Minnesota;

167.4 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
167.5 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
167.6 and (ii) the total licensed capacity of the replacement hospital, either at the time of
167.7 construction of the initial building or as the result of future expansion, will not exceed 70
167.8 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

167.9 (11) the relocation of licensed hospital beds from an existing state facility operated by
167.10 the commissioner of human services to a new or existing facility, building, or complex
167.11 operated by the commissioner of human services; from one regional treatment center site
167.12 to another; or from one building or site to a new or existing building or site on the same
167.13 campus;

167.14 (12) the construction or relocation of hospital beds operated by a hospital having a
167.15 statutory obligation to provide hospital and medical services for the indigent that does not
167.16 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
167.17 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
167.18 Medical Center to Regions Hospital under this clause;

167.19 (13) a construction project involving the addition of up to 31 new beds in an existing
167.20 nonfederal hospital in Beltrami County;

167.21 (14) a construction project involving the addition of up to eight new beds in an existing
167.22 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

167.23 (15) a construction project involving the addition of 20 new hospital beds in an existing
167.24 hospital in Carver County serving the southwest suburban metropolitan area;

167.25 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
167.26 of up to two psychiatric facilities or units for children provided that the operation of the
167.27 facilities or units have received the approval of the commissioner of human services;

167.28 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
167.29 services in an existing hospital in Itasca County;

167.30 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
167.31 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
167.32 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
167.33 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

168.1 (19) a critical access hospital established under section 144.1483, clause (9), and section
168.2 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
168.3 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
168.4 to the extent that the critical access hospital does not seek to exceed the maximum number
168.5 of beds permitted such hospital under federal law;

168.6 (20) notwithstanding section 144.552, a project for the construction of a new hospital
168.7 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

168.8 (i) the project, including each hospital or health system that will own or control the entity
168.9 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
168.10 Council as of March 1, 2006;

168.11 (ii) the entity that will hold the new hospital license will be owned or controlled by one
168.12 or more not-for-profit hospitals or health systems that have previously submitted a plan or
168.13 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
168.14 have been found to be in the public interest by the commissioner of health as of April 1,
168.15 2005;

168.16 (iii) the new hospital's initial inpatient services must include, but are not limited to,
168.17 medical and surgical services, obstetrical and gynecological services, intensive care services,
168.18 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
168.19 services, and emergency room services;

168.20 (iv) the new hospital:

168.21 (A) will have the ability to provide and staff sufficient new beds to meet the growing
168.22 needs of the Maple Grove service area and the surrounding communities currently being
168.23 served by the hospital or health system that will own or control the entity that will hold the
168.24 new hospital license;

168.25 (B) will provide uncompensated care;

168.26 (C) will provide mental health services, including inpatient beds;

168.27 (D) will be a site for workforce development for a broad spectrum of health-care-related
168.28 occupations and have a commitment to providing clinical training programs for physicians
168.29 and other health care providers;

168.30 (E) will demonstrate a commitment to quality care and patient safety;

168.31 (F) will have an electronic medical records system, including physician order entry;

168.32 (G) will provide a broad range of senior services;

169.1 (H) will provide emergency medical services that will coordinate care with regional
169.2 providers of trauma services and licensed emergency ambulance services in order to enhance
169.3 the continuity of care for emergency medical patients; and

169.4 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
169.5 the control of the entity holding the new hospital license; and

169.6 (v) as of 30 days following submission of a written plan, the commissioner of health
169.7 has not determined that the hospitals or health systems that will own or control the entity
169.8 that will hold the new hospital license are unable to meet the criteria of this clause;

169.9 (21) a project approved under section 144.553;

169.10 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
169.11 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
169.12 is approved by the Cass County Board;

169.13 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
169.14 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
169.15 a separately licensed 13-bed skilled nursing facility;

169.16 (24) notwithstanding section 144.552, a project for the construction and expansion of a
169.17 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
169.18 who are under 21 years of age on the date of admission. The commissioner conducted a
169.19 public interest review of the mental health needs of Minnesota and the Twin Cities
169.20 metropolitan area in 2008. No further public interest review shall be conducted for the
169.21 construction or expansion project under this clause;

169.22 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
169.23 commissioner finds the project is in the public interest after the public interest review
169.24 conducted under section 144.552 is complete;

169.25 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
169.26 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
169.27 admission, if the commissioner finds the project is in the public interest after the public
169.28 interest review conducted under section 144.552 is complete;

169.29 (ii) this project shall serve patients in the continuing care benefit program under section
169.30 256.9693. The project may also serve patients not in the continuing care benefit program;
169.31 and

169.32 (iii) if the project ceases to participate in the continuing care benefit program, the
169.33 commissioner must complete a subsequent public interest review under section 144.552. If

170.1 the project is found not to be in the public interest, the license must be terminated six months
170.2 from the date of that finding. If the commissioner of human services terminates the contract
170.3 without cause or reduces per diem payment rates for patients under the continuing care
170.4 benefit program below the rates in effect for services provided on December 31, 2015, the
170.5 project may cease to participate in the continuing care benefit program and continue to
170.6 operate without a subsequent public interest review;

170.7 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
170.8 in Hennepin County that is exclusively for patients who are under 21 years of age on the
170.9 date of admission;

170.10 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
170.11 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
170.12 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
170.13 In addition, five unlicensed observation mental health beds shall be added;

170.14 (29) upon submission of a plan to the commissioner for public interest review under
170.15 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause
170.16 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I
170.17 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision
170.18 5. Five of the 45 additional beds authorized under this clause must be designated for use
170.19 for inpatient mental health and must be added to the hospital's bed capacity before the
170.20 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed
170.21 beds under this clause prior to completion of the public interest review, provided the hospital
170.22 submits its plan by the 2021 deadline and adheres to the timelines for the public interest
170.23 review described in section 144.552;

170.24 (30) upon submission of a plan to the commissioner for public interest review under
170.25 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital
170.26 in Hennepin County that exclusively provides care to patients who are under 21 years of
170.27 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital
170.28 may add licensed beds under this clause prior to completion of the public interest review,
170.29 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for
170.30 the public interest review described in section 144.552;

170.31 (31) any project to add licensed beds in a hospital located in Cook County or Mahanomen
170.32 County that: (i) is designated as a critical access hospital under section 144.1483, clause
170.33 (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of
170.34 fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of

171.1 licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding
171.2 section 144.552, a public interest review is not required for a project authorized under this
171.3 clause;

171.4 (32) upon submission of a plan to the commissioner for public interest review under
171.5 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's
171.6 hospital in St. Paul that is part of an independent pediatric health system with freestanding
171.7 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric
171.8 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add
171.9 licensed beds under this clause prior to completion of the public interest review, provided
171.10 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public
171.11 interest review described in section 144.552; ~~or~~

171.12 (33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda
171.13 hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is
171.14 in the public interest after the public interest review conducted under section 144.552 is
171.15 complete. Following the completion of the construction project, the commissioner of health
171.16 shall monitor the hospital, including by assessing the hospital's case mix and payer mix,
171.17 patient transfers, and patient diversions. The hospital must have an intake and assessment
171.18 area. The hospital must accommodate patients with acute mental health needs, whether they
171.19 walk up to the facility, are delivered by ambulances or law enforcement, or are transferred
171.20 from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The
171.21 hospital must annually submit de-identified data to the department in the format and manner
171.22 defined by the commissioner; or

171.23 (34) a project involving the relocation of up to 26 licensed long-term acute care hospital
171.24 beds from an existing long-term care hospital located in Hennepin County with a licensed
171.25 capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing
171.26 safety net, level I trauma center hospital in Ramsey County as designated under section
171.27 383A.91, subdivision 5, provided both the commissioner finds the project is in the public
171.28 interest after the public interest review conducted under section 144.552 is complete and
171.29 the relocated beds continue to be used as long-term acute care hospital beds after the
171.30 relocation.

172.1 Sec. 27. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision
172.2 to read:

172.3 Subd. 10. **Chapter 16C waiver.** Pursuant to subdivisions 4, paragraph (b), and 5,
172.4 paragraph (b), the commissioner of administration may waive provisions of chapter 16C
172.5 for the purposes of approving contracts for independent clinical teams.

172.6 Sec. 28. [144.6985] **COMMUNITY HEALTH NEEDS ASSESSMENT; COMMUNITY**
172.7 **HEALTH IMPROVEMENT SERVICES; IMPLEMENTATION.**

172.8 Subdivision 1. **Community health needs assessment.** A nonprofit hospital that is exempt
172.9 from taxation under section 501(c)(3) of the Internal Revenue Code must make available
172.10 to the public and submit to the commissioner of health, by January 15, 2026, the most recent
172.11 community health needs assessment submitted by the hospital to the Internal Revenue
172.12 Service. Each time the hospital conducts a subsequent community health needs assessment,
172.13 the hospital must, within 15 business days after submitting the subsequent community health
172.14 needs assessment to the Internal Revenue Service, make the subsequent assessment available
172.15 to the public and submit the subsequent assessment to the commissioner.

172.16 Subd. 2. **Description of community.** A nonprofit hospital subject to subdivision 1 must
172.17 make available to the public and submit to the commissioner of health a description of the
172.18 community served by the hospital. The description must include a geographic description
172.19 of the area where the hospital is located, a description of the general population served by
172.20 the hospital, and demographic information about the community served by the hospital,
172.21 such as leading causes of death, levels of chronic illness, and descriptions of the medically
172.22 underserved, low-income, minority, or chronically ill populations in the community. A
172.23 hospital is not required to separately make the information available to the public or
172.24 separately submit the information to the commissioner if the information is included in the
172.25 hospital's community health needs assessment made available and submitted under
172.26 subdivision 1.

172.27 Subd. 3. **Addendum; community health improvement services.** (a) A nonprofit hospital
172.28 subject to subdivision 1 must annually submit to the commissioner an addendum which
172.29 details information about hospital activities identified as community health improvement
172.30 services with a cost of \$5,000 or more. The addendum must include the type of activity, the
172.31 method through which the activity was delivered, how the activity relates to an identified
172.32 community need in the community health needs assessment, the target population for the
172.33 activity, strategies to reach the target population, identified outcome metrics, the cost to the
172.34 hospital to provide the activity, the methodology used to calculate the hospital's costs, and

173.1 the number of people served by the activity. If a community health improvement service is
173.2 administered by an entity other than the hospital, the administering entity must be identified
173.3 in the addendum. This paragraph does not apply to hospitals required to submit an addendum
173.4 under paragraph (b).

173.5 (b) A nonprofit hospital subject to subdivision 1 must annually submit to the
173.6 commissioner an addendum which details information about the ten highest-cost activities
173.7 of the hospital identified as community health improvement services if the nonprofit hospital:

173.8 (1) is designated as a critical access hospital under section 144.1483, clause (9), and
173.9 United States Code, title 42, section 1395i-4;

173.10 (2) meets the definition of sole community hospital in section 62Q.19, subdivision 1,
173.11 paragraph (a), clause (5); or

173.12 (3) meets the definition of rural emergency hospital in United States Code, title 42,
173.13 section 1395x(kkk)(2).

173.14 The addendum must include the type of activity, the method in which the activity was
173.15 delivered, how the activity relates to an identified community need in the community health
173.16 needs assessment, the target population for the activity, strategies to reach the target
173.17 population, identified outcome metrics, the cost to the hospital to provide the activity, the
173.18 methodology used to calculate the hospital's costs, and the number of people served by the
173.19 activity. If a community health improvement service is administered by an entity other than
173.20 the hospital, the administering entity must be identified in the addendum.

173.21 Subd. 4. **Community benefit implementation strategy.** A nonprofit hospital subject
173.22 to subdivision 1 must make available to the public, within one year after completing each
173.23 community health needs assessment, a community benefit implementation strategy. In
173.24 developing the community benefit implementation strategy, the hospital must consult with
173.25 community-based organizations, stakeholders, local public health organizations, and others
173.26 as determined by the hospital. The implementation strategy must include how the hospital
173.27 shall address the top three community health priorities identified in the community health
173.28 needs assessment. Implementation strategies must be evidence-based, when available, and
173.29 development and implementation of innovative programs and strategies may be supported
173.30 by evaluation measures.

173.31 Subd. 5. **Information made available to the public.** A nonprofit hospital required to
173.32 make information available to the public under this section may do so by posting the
173.33 information on the hospital's website in a consolidated location and with clear labeling.

174.1 **EFFECTIVE DATE.** This section is effective January 1, 2026.

174.2 Sec. 29. Minnesota Statutes 2022, section 144.7067, subdivision 2, is amended to read:

174.3 Subd. 2. **Duty to analyze reports; communicate findings.** (a) The commissioner shall:

174.4 (1) analyze adverse event reports, corrective action plans, and findings of the root cause
174.5 analyses to determine patterns of systemic failure in the health care system and successful
174.6 methods to correct these failures;

174.7 (2) communicate to individual facilities the commissioner's conclusions, if any, regarding
174.8 an adverse event reported by the facility;

174.9 (3) communicate with relevant health care facilities any recommendations for corrective
174.10 action resulting from the commissioner's analysis of submissions from facilities; and

174.11 (4) publish an annual report:

174.12 (i) describing, by institution, adverse events reported;

174.13 (ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses;
174.14 and

174.15 (iii) making recommendations for modifications of state health care operations.

174.16 (b) Notwithstanding section 144.05, subdivision 7, the mandate to publish an annual
174.17 report under this subdivision does not expire.

174.18 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2023.

174.19 Sec. 30. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

174.20 Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to
174.21 a request from a nursing facility certified under the federal Medicare and Medicaid programs
174.22 for an informal dispute resolution within ~~30 days of the exit date of the facility's survey~~ ten
174.23 calendar days of the facility's receipt of the notice of deficiencies. The commissioner's
174.24 response shall identify the commissioner's decision regarding ~~the continuation of each~~
174.25 deficiency citation challenged by the nursing facility, as well as a statement of any changes
174.26 in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency
174.27 citation.

174.28 **EFFECTIVE DATE.** This section is effective August 1, 2024.

175.1 Sec. 31. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

175.2 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision
175.3 15, a facility certified under the federal Medicare or Medicaid programs that has been
175.4 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section
175.5 488.430, may request from the commissioner, in writing, an independent informal dispute
175.6 resolution process regarding any deficiency citation issued to the facility. The facility must
175.7 specify in its written request each deficiency citation that it disputes. The commissioner
175.8 shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,
175.9 the parties must submit the issues raised to arbitration by an administrative law judge submit
175.10 its request in writing within ten calendar days of receiving notice that a civil money penalty
175.11 will be imposed.

175.12 (b) The facility and commissioner have the right to be represented by an attorney at the
175.13 hearing.

175.14 (c) An independent informal dispute resolution may not be requested for any deficiency
175.15 that is the subject of an active informal dispute resolution requested under subdivision 15.
175.16 The facility must withdraw its informal dispute resolution prior to requesting independent
175.17 informal dispute resolution.

175.18 ~~(b) Upon~~ (d) Within five calendar days of receipt of a written request for an arbitration
175.19 proceeding independent informal dispute resolution, the commissioner shall file with the
175.20 Office of Administrative Hearings a request for the appointment of an arbitrator
175.21 administrative law judge from the Office of Administrative Hearings and simultaneously
175.22 serve the facility with notice of the request. The arbitrator for the dispute shall be an
175.23 administrative law judge appointed by the Office of Administrative Hearings. The disclosure
175.24 provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (e),
175.25 apply. The facility and the commissioner have the right to be represented by an attorney.

175.26 (e) An independent informal dispute resolution proceeding shall be scheduled to occur
175.27 within 30 calendar days of the commissioner's request to the Office of Administrative
175.28 Hearings, unless the parties agree otherwise or the chief administrative law judge deems
175.29 the timing to be unreasonable. The independent informal dispute resolution process must
175.30 be completed within 60 calendar days of the facility's request.

175.31 ~~(e)~~ (f) Five working days in advance of the scheduled proceeding, the commissioner
175.32 and the facility may present must submit written statements and arguments, documentary
175.33 evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral

176.1 ~~statements and arguments may be made by telephone~~ any other materials supporting their
176.2 position to the administrative law judge.

176.3 (g) The independent informal dispute resolution proceeding shall be informal and
176.4 conducted in a manner so as to allow the parties to fully present their positions and respond
176.5 to the opposing party's positions. This may include presentation of oral statements and
176.6 arguments at the proceeding.

176.7 ~~(d)~~ (h) Within ten working days of the close of the ~~arbitration~~ proceeding, the
176.8 administrative law judge shall issue findings and recommendations regarding each of the
176.9 deficiencies in dispute. The findings shall be one or more of the following:

176.10 (1) Supported in full. The citation is supported in full, with no deletion of findings and
176.11 no change in the scope or severity assigned to the deficiency citation.

176.12 (2) Supported in substance. The citation is supported, but one or more findings are
176.13 deleted without any change in the scope or severity assigned to the deficiency.

176.14 (3) Deficient practice cited under wrong requirement of participation. The citation is
176.15 amended by moving it to the correct requirement of participation.

176.16 (4) Scope not supported. The citation is amended through a change in the scope assigned
176.17 to the citation.

176.18 (5) Severity not supported. The citation is amended through a change in the severity
176.19 assigned to the citation.

176.20 (6) No deficient practice. The citation is deleted because the findings did not support
176.21 the citation or the negative resident outcome was unavoidable. ~~The findings of the arbitrator~~
176.22 ~~are not binding on the commissioner.~~

176.23 (i) The findings and recommendations of the administrative law judge are not binding
176.24 on the commissioner.

176.25 (j) Within ten calendar days of receiving the administrative law judge's findings and
176.26 recommendations, the commissioner shall issue a recommendation to the Center for Medicare
176.27 and Medicaid Services.

176.28 ~~(e)~~ (k) The commissioner shall reimburse the Office of Administrative Hearings for the
176.29 costs incurred by that office for the ~~arbitration~~ proceeding. ~~The facility shall reimburse the~~
176.30 ~~commissioner for the proportion of the costs that represent the sum of deficiency citations~~
176.31 ~~supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause~~
176.32 ~~(2), divided by the total number of deficiencies disputed. A deficiency citation for which~~

177.1 ~~the administrative law judge's sole finding is that the deficient practice was cited under the~~
177.2 ~~wrong requirements of participation shall not be counted in the numerator or denominator~~
177.3 ~~in the calculation of the proportion of costs.~~

177.4 **EFFECTIVE DATE.** This section is effective October 1, 2024, or upon federal approval,
177.5 whichever is later, and applies to appeals of deficiencies which are issued after October 1,
177.6 2024, or on or after the date upon which federal approval is obtained, whichever is later.
177.7 The commissioner of health shall notify the revisor of statutes when federal approval is
177.8 obtained.

177.9 Sec. 32. Minnesota Statutes 2022, section 144A.44, subdivision 1, is amended to read:

177.10 Subdivision 1. **Statement of rights.** (a) A client who receives home care services ~~in the~~
177.11 ~~community or in an assisted living facility licensed under chapter 144G~~ has these rights:

177.12 (1) receive written information, in plain language, about rights before receiving services,
177.13 including what to do if rights are violated;

177.14 (2) receive care and services according to a suitable and up-to-date plan, and subject to
177.15 accepted health care, medical or nursing standards and person-centered care, to take an
177.16 active part in developing, modifying, and evaluating the plan and services;

177.17 (3) be told before receiving services the type and disciplines of staff who will be providing
177.18 the services, the frequency of visits proposed to be furnished, other choices that are available
177.19 for addressing home care needs, and the potential consequences of refusing these services;

177.20 (4) be told in advance of any recommended changes by the provider in the service plan
177.21 and to take an active part in any decisions about changes to the service plan;

177.22 (5) refuse services or treatment;

177.23 (6) know, before receiving services or during the initial visit, any limits to the services
177.24 available from a home care provider;

177.25 (7) be told before services are initiated what the provider charges for the services; to
177.26 what extent payment may be expected from health insurance, public programs, or other
177.27 sources, if known; and what charges the client may be responsible for paying;

177.28 (8) know that there may be other services available in the community, including other
177.29 home care services and providers, and to know where to find information about these
177.30 services;

- 178.1 (9) choose freely among available providers and to change providers after services have
178.2 begun, within the limits of health insurance, long-term care insurance, medical assistance,
178.3 other health programs, or public programs;
- 178.4 (10) have personal, financial, and medical information kept private, and to be advised
178.5 of the provider's policies and procedures regarding disclosure of such information;
- 178.6 (11) access the client's own records and written information from those records in
178.7 accordance with sections 144.291 to 144.298;
- 178.8 (12) be served by people who are properly trained and competent to perform their duties;
- 178.9 (13) be treated with courtesy and respect, and to have the client's property treated with
178.10 respect;
- 178.11 (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms
178.12 of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors
178.13 Act;
- 178.14 (15) reasonable, advance notice of changes in services or charges;
- 178.15 (16) know the provider's reason for termination of services;
- 178.16 (17) at least ten calendar days' advance notice of the termination of a service by a home
178.17 care provider, ~~except at least 30 calendar days' advance notice of the service termination~~
178.18 ~~shall be given by a home care provider for services provided to a client residing in an assisted~~
178.19 ~~living facility as defined in section 144G.08, subdivision 7. This clause does not apply in~~
178.20 cases where:
- 178.21 (i) the client engages in conduct that significantly alters the terms of the service plan
178.22 with the home care provider;
- 178.23 (ii) the client, person who lives with the client, or others create an abusive or unsafe
178.24 work environment for the person providing home care services; or
- 178.25 (iii) an emergency or a significant change in the client's condition has resulted in service
178.26 needs that exceed the current service plan and that cannot be safely met by the home care
178.27 provider;
- 178.28 (18) a coordinated transfer when there will be a change in the provider of services;
- 178.29 (19) complain to staff and others of the client's choice about services that are provided,
178.30 or fail to be provided, and the lack of courtesy or respect to the client or the client's property
178.31 and the right to recommend changes in policies and services, free from retaliation including
178.32 the threat of termination of services;

179.1 (20) know how to contact an individual associated with the home care provider who is
179.2 responsible for handling problems and to have the home care provider investigate and
179.3 attempt to resolve the grievance or complaint;

179.4 (21) know the name and address of the state or county agency to contact for additional
179.5 information or assistance; and

179.6 (22) assert these rights personally, or have them asserted by the client's representative
179.7 or by anyone on behalf of the client, without retaliation; and

179.8 ~~(23) place an electronic monitoring device in the client's or resident's space in compliance~~
179.9 ~~with state requirements.~~

179.10 (b) When providers violate the rights in this section, they are subject to the fines and
179.11 license actions in sections 144A.474, subdivision 11, and 144A.475.

179.12 (c) Providers must do all of the following:

179.13 (1) encourage and assist in the fullest possible exercise of these rights;

179.14 (2) provide the names and telephone numbers of individuals and organizations that
179.15 provide advocacy and legal services for clients ~~and residents~~ seeking to assert their rights;

179.16 (3) make every effort to assist clients ~~or residents~~ in obtaining information regarding
179.17 whether Medicare, medical assistance, other health programs, or public programs will pay
179.18 for services;

179.19 (4) make reasonable accommodations for people who have communication disabilities,
179.20 or those who speak a language other than English; and

179.21 (5) provide all information and notices in plain language and in terms the client ~~or~~
179.22 ~~resident~~ can understand.

179.23 (d) No provider may require or request a client ~~or resident~~ to waive any of the rights
179.24 listed in this section at any time or for any reasons, including as a condition of initiating
179.25 services ~~or entering into an assisted living contract.~~

179.26 Sec. 33. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision
179.27 to read:

179.28 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping
179.29 accommodations as a provision of home care services. For purposes of this subdivision, the
179.30 provision of sleeping accommodations and assisted living services under section 144G.08,
179.31 subdivision 9, requires assisted living licensure under chapter 144G.

180.1 Sec. 34. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

180.2 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey,
180.3 each home care surveyor must receive training on the following topics:

180.4 (1) Minnesota home care licensure requirements;

180.5 (2) Minnesota home care bill of rights;

180.6 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

180.7 (4) principles of documentation;

180.8 (5) survey protocol and processes;

180.9 (6) Offices of the Ombudsman roles;

180.10 (7) Office of Health Facility Complaints;

180.11 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;

180.12 (9) types of payors for home care services; and

180.13 (10) Minnesota Nurse Practice Act for nurse surveyors.

180.14 (b) Materials used for the training in paragraph (a) shall be posted on the department
180.15 website. Requisite understanding of these topics will be reviewed as part of the quality
180.16 improvement plan in section 144A.483.

180.17 Sec. 35. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is
180.18 amended to read:

180.19 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service
180.20 plan with a client, and the client continues to need home care services, the home care provider
180.21 shall provide the client and the client's representative, if any, with a written notice of
180.22 termination which includes the following information:

180.23 (1) the effective date of termination;

180.24 (2) the reason for termination;

180.25 (3) for clients age 18 or older, a statement that the client may contact the Office of
180.26 Ombudsman for Long-Term Care to request an advocate to assist regarding the termination
180.27 and contact information for the office, including the office's central telephone number;

180.28 (4) a list of known licensed home care providers in the client's immediate geographic
180.29 area;

181.1 (5) a statement that the home care provider will participate in a coordinated transfer of
181.2 care of the client to another home care provider, health care provider, or caregiver, as
181.3 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and

181.4 (6) the name and contact information of a person employed by the home care provider
181.5 with whom the client may discuss the notice of termination; and.

181.6 ~~(7) if applicable, a statement that the notice of termination of home care services does~~
181.7 ~~not constitute notice of termination of any housing contract.~~

181.8 (b) When the home care provider voluntarily discontinues services to all clients, the
181.9 home care provider must notify the commissioner, lead agencies, and ombudsman for
181.10 long-term care about its clients and comply with the requirements in this subdivision.

181.11 Sec. 36. Minnesota Statutes 2022, section 144E.16, subdivision 7, is amended to read:

181.12 Subd. 7. **Stroke transport protocols.** Regional emergency medical services programs
181.13 and any ambulance service licensed under this chapter must develop stroke transport
181.14 protocols. The protocols must include standards of care for triage and transport of acute
181.15 stroke patients within a specific time frame from symptom onset until transport to the most
181.16 appropriate designated acute stroke ready hospital, primary stroke center,
181.17 thrombectomy-capable stroke center, or comprehensive stroke center.

181.18 Sec. 37. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

181.19 Subd. 29. **Licensed health professional.** "Licensed health professional" means a person
181.20 ~~licensed in Minnesota to practice a profession described in section 214.01, subdivision 2,~~
181.21 other than a registered nurse or licensed practical nurse, who provides assisted living services
181.22 within the scope of practice of that person's health occupation license, registration, or
181.23 certification as a regulated person who is licensed by an appropriate Minnesota state board
181.24 or agency.

181.25 Sec. 38. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision
181.26 to read:

181.27 Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, 2026, no person
181.28 or entity may use the phrase "assisted living," whether alone or in combination with other
181.29 words and whether orally or in writing, to: advertise; market; or otherwise describe, offer,
181.30 or promote itself, or any housing, service, service package, or program that it provides
181.31 within this state, unless the person or entity is a licensed assisted living facility that meets
181.32 the requirements of this chapter. A person or entity entitled to use the phrase "assisted living"

182.1 shall use the phrase only in the context of its participation that meets the requirements of
182.2 this chapter.

182.3 (b) Effective January 1, 2026, the licensee's name for a new assisted living facility may
182.4 not include the terms "home care" or "nursing home."

182.5 Sec. 39. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

182.6 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license
182.7 is denied must comply with the requirements for notification and the coordinated move of
182.8 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the
182.9 reconsideration process, the licensee must submit a closure plan as required by section
182.10 144G.57 within ten calendar days of receipt of the reconsideration decision.

182.11 Sec. 40. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

182.12 Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a
182.13 jurisdiction with which Minnesota has reciprocity for at least:

182.14 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or
182.15 8, in order to supervise a temporary tattoo technician; or

182.16 (2) one year as a body piercing technician licensed under section 146B.03, subdivision
182.17 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a
182.18 temporary body piercing technician.

182.19 (b) Any technician who agrees to supervise more than two temporary tattoo technicians
182.20 during the same time period, or more than four body piercing technicians during the same
182.21 time period, must provide to the commissioner a supervisory plan that describes how the
182.22 technician will provide supervision to each temporary technician in accordance with section
182.23 146B.01, subdivision 28.

182.24 (c) The supervisory plan must include, at a minimum:

182.25 (1) the areas of practice under supervision;

182.26 (2) the anticipated supervision hours per week;

182.27 (3) the anticipated duration of the training period; and

182.28 (4) the method of providing supervision if there are multiple technicians being supervised
182.29 during the same time period.

183.1 (d) If the supervisory plan is terminated before completion of the technician's supervised
183.2 practice, the supervisor must notify the commissioner in writing within 14 days of the change
183.3 in supervision and include an explanation of why the plan was not completed.

183.4 (e) The commissioner may refuse to approve as a supervisor a technician who has been
183.5 disciplined in Minnesota or in another jurisdiction after considering the criteria in section
183.6 146B.02, subdivision 10, paragraph (b).

183.7 Sec. 41. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

183.8 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure application
183.9 and biennial licensure renewal application is \$420.

183.10 (b) The fee for temporary technician licensure application is \$240.

183.11 (c) The fee for the temporary guest artist license application is \$140.

183.12 (d) The fee for a dual body art technician license application is \$420.

183.13 (e) The fee for a provisional establishment license application required in section 146B.02,
183.14 subdivision 5, paragraph (c), is \$1,500.

183.15 (f) The fee for an initial establishment license application and the two-year license
183.16 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is
183.17 \$1,500.

183.18 (g) The fee for a temporary body art establishment event permit application is \$200.

183.19 (h) The commissioner shall prorate the initial two-year technician license fee based on
183.20 the number of months in the initial licensure period. The commissioner shall prorate the
183.21 first renewal fee for the establishment license based on the number of months from issuance
183.22 of the provisional license to the first renewal.

183.23 (i) The fee for verification of licensure to other states is \$25.

183.24 ~~(j) The fee to reissue a provisional establishment license that relocates prior to inspection~~
183.25 ~~and removal of provisional status is \$350. The expiration date of the provisional license~~
183.26 ~~does not change.~~

183.27 ~~(j)~~ (j) The fee to change an establishment name or establishment type, such as tattoo,
183.28 piercing, or dual, is \$50.

184.1 Sec. 42. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

184.2 Subd. 3. **Deposit.** Fees collected by the commissioner under this section must be deposited
184.3 in the state government special revenue fund. All fees are nonrefundable.

184.4 Sec. 43. Minnesota Statutes 2022, section 149A.65, is amended to read:

184.5 **149A.65 FEES.**

184.6 Subdivision 1. **Generally.** This section establishes the application fees for registrations,
184.7 examinations, initial and renewal licenses, and late fees authorized under the provisions of
184.8 this chapter.

184.9 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

184.10 (1) \$75 for the initial and renewal registration of a mortuary science intern;

184.11 (2) \$125 for the mortuary science examination;

184.12 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

184.13 (4) \$100 late fee charge for a license renewal application; and

184.14 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

184.15 Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is
184.16 \$200. The late fee charge for a license renewal is \$100.

184.17 Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral
184.18 establishments is \$425. The late fee charge for a license renewal is \$100.

184.19 Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is \$425.
184.20 The late fee charge for a license renewal is \$100.

184.21 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an
184.22 alkaline hydrolysis facility is \$425. The late fee charge for a license renewal is \$100.

184.23 Subd. 7. **State government special revenue fund.** Fees collected by the commissioner
184.24 under this section must be deposited in the state treasury and credited to the state government
184.25 special revenue fund. All fees are nonrefundable.

184.26 Sec. 44. Minnesota Statutes 2022, section 256R.02, subdivision 20, is amended to read:

184.27 Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI"
184.28 means a numerical score that describes the relative resource use for all residents within the
184.29 case mix ~~classifications under the resource utilization group (RUG) classification system~~

185.1 prescribed by the commissioner based on an assessment of each resident. The facility average
185.2 CMI shall be computed as the standardized days divided by the sum of the facility's resident
185.3 days. The case mix indices used shall be based on the system prescribed in section 256R.17.

185.4 Sec. 45. REVISOR INSTRUCTION.

185.5 The revisor of statutes shall substitute the term "employee" with the term "staff" in the
185.6 following sections of Minnesota Statutes and make any grammatical changes needed without
185.7 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions
185.8 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;
185.9 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,
185.10 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),
185.11 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision
185.12 7; and 144G.92, subdivisions 1 and 3.

185.13 Sec. 46. REPEALER.

185.14 (a) Minnesota Statutes 2022, sections 144.497; and 256R.02, subdivision 46, are repealed.

185.15 (b) Minnesota Statutes 2023 Supplement, section 62J.312, subdivision 6, is repealed.

185.16 **ARTICLE 7**

185.17 **EMERGENCY MEDICAL SERVICES**

185.18 Section 1. Minnesota Statutes 2023 Supplement, section 15A.0815, subdivision 2, is
185.19 amended to read:

185.20 Subd. 2. **Agency head salaries.** The salary for a position listed in this subdivision shall
185.21 be determined by the Compensation Council under section 15A.082. The commissioner of
185.22 management and budget must publish the salaries on the department's website. This
185.23 subdivision applies to the following positions:

185.24 Commissioner of administration;

185.25 Commissioner of agriculture;

185.26 Commissioner of education;

185.27 Commissioner of children, youth, and families;

185.28 Commissioner of commerce;

185.29 Commissioner of corrections;

- 186.1 Commissioner of health;
- 186.2 Commissioner, Minnesota Office of Higher Education;
- 186.3 Commissioner, Minnesota IT Services;
- 186.4 Commissioner, Housing Finance Agency;
- 186.5 Commissioner of human rights;
- 186.6 Commissioner of human services;
- 186.7 Commissioner of labor and industry;
- 186.8 Commissioner of management and budget;
- 186.9 Commissioner of natural resources;
- 186.10 Commissioner, Pollution Control Agency;
- 186.11 Commissioner of public safety;
- 186.12 Commissioner of revenue;
- 186.13 Commissioner of employment and economic development;
- 186.14 Commissioner of transportation;
- 186.15 Commissioner of veterans affairs;
- 186.16 Executive director of the Gambling Control Board;
- 186.17 Executive director of the Minnesota State Lottery;
- 186.18 Commissioner of Iron Range resources and rehabilitation;
- 186.19 Commissioner, Bureau of Mediation Services;
- 186.20 Ombudsman for mental health and developmental disabilities;
- 186.21 Ombudsperson for corrections;
- 186.22 Chair, Metropolitan Council;
- 186.23 Chair, Metropolitan Airports Commission;
- 186.24 School trust lands director;
- 186.25 Executive director of pari-mutuel racing; ~~and~~
- 186.26 Commissioner, Public Utilities Commission; and
- 186.27 Director of the Office of Emergency Medical Services.

187.1 **EFFECTIVE DATE.** This section is effective January 1, 2025.

187.2 Sec. 2. Minnesota Statutes 2023 Supplement, section 43A.08, subdivision 1a, is amended
187.3 to read:

187.4 Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following
187.5 agencies may designate additional unclassified positions according to this subdivision: the
187.6 Departments of Administration; Agriculture; Children, Youth, and Families; Commerce;
187.7 Corrections; Direct Care and Treatment; Education; Employment and Economic
187.8 Development; Explore Minnesota Tourism; Management and Budget; Health; Human
187.9 Rights; Human Services; Labor and Industry; Natural Resources; Public Safety; Revenue;
187.10 Transportation; and Veterans Affairs; the Housing Finance and Pollution Control Agencies;
187.11 the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the
187.12 Department of Information Technology Services; the Offices of the Attorney General,
187.13 Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the
187.14 Minnesota Office of Higher Education; the Perpich Center for Arts Education; ~~and~~ the
187.15 Minnesota Zoological Board; and the Office of Emergency Medical Services.

187.16 A position designated by an appointing authority according to this subdivision must
187.17 meet the following standards and criteria:

187.18 (1) the designation of the position would not be contrary to other law relating specifically
187.19 to that agency;

187.20 (2) the person occupying the position would report directly to the agency head or deputy
187.21 agency head and would be designated as part of the agency head's management team;

187.22 (3) the duties of the position would involve significant discretion and substantial
187.23 involvement in the development, interpretation, and implementation of agency policy;

187.24 (4) the duties of the position would not require primarily personnel, accounting, or other
187.25 technical expertise where continuity in the position would be important;

187.26 (5) there would be a need for the person occupying the position to be accountable to,
187.27 loyal to, and compatible with, the governor and the agency head, the employing statutory
187.28 board or commission, or the employing constitutional officer;

187.29 (6) the position would be at the level of division or bureau director or assistant to the
187.30 agency head; and

187.31 (7) the commissioner has approved the designation as being consistent with the standards
187.32 and criteria in this subdivision.

188.1 **EFFECTIVE DATE.** This section is effective January 1, 2025.

188.2 Sec. 3. Minnesota Statutes 2022, section 62J.49, subdivision 1, is amended to read:

188.3 Subdivision 1. **Establishment.** The director of the Office of Emergency Medical Services
188.4 ~~Regulatory Board~~ established under chapter ~~144~~ 144E shall establish a financial data
188.5 collection system for all ambulance services licensed in this state. To establish the financial
188.6 database, the ~~Emergency Medical Services Regulatory Board~~ director may contract with
188.7 an entity that has experience in ambulance service financial data collection.

188.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

188.9 Sec. 4. Minnesota Statutes 2022, section 144E.001, subdivision 3a, is amended to read:

188.10 Subd. 3a. **Ambulance service personnel.** "Ambulance service personnel" means
188.11 individuals who are authorized by a licensed ambulance service to provide emergency care
188.12 for the ambulance service and are:

188.13 (1) EMTs, AEMTs, or paramedics;

188.14 (2) Minnesota registered nurses who are: (i) EMTs, are currently practicing nursing, and
188.15 ~~have passed a paramedic practical skills test, as approved by the board and administered by~~
188.16 ~~an educational program approved by the board~~ been approved by the ambulance service
188.17 medical director; (ii) on the roster of an ambulance service on or before January 1, 2000;
188.18 ~~or~~ (iii) after petitioning the board, deemed by the board to have training and skills equivalent
188.19 to an EMT, as determined on a case-by-case basis; or (iv) certified as a certified flight
188.20 registered nurse or certified emergency nurse; or

188.21 (3) Minnesota licensed physician assistants who are: (i) EMTs, are currently practicing
188.22 as physician assistants, and have ~~passed a paramedic practical skills test, as approved by~~
188.23 ~~the board and administered by an educational program approved by the board~~ been approved
188.24 by the ambulance service medical director; (ii) on the roster of an ambulance service on or
188.25 before January 1, 2000; or (iii) after petitioning the board, deemed by the board to have
188.26 training and skills equivalent to an EMT, as determined on a case-by-case basis.

188.27 Sec. 5. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision
188.28 to read:

188.29 **Subd. 16. Director.** "Director" means the director of the Office of Emergency Medical
188.30 Services.

188.31 **EFFECTIVE DATE.** This section is effective January 1, 2025.

189.1 Sec. 6. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision
189.2 to read:

189.3 Subd. 17. **Office.** "Office" means the Office of Emergency Medical Services.

189.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

189.5 Sec. 7. **[144E.011] OFFICE OF EMERGENCY MEDICAL SERVICES.**

189.6 Subdivision 1. **Establishment.** The Office of Emergency Medical Services is established
189.7 with the powers and duties established in law. In administering this chapter, the office must
189.8 promote the public health and welfare, protect the safety of the public, and effectively
189.9 regulate and support the operation of the emergency medical services system in this state.

189.10 Subd. 2. **Director.** The governor must appoint a director for the office with the advice
189.11 and consent of the senate. The director must be in the unclassified service and must serve
189.12 at the pleasure of the governor. The salary of the director shall be determined according to
189.13 section 15A.0815. The director shall direct the activities of the office.

189.14 Subd. 3. **Powers and duties.** The director has the following powers and duties:

189.15 (1) administer and enforce this chapter and adopt rules as needed to implement this
189.16 chapter. Rules for which notice is published in the State Register before July 1, 2026, may
189.17 be adopted using the expedited rulemaking process in section 14.389;

189.18 (2) license ambulance services in the state and regulate their operation;

189.19 (3) establish and modify primary service areas;

189.20 (4) designate an ambulance service as authorized to provide service in a primary service
189.21 area and remove an ambulance service's authorization to provide service in a primary service
189.22 area;

189.23 (5) register medical response units in the state and regulate their operation;

189.24 (6) certify emergency medical technicians, advanced emergency medical technicians,
189.25 community emergency medical technicians, paramedics, and community paramedics and
189.26 to register emergency medical responders;

189.27 (7) approve education programs for ambulance service personnel and emergency medical
189.28 responders and administer qualifications for instructors of education programs;

189.29 (8) administer grant programs related to emergency medical services;

189.30 (9) report to the legislature by February 15 each year on the work of the office and the
189.31 advisory councils in the previous calendar year and with recommendations for any needed

190.1 policy changes related to emergency medical services, including but not limited to improving
190.2 access to emergency medical services, improving service delivery by ambulance services
190.3 and medical response units, and improving the effectiveness of the state's emergency medical
190.4 services system. The director must develop the reports and recommendations in consultation
190.5 with the office's deputy directors and advisory councils;

190.6 (10) investigate complaints against and hold hearings regarding ambulance services,
190.7 ambulance service personnel, and emergency medical responders and to impose disciplinary
190.8 action or otherwise resolve complaints; and

190.9 (11) perform other duties related to the provision of emergency medical services in the
190.10 state.

190.11 Subd. 4. **Employees.** The director may employ personnel in the classified service and
190.12 unclassified personnel as necessary to carry out the duties of this chapter.

190.13 Subd. 5. **Work plan.** The director must prepare a work plan to guide the work of the
190.14 office. The work plan must be updated biennially.

190.15 **EFFECTIVE DATE.** This section is effective January 1, 2025.

190.16 Sec. 8. **[144E.015] MEDICAL SERVICES DIVISION.**

190.17 A Medical Services Division is created in the Office of Emergency Medical Services.
190.18 The Medical Services Division shall be under the supervision of a deputy director of medical
190.19 services appointed by the director. The deputy director of medical services must be a
190.20 physician licensed under chapter 147. The deputy director, under the direction of the director,
190.21 shall enforce and coordinate the laws, rules, and policies assigned by the director, which
190.22 may include overseeing the clinical aspects of prehospital medical care and education
190.23 programs for emergency medical service personnel.

190.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

190.25 Sec. 9. **[144E.016] AMBULANCE SERVICES DIVISION.**

190.26 An Ambulance Services Division is created in the Office of Emergency Medical Services.
190.27 The Ambulance Services Division shall be under the supervision of a deputy director of
190.28 ambulance services appointed by the director. The deputy director, under the direction of
190.29 the director, shall enforce and coordinate the laws, rules, and policies assigned by the director,
190.30 which may include operating standards and licensing of ambulance services, registration
190.31 and operation of medical response units, establishment and modification of primary service
190.32 areas, authorization of ambulance services to provide service in a primary service area and

191.1 revocation of such authorization, coordination of ambulance services within regions and
191.2 across the state, and administration of grants.

191.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

191.4 Sec. 10. **[144E.017] EMERGENCY MEDICAL SERVICE PROVIDERS DIVISION.**

191.5 An Emergency Medical Service Providers Division is created in the Office of Emergency
191.6 Medical Services. The Emergency Medical Service Providers Division shall be under the
191.7 supervision of a deputy director of emergency medical service providers appointed by the
191.8 director. The deputy director, under the direction of the director, shall enforce and coordinate
191.9 the laws, rules, and policies assigned by the director, which may include certification and
191.10 registration of individual emergency medical service providers; overseeing worker safety,
191.11 worker well-being, and working conditions; implementation of education programs; and
191.12 administration of grants.

191.13 **EFFECTIVE DATE.** This section is effective January 1, 2025.

191.14 Sec. 11. **[144E.03] EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL.**

191.15 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Advisory
191.16 Council is established and consists of the following members:

191.17 (1) one emergency medical technician currently practicing with a licensed ambulance
191.18 service, appointed by the Minnesota Ambulance Association;

191.19 (2) one paramedic currently practicing with a licensed ambulance service or a medical
191.20 response unit, appointed jointly by the Minnesota Professional Fire Fighters Association
191.21 and the Minnesota Ambulance Association;

191.22 (3) one medical director of a licensed ambulance service, appointed by the National
191.23 Association of EMS Physicians, Minnesota Chapter;

191.24 (4) one firefighter currently serving as an emergency medical responder, appointed by
191.25 the Minnesota State Fire Chiefs Association;

191.26 (5) one registered nurse who is certified or currently practicing as a flight nurse, appointed
191.27 jointly by the regional emergency services boards of the designated regional emergency
191.28 medical services systems;

191.29 (6) one hospital administrator, appointed by the Minnesota Hospital Association;

191.30 (7) one social worker, appointed by the Board of Social Work;

192.1 (8) one member of a federally recognized Tribal Nation in Minnesota, appointed by the
192.2 Minnesota Indian Affairs Council;

192.3 (9) three public members, appointed by the governor;

192.4 (10) one member with experience working as an employee organization representative
192.5 representing emergency medical service providers, appointed by an employee organization
192.6 representing emergency medical service providers;

192.7 (11) one member representing a local government, appointed by the Coalition of Greater
192.8 Minnesota Cities;

192.9 (12) one member representing a local government in the seven-county metropolitan area,
192.10 appointed by the League of Minnesota Cities;

192.11 (13) one member of the house of representatives and one member of the senate, appointed
192.12 according to subdivision 2; and

192.13 (14) the commissioner of health and commissioner of public safety or their designees
192.14 as ex officio members.

192.15 Subd. 2. **Legislative members.** The speaker of the house must appoint one member of
192.16 the house of representatives to serve on the advisory council and the senate majority leader
192.17 must appoint one member of the senate to serve on the advisory council. Legislative members
192.18 appointed under this subdivision serve until successors are appointed. Legislative members
192.19 may receive per diem compensation and reimbursement for expenses according to the rules
192.20 of their respective bodies.

192.21 Subd. 3. **Terms, compensation, removal, vacancies, and expiration.** Compensation
192.22 and reimbursement for expenses for members appointed under subdivision 1, clauses (1)
192.23 to (12); removal of members; filling of vacancies of members; and, except for initial
192.24 appointments, membership terms are governed by section 15.059. Notwithstanding section
192.25 15.059, subdivision 6, the advisory council does not expire.

192.26 Subd. 4. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair
192.27 from among its membership and may elect other officers as the advisory council deems
192.28 necessary.

192.29 (b) The advisory council must meet quarterly or at the call of the chair.

192.30 (c) Meetings of the advisory council are subject to chapter 13D.

192.31 Subd. 5. **Duties.** The advisory council must review and make recommendations to the
192.32 director and the deputy director of ambulance services on the administration of this chapter,

193.1 the regulation of ambulance services and medical response units, the operation of the
193.2 emergency medical services system in the state, and other topics as directed by the director.

193.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

193.4 Sec. 12. **[144E.035] EMERGENCY MEDICAL SERVICES PHYSICIAN ADVISORY**
193.5 **COUNCIL.**

193.6 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Physician
193.7 Advisory Council is established and consists of the following members:

193.8 (1) eight physicians who meet the qualifications for medical directors in section 144E.265,
193.9 subdivision 1, with one physician appointed by each of the regional emergency services
193.10 boards of the designated regional emergency medical services systems;

193.11 (2) one physician who meets the qualifications for medical directors in section 144E.265,
193.12 subdivision 1, appointed by the Minnesota State Fire Chiefs Association;

193.13 (3) one physician who is board-certified in pediatrics, appointed by the Minnesota
193.14 Emergency Medical Services for Children program; and

193.15 (4) the medical director member of the Emergency Medical Services Advisory Council
193.16 appointed under section 144E.03, subdivision 1, clause (3).

193.17 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation
193.18 and reimbursement for expenses, removal of members, filling of vacancies of members,
193.19 and, except for initial appointments, membership terms are governed by section 15.059.
193.20 Notwithstanding section 15.059, subdivision 6, the advisory council does not expire.

193.21 Subd. 3. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair
193.22 from among its membership and may elect other officers as it deems necessary.

193.23 (b) The advisory council must meet twice per year or upon the call of the chair.

193.24 (c) Meetings of the advisory council are subject to chapter 13D.

193.25 Subd. 4. **Duties.** The advisory council must:

193.26 (1) review and make recommendations to the director and deputy director of medical
193.27 services on clinical aspects of prehospital medical care. In doing so, the advisory council
193.28 must incorporate information from medical literature, advances in bedside clinical practice,
193.29 and advisory council member experience; and

194.1 (2) serve as subject matter experts for the director and deputy director of medical services
194.2 on evolving topics in clinical medicine, including but not limited to infectious disease,
194.3 pharmaceutical and equipment shortages, and implementation of new therapeutics.

194.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

194.5 Sec. 13. **[144E.04] LABOR AND EMERGENCY MEDICAL SERVICE PROVIDERS**
194.6 **ADVISORY COUNCIL.**

194.7 Subdivision 1. **Establishment; membership.** The Labor and Emergency Medical Service
194.8 Providers Advisory Council is established and consists of the following members:

194.9 (1) one emergency medical service provider of any type from each of the designated
194.10 regional emergency medical services systems, appointed by their respective regional
194.11 emergency services boards;

194.12 (2) one emergency medical technician instructor, appointed by an employee organization
194.13 representing emergency medical service providers;

194.14 (3) two members with experience working as an employee organization representative
194.15 representing emergency medical service providers, appointed by an employee organization
194.16 representing emergency medical service providers;

194.17 (4) one emergency medical service provider based in a fire department, appointed jointly
194.18 by the Minnesota State Fire Chiefs Association and the Minnesota Professional Fire Fighters
194.19 Association; and

194.20 (5) one emergency medical service provider not based in a fire department, appointed
194.21 by the League of Minnesota Cities.

194.22 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation
194.23 and reimbursement for expenses for members appointed under subdivision 1; removal of
194.24 members; filling of vacancies of members; and, except for initial appointments, membership
194.25 terms are governed by section 15.059. Notwithstanding section 15.059, subdivision 6, the
194.26 advisory council does not expire.

194.27 Subd. 3. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair
194.28 from among its membership and may elect other officers as the advisory council deems
194.29 necessary.

194.30 (b) The advisory council must meet quarterly or at the call of the chair.

194.31 (c) Meetings of the advisory council are subject to chapter 13D.

195.1 Subd. 4. Duties. The advisory council must review and make recommendations to the
 195.2 director and deputy director of emergency medical service providers on the laws, rules, and
 195.3 policies assigned to the Emergency Medical Service Providers Division and other topics as
 195.4 directed by the director.

195.5 EFFECTIVE DATE. This section is effective January 1, 2025.

195.6 Sec. 14. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 6, is amended
 195.7 to read:

195.8 Subd. 6. **Basic life support.** (a) Except as provided in paragraph (f) or subdivision 6a,
 195.9 a basic life-support ambulance shall be staffed by at least two EMTs, one of whom individuals
 195.10 who meet one of the following requirements: (1) are certified as an EMT; (2) are a Minnesota
 195.11 registered nurse who meets the qualification requirements in section 144E.001, subdivision
 195.12 3a, clause (2); or (3) are a Minnesota licensed physician assistant who meets the qualification
 195.13 requirements in section 144E.001, subdivision 3a, clause (3). One of the individuals staffing
 195.14 a basic life-support ambulance must accompany the patient and provide a level of care so
 195.15 as to ensure that:

195.16 ~~(1)~~ (i) life-threatening situations and potentially serious injuries are recognized;

195.17 ~~(2)~~ (ii) patients are protected from additional hazards;

195.18 ~~(3)~~ (iii) basic treatment to reduce the seriousness of emergency situations is administered;
 195.19 and

195.20 ~~(4)~~ (iv) patients are transported to an appropriate medical facility for treatment.

195.21 (b) A basic life-support service shall provide basic airway management.

195.22 (c) A basic life-support service shall provide automatic defibrillation.

195.23 (d) A basic life-support service shall administer opiate antagonists consistent with
 195.24 protocols established by the service's medical director.

195.25 (e) A basic life-support service licensee's medical director may authorize ambulance
 195.26 service personnel to perform intravenous infusion and use equipment that is within the
 195.27 licensure level of the ambulance service. Ambulance service personnel must be properly
 195.28 trained. Documentation of authorization for use, guidelines for use, continuing education,
 195.29 and skill verification must be maintained in the licensee's files.

195.30 (f) For emergency ambulance calls and interfacility transfers, an ambulance service may
 195.31 staff its basic life-support ambulances with one EMT individual who meets the qualification
 195.32 requirements in paragraph (a), who must accompany the patient, and one registered

196.1 emergency medical responder driver. ~~For purposes of this paragraph, "ambulance service"~~
196.2 ~~means either an ambulance service whose primary service area is mainly located outside~~
196.3 ~~the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of~~
196.4 ~~Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an ambulance service based in~~
196.5 ~~a community with a population of less than 2,500.~~

196.6 (g) In order for a registered nurse to staff a basic life-support ambulance as a driver, the
196.7 registered nurse must have successfully completed a certified emergency vehicle operators
196.8 program.

196.9 Sec. 15. Minnesota Statutes 2022, section 144E.101, is amended by adding a subdivision
196.10 to read:

196.11 Subd. 6a. **Variance; staffing of basic life-support ambulance.** (a) Upon application
196.12 from an ambulance service that includes evidence demonstrating hardship, the board may
196.13 grant a variance from the staff requirements in subdivision 6, paragraph (a), and may
196.14 authorize a basic life-support ambulance to be staffed, for all emergency calls and interfacility
196.15 transfers, with one individual who meets the qualification requirements in paragraph (b) to
196.16 drive the ambulance and one individual who meets the qualification requirements in
196.17 subdivision 6, paragraph (a), and who must accompany the patient. The variance applies to
196.18 basic life-support ambulances until the ambulance service renews its license. When the
196.19 variance expires, the ambulance service may apply for a new variance under this subdivision.

196.20 (b) In order to drive an ambulance under a variance granted under this subdivision, an
196.21 individual must:

196.22 (1) hold a valid driver's license from any state;

196.23 (2) have attended an emergency vehicle driving course approved by the ambulance
196.24 service;

196.25 (3) have completed a course on cardiopulmonary resuscitation approved by the ambulance
196.26 service; and

196.27 (4) register with the board according to a process established by the board.

196.28 (c) If an individual serving as a driver under this subdivision commits or has a record
196.29 of committing an act listed in section 144E.27, subdivision 5, paragraph (a), the board may
196.30 temporarily suspend or prohibit the individual from driving an ambulance or place conditions
196.31 on the individual's ability to drive an ambulance using the procedures and authority in
196.32 section 144E.27, subdivisions 5 and 6.

197.1 Sec. 16. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 7, as amended
197.2 by Laws 2024, chapter 85, section 32, is amended to read:

197.3 Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an
197.4 advanced life-support ambulance shall be staffed by at least:

197.5 (1) one EMT or one AEMT and one paramedic;

197.6 (2) one EMT or one AEMT and one registered nurse who: (i) is an EMT or an AEMT,
197.7 is currently practicing nursing, and has passed a paramedic practical skills test approved by
197.8 the board and administered by an education program has been approved by the ambulance
197.9 service medical director; or (ii) is certified as a certified flight registered nurse or certified
197.10 emergency nurse; or

197.11 (3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT,
197.12 is currently practicing as a physician assistant, and ~~has passed a paramedic practical skills~~
197.13 ~~test approved by the board and administered by an education program~~ has been approved
197.14 by the ambulance service medical director.

197.15 (b) An advanced life-support service shall provide basic life support, as specified under
197.16 subdivision 6, paragraph (a), advanced airway management, manual defibrillation,
197.17 administration of intravenous fluids and pharmaceuticals, and administration of opiate
197.18 antagonists.

197.19 (c) In addition to providing advanced life support, an advanced life-support service may
197.20 staff additional ambulances to provide basic life support according to subdivision 6 and
197.21 section 144E.103, subdivision 1.

197.22 (d) An ambulance service providing advanced life support shall have a written agreement
197.23 with its medical director to ensure medical control for patient care 24 hours a day, seven
197.24 days a week. The terms of the agreement shall include a written policy on the administration
197.25 of medical control for the service. The policy shall address the following issues:

197.26 (1) two-way communication for physician direction of ambulance service personnel;

197.27 (2) patient triage, treatment, and transport;

197.28 (3) use of standing orders; and

197.29 (4) the means by which medical control will be provided 24 hours a day.

197.30 The agreement shall be signed by the licensee's medical director and the licensee or the
197.31 licensee's designee and maintained in the files of the licensee.

198.1 (e) When an ambulance service provides advanced life support, the authority of a
198.2 paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician
198.3 assistant-EMT to determine the delivery of patient care prevails over the authority of an
198.4 EMT.

198.5 (f) Upon application from an ambulance service that includes evidence demonstrating
198.6 hardship, the board may grant a variance from the staff requirements in paragraph (a), clause
198.7 (1), and may authorize an advanced life-support ambulance to be staffed by a registered
198.8 emergency medical responder driver with a paramedic for all emergency calls and interfacility
198.9 transfers. The variance shall apply to advanced life-support ambulance services until the
198.10 ambulance service renews its license. When the variance expires, an ambulance service
198.11 may apply for a new variance under this paragraph. ~~This paragraph applies only to an
198.12 ambulance service whose primary service area is mainly located outside the metropolitan
198.13 counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato,
198.14 Moorhead, Rochester, and St. Cloud, or an ambulance service based in a community with
198.15 a population of less than 1,000 persons.~~

198.16 (g) After an initial emergency ambulance call, each subsequent emergency ambulance
198.17 response, until the initial ambulance is again available, and interfacility transfers, may be
198.18 staffed by one registered emergency medical responder driver and an EMT or paramedic.
198.19 ~~This paragraph applies only to an ambulance service whose primary service area is mainly
198.20 located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
198.21 the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance service
198.22 based in a community with a population of less than 1,000 persons.~~

198.23 (h) In order for a registered nurse to staff an advanced life-support ambulance as a driver,
198.24 the registered nurse must have successfully completed a certified emergency vehicle operators
198.25 program.

198.26 Sec. 17. Minnesota Statutes 2022, section 144E.16, subdivision 5, is amended to read:

198.27 Subd. 5. **Local government's powers.** (a) Local units of government may, with the
198.28 approval of the ~~board~~ director, establish standards for ambulance services which impose
198.29 additional requirements upon such services. Local units of government intending to impose
198.30 additional requirements shall consider whether any benefit accruing to the public health
198.31 would outweigh the costs associated with the additional requirements.

198.32 (b) Local units of government that desire to impose additional requirements shall, prior
198.33 to adoption of relevant ordinances, rules, or regulations, furnish the ~~board~~ director with a

199.1 copy of the proposed ordinances, rules, or regulations, along with information that
199.2 affirmatively substantiates that the proposed ordinances, rules, or regulations:

199.3 (1) will in no way conflict with the relevant rules of the ~~board~~ office;

199.4 (2) will establish additional requirements tending to protect the public health;

199.5 (3) will not diminish public access to ambulance services of acceptable quality; and

199.6 (4) will not interfere with the orderly development of regional systems of emergency
199.7 medical care.

199.8 (c) The ~~board~~ director shall base any decision to approve or disapprove local standards
199.9 upon whether or not the local unit of government in question has affirmatively substantiated
199.10 that the proposed ordinances, rules, or regulations meet the criteria specified in paragraph
199.11 (b).

199.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

199.13 Sec. 18. Minnesota Statutes 2022, section 144E.19, subdivision 3, is amended to read:

199.14 Subd. 3. **Temporary suspension.** (a) In addition to any other remedy provided by law,
199.15 the ~~board~~ director may temporarily suspend the license of a licensee after conducting a
199.16 preliminary inquiry to determine whether the ~~board~~ director believes that the licensee has
199.17 violated a statute or rule that the ~~board~~ director is empowered to enforce and determining
199.18 that the continued provision of service by the licensee would create an imminent risk to
199.19 public health or harm to others.

199.20 (b) A temporary suspension order prohibiting a licensee from providing ambulance
199.21 service shall give notice of the right to a preliminary hearing according to paragraph (d)
199.22 and shall state the reasons for the entry of the temporary suspension order.

199.23 (c) Service of a temporary suspension order is effective when the order is served on the
199.24 licensee personally or by certified mail, which is complete upon receipt, refusal, or return
199.25 for nondelivery to the most recent address provided to the ~~board~~ director for the licensee.

199.26 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
199.27 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
199.28 that shall begin within 60 days after issuance of the temporary suspension order or within
199.29 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
199.30 a licensee, whichever is sooner. The hearing shall be on the sole issue of whether there is
199.31 a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under
199.32 this paragraph is not subject to chapter 14.

200.1 (e) Evidence presented by the ~~board~~ director or licensee may be in the form of an affidavit.
200.2 The licensee or the licensee's designee may appear for oral argument.

200.3 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
200.4 if the suspension is continued, notify the licensee of the right to a contested case hearing
200.5 under chapter 14.

200.6 (g) If a licensee requests a contested case hearing within 30 days after receiving notice
200.7 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to
200.8 chapter 14. The administrative law judge shall issue a report and recommendation within
200.9 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
200.10 a final order within 30 days after receipt of the administrative law judge's report.

200.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

200.12 Sec. 19. Minnesota Statutes 2022, section 144E.27, subdivision 3, is amended to read:

200.13 Subd. 3. **Renewal.** (a) The board may renew the registration of an emergency medical
200.14 responder who:

200.15 (1) successfully completes a board-approved refresher course; ~~and~~

200.16 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
200.17 board or by the licensee's medical director. This course may be a component of a
200.18 board-approved refresher course; and

200.19 ~~(2)~~ (3) submits a completed renewal application to the board before the registration
200.20 expiration date.

200.21 (b) The board may renew the lapsed registration of an emergency medical responder
200.22 who:

200.23 (1) successfully completes a board-approved refresher course; ~~and~~

200.24 (2) successfully completes a course in cardiopulmonary resuscitation approved by the
200.25 board or by the licensee's medical director. This course may be a component of a
200.26 board-approved refresher course; and

200.27 ~~(2)~~ (3) submits a completed renewal application to the board within ~~12~~ 48 months after
200.28 the registration expiration date.

201.1 Sec. 20. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

201.2 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny, suspend,
201.3 revoke, place conditions on, or refuse to renew the registration of an individual who the
201.4 ~~board~~ director determines:

201.5 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an
201.6 agreement for corrective action, or an order that the ~~board~~ director issued or is otherwise
201.7 empowered to enforce;

201.8 (2) misrepresents or falsifies information on an application form for registration;

201.9 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
201.10 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
201.11 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
201.12 alcohol;

201.13 (4) is actually or potentially unable to provide emergency medical services with
201.14 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,
201.15 or any other material, or as a result of any mental or physical condition;

201.16 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
201.17 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,
201.18 welfare, or safety of the public;

201.19 (6) maltreats or abandons a patient;

201.20 (7) violates any state or federal controlled substance law;

201.21 (8) engages in unprofessional conduct or any other conduct which has the potential for
201.22 causing harm to the public, including any departure from or failure to conform to the
201.23 minimum standards of acceptable and prevailing practice without actual injury having to
201.24 be established;

201.25 (9) provides emergency medical services under lapsed or nonrenewed credentials;

201.26 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
201.27 jurisdiction or by another regulatory authority;

201.28 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
201.29 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
201.30 to a patient; ~~or~~

202.1 (12) makes a false statement or knowingly provides false information to the ~~board~~
202.2 director, or fails to cooperate with an investigation of the ~~board~~ director as required by
202.3 section 144E.30; or

202.4 (13) fails to engage with the health professionals services program or diversion program
202.5 required under section 144E.287 after being referred to the program, violates the terms of
202.6 the program participation agreement, or leaves the program except upon fulfilling the terms
202.7 for successful completion of the program as set forth in the participation agreement.

202.8 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an
202.9 individual of the right to a contested case hearing under chapter 14. If an individual requests
202.10 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate
202.11 a contested case hearing according to chapter 14.

202.12 (c) The administrative law judge shall issue a report and recommendation within 30
202.13 days after closing the contested case hearing record. The ~~board~~ director shall issue a final
202.14 order within 30 days after receipt of the administrative law judge's report.

202.15 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions
202.16 on, or refuse renewal of an individual's registration for disciplinary action, the individual
202.17 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

202.18 **EFFECTIVE DATE.** This section is effective January 1, 2025.

202.19 Sec. 21. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

202.20 Subd. 5. **Denial, suspension, revocation; emergency medical responders and**
202.21 **drivers.** (a) This subdivision applies to individuals seeking registration or registered as an
202.22 emergency medical responder and to individuals seeking registration or registered as a driver
202.23 of a basic life-support ambulance under section 144E.101, subdivision 6a. The board may
202.24 deny, suspend, revoke, place conditions on, or refuse to renew the registration of an individual
202.25 who the board determines:

202.26 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an
202.27 agreement for corrective action, or an order that the board issued or is otherwise empowered
202.28 to enforce;

202.29 (2) misrepresents or falsifies information on an application form for registration;

202.30 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
202.31 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any

203.1 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
203.2 alcohol;

203.3 (4) is actually or potentially unable to provide emergency medical services or drive an
203.4 ambulance with reasonable skill and safety to patients by reason of illness, use of alcohol,
203.5 drugs, chemicals, or any other material, or as a result of any mental or physical condition;

203.6 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
203.7 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,
203.8 welfare, or safety of the public;

203.9 (6) maltreats or abandons a patient;

203.10 (7) violates any state or federal controlled substance law;

203.11 (8) engages in unprofessional conduct or any other conduct which has the potential for
203.12 causing harm to the public, including any departure from or failure to conform to the
203.13 minimum standards of acceptable and prevailing practice without actual injury having to
203.14 be established;

203.15 (9) for emergency medical responders, provides emergency medical services under
203.16 lapsed or nonrenewed credentials;

203.17 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
203.18 jurisdiction or by another regulatory authority;

203.19 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
203.20 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
203.21 to a patient; or

203.22 (12) makes a false statement or knowingly provides false information to the board, or
203.23 fails to cooperate with an investigation of the board as required by section 144E.30.

203.24 (b) Before taking action under paragraph (a), the board shall give notice to an individual
203.25 of the right to a contested case hearing under chapter 14. If an individual requests a contested
203.26 case hearing within 30 days after receiving notice, the board shall initiate a contested case
203.27 hearing according to chapter 14.

203.28 (c) The administrative law judge shall issue a report and recommendation within 30
203.29 days after closing the contested case hearing record. The board shall issue a final order
203.30 within 30 days after receipt of the administrative law judge's report.

204.1 (d) After six months from the board's decision to deny, revoke, place conditions on, or
204.2 refuse renewal of an individual's registration for disciplinary action, the individual shall
204.3 have the opportunity to apply to the board for reinstatement.

204.4 Sec. 22. Minnesota Statutes 2022, section 144E.27, subdivision 6, is amended to read:

204.5 Subd. 6. **Temporary suspension; emergency medical responders and drivers.** (a)
204.6 This subdivision applies to emergency medical responders registered under this section and
204.7 to individuals registered as drivers of basic life-support ambulances under section 144E.101,
204.8 subdivision 6a. In addition to any other remedy provided by law, the board may temporarily
204.9 suspend the registration of an individual after conducting a preliminary inquiry to determine
204.10 whether the board believes that the individual has violated a statute or rule that the board
204.11 is empowered to enforce and determining that the continued provision of service by the
204.12 individual would create an imminent risk to public health or harm to others.

204.13 (b) A temporary suspension order prohibiting an individual from providing emergency
204.14 medical care or from driving a basic life-support ambulance shall give notice of the right
204.15 to a preliminary hearing according to paragraph (d) and shall state the reasons for the entry
204.16 of the temporary suspension order.

204.17 (c) Service of a temporary suspension order is effective when the order is served on the
204.18 individual personally or by certified mail, which is complete upon receipt, refusal, or return
204.19 for nondelivery to the most recent address provided to the board for the individual.

204.20 (d) At the time the board issues a temporary suspension order, the board shall schedule
204.21 a hearing, to be held before a group of its members designated by the board, that shall begin
204.22 within 60 days after issuance of the temporary suspension order or within 15 working days
204.23 of the date of the board's receipt of a request for a hearing from the individual, whichever
204.24 is sooner. The hearing shall be on the sole issue of whether there is a reasonable basis to
204.25 continue, modify, or lift the temporary suspension. A hearing under this paragraph is not
204.26 subject to chapter 14.

204.27 (e) Evidence presented by the board or the individual may be in the form of an affidavit.
204.28 The individual or the individual's designee may appear for oral argument.

204.29 (f) Within five working days of the hearing, the board shall issue its order and, if the
204.30 suspension is continued, notify the individual of the right to a contested case hearing under
204.31 chapter 14.

204.32 (g) If an individual requests a contested case hearing within 30 days after receiving
204.33 notice under paragraph (f), the board shall initiate a contested case hearing according to

205.1 chapter 14. The administrative law judge shall issue a report and recommendation within
205.2 30 days after the closing of the contested case hearing record. The board shall issue a final
205.3 order within 30 days after receipt of the administrative law judge's report.

205.4 Sec. 23. Minnesota Statutes 2022, section 144E.28, subdivision 3, is amended to read:

205.5 Subd. 3. **Reciprocity.** The board may certify an individual who possesses a current
205.6 National Registry of Emergency Medical Technicians ~~registration~~ certification from another
205.7 jurisdiction if the individual submits a board-approved application form. The board
205.8 certification classification shall be the same as the National Registry's classification.
205.9 Certification shall be for the duration of the applicant's ~~registration~~ certification period in
205.10 another jurisdiction, not to exceed two years.

205.11 Sec. 24. Minnesota Statutes 2022, section 144E.28, subdivision 5, is amended to read:

205.12 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny certification
205.13 or take any action authorized in subdivision 4 against an individual who the ~~board~~ director
205.14 determines:

205.15 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, or
205.16 an order that the ~~board~~ director issued or is otherwise authorized or empowered to enforce,
205.17 or agreement for corrective action;

205.18 (2) misrepresents or falsifies information on an application form for certification;

205.19 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor
205.20 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any
205.21 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or
205.22 alcohol;

205.23 (4) is actually or potentially unable to provide emergency medical services with
205.24 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,
205.25 or any other material, or as a result of any mental or physical condition;

205.26 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,
205.27 defraud, or harm the public or demonstrating a willful or careless disregard for the health,
205.28 welfare, or safety of the public;

205.29 (6) maltreats or abandons a patient;

205.30 (7) violates any state or federal controlled substance law;

206.1 (8) engages in unprofessional conduct or any other conduct which has the potential for
206.2 causing harm to the public, including any departure from or failure to conform to the
206.3 minimum standards of acceptable and prevailing practice without actual injury having to
206.4 be established;

206.5 (9) provides emergency medical services under lapsed or nonrenewed credentials;

206.6 (10) is subject to a denial, corrective, disciplinary, or other similar action in another
206.7 jurisdiction or by another regulatory authority;

206.8 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted
206.9 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
206.10 to a patient; ~~or~~

206.11 (12) makes a false statement or knowingly provides false information to the ~~board~~ director
206.12 or fails to cooperate with an investigation of the ~~board~~ director as required by section
206.13 144E.30; or

206.14 (13) fails to engage with the health professionals services program or diversion program
206.15 required under section 144E.287 after being referred to the program, violates the terms of
206.16 the program participation agreement, or leaves the program except upon fulfilling the terms
206.17 for successful completion of the program as set forth in the participation agreement.

206.18 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an
206.19 individual of the right to a contested case hearing under chapter 14. If an individual requests
206.20 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate
206.21 a contested case hearing according to chapter 14 and no disciplinary action shall be taken
206.22 at that time.

206.23 (c) The administrative law judge shall issue a report and recommendation within 30
206.24 days after closing the contested case hearing record. The ~~board~~ director shall issue a final
206.25 order within 30 days after receipt of the administrative law judge's report.

206.26 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions
206.27 on, or refuse renewal of an individual's certification for disciplinary action, the individual
206.28 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

206.29 **EFFECTIVE DATE.** This section is effective January 1, 2025.

206.30 Sec. 25. Minnesota Statutes 2022, section 144E.28, subdivision 6, is amended to read:

206.31 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,
206.32 the ~~board~~ director may temporarily suspend the certification of an individual after conducting

207.1 a preliminary inquiry to determine whether the ~~board~~ director believes that the individual
207.2 has violated a statute or rule that the ~~board~~ director is empowered to enforce and determining
207.3 that the continued provision of service by the individual would create an imminent risk to
207.4 public health or harm to others.

207.5 (b) A temporary suspension order prohibiting an individual from providing emergency
207.6 medical care shall give notice of the right to a preliminary hearing according to paragraph
207.7 (d) and shall state the reasons for the entry of the temporary suspension order.

207.8 (c) Service of a temporary suspension order is effective when the order is served on the
207.9 individual personally or by certified mail, which is complete upon receipt, refusal, or return
207.10 for nondelivery to the most recent address provided to the ~~board~~ director for the individual.

207.11 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
207.12 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
207.13 that shall begin within 60 days after issuance of the temporary suspension order or within
207.14 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
207.15 the individual, whichever is sooner. The hearing shall be on the sole issue of whether there
207.16 is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under
207.17 this paragraph is not subject to chapter 14.

207.18 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an
207.19 affidavit. The individual or individual's designee may appear for oral argument.

207.20 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
207.21 if the suspension is continued, notify the individual of the right to a contested case hearing
207.22 under chapter 14.

207.23 (g) If an individual requests a contested case hearing within 30 days of receiving notice
207.24 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to
207.25 chapter 14. The administrative law judge shall issue a report and recommendation within
207.26 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
207.27 a final order within 30 days after receipt of the administrative law judge's report.

207.28 **EFFECTIVE DATE.** This section is effective January 1, 2025.

207.29 Sec. 26. Minnesota Statutes 2022, section 144E.28, subdivision 8, is amended to read:

207.30 Subd. 8. **Reinstatement.** (a) Within four years of a certification expiration date, a person
207.31 whose certification has expired under subdivision 7, paragraph (d), may have the certification
207.32 reinstated upon submission of:

208.1 (1) evidence to the board of training equivalent to the continuing education requirements
208.2 of subdivision 7 or, for community paramedics, evidence to the board of training equivalent
208.3 to the continuing education requirements of subdivision 9, paragraph (c); and

208.4 (2) a board-approved application form.

208.5 (b) If more than four years have passed since a certificate expiration date, an applicant
208.6 must complete the initial certification process required under subdivision 1.

208.7 (c) Beginning July 1, 2024, through December 31, 2025, and notwithstanding paragraph
208.8 (b), a person whose certification as an EMT, AEMT, paramedic, or community paramedic
208.9 expired more than four years ago but less than ten years ago may have the certification
208.10 reinstated upon submission of:

208.11 (1) evidence to the board of the training required under paragraph (a), clause (1). This
208.12 training must have been completed within the 24 months prior to the date of the application
208.13 for reinstatement;

208.14 (2) a board-approved application form; and

208.15 (3) a recommendation from an ambulance service medical director.

208.16 This paragraph expires December 31, 2025.

208.17 Sec. 27. Minnesota Statutes 2022, section 144E.285, subdivision 1, is amended to read:

208.18 Subdivision 1. **Approval required.** (a) All education programs for an EMR, EMT,
208.19 AEMT, or paramedic must be approved by the board.

208.20 (b) To be approved by the board, an education program must:

208.21 (1) submit an application prescribed by the board that includes:

208.22 (i) ~~type and length~~ of course to be offered;

208.23 (ii) names, addresses, and qualifications of the program medical director, program
208.24 education coordinator, and instructors;

208.25 ~~(iii) names and addresses of clinical sites, including a contact person and telephone~~
208.26 ~~number;~~

208.27 ~~(iv)~~ (iii) admission criteria for students; and

208.28 ~~(v)~~ (iv) materials and equipment to be used;

209.1 (2) for each course, implement the most current version of the United States Department
209.2 of Transportation EMS Education Standards, or its equivalent as determined by the board
209.3 applicable to EMR, EMT, AEMT, or paramedic education;

209.4 (3) have a program medical director and a program coordinator;

209.5 (4) utilize instructors who meet the requirements of section 144E.283 for teaching at
209.6 least 50 percent of the course content. The remaining 50 percent of the course may be taught
209.7 by guest lecturers approved by the education program coordinator or medical director;

209.8 ~~(5) have at least one instructor for every ten students at the practical skill stations;~~

209.9 ~~(6) maintain a written agreement with a licensed hospital or licensed ambulance service~~
209.10 ~~designating a clinical training site;~~

209.11 ~~(7)~~ (5) retain documentation of program approval by the board, course outline, and
209.12 student information;

209.13 ~~(8)~~ (6) notify the board of the starting date of a course prior to the beginning of a course;
209.14 and

209.15 ~~(9)~~ (7) submit the appropriate fee as required under section 144E.29; and.

209.16 ~~(10) maintain a minimum average yearly pass rate as set by the board on an annual basis.~~
209.17 ~~The pass rate will be determined by the percent of candidates who pass the exam on the~~
209.18 ~~first attempt. An education program not meeting this yearly standard shall be placed on~~
209.19 ~~probation and shall be on a performance improvement plan approved by the board until~~
209.20 ~~meeting the pass rate standard. While on probation, the education program may continue~~
209.21 ~~providing classes if meeting the terms of the performance improvement plan as determined~~
209.22 ~~by the board. If an education program having probation status fails to meet the pass rate~~
209.23 ~~standard after two years in which an EMT initial course has been taught, the board may~~
209.24 ~~take disciplinary action under subdivision 5.~~

209.25 Sec. 28. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision
209.26 to read:

209.27 Subd. 1a. **EMR education program requirements.** The National EMS Education
209.28 Standards established by the National Highway Traffic Safety Administration of the United
209.29 States Department of Transportation specify the minimum requirements for knowledge and
209.30 skills for emergency medical responders. An education program applying for approval to
209.31 teach EMRs must comply with the requirements under subdivision 1, paragraph (b). A

210.1 medical director of an emergency medical responder group may establish additional
210.2 knowledge and skill requirements for EMRs.

210.3 Sec. 29. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision
210.4 to read:

210.5 Subd. 1b. **EMT education program requirements.** In addition to the requirements
210.6 under subdivision 1, paragraph (b), an education program applying for approval to teach
210.7 EMTs must:

210.8 (1) include in the application prescribed by the board the names and addresses of clinical
210.9 sites, including a contact person and telephone number;

210.10 (2) maintain a written agreement with at least one clinical training site that is of a type
210.11 recognized by the National EMS Education Standards established by the National Highway
210.12 Traffic Safety Administration; and

210.13 (3) maintain a minimum average yearly pass rate as set by the board. An education
210.14 program not meeting this standard must be placed on probation and must comply with a
210.15 performance improvement plan approved by the board until the program meets the pass
210.16 rate standard. While on probation, the education program may continue to provide classes
210.17 if the program meets the terms of the performance improvement plan, as determined by the
210.18 board. If an education program that is on probation status fails to meet the pass rate standard
210.19 after two years in which an EMT initial course has been taught, the board may take
210.20 disciplinary action under subdivision 5.

210.21 Sec. 30. Minnesota Statutes 2022, section 144E.285, subdivision 2, is amended to read:

210.22 Subd. 2. **AEMT and paramedic education program requirements.** (a) In addition to
210.23 the requirements under subdivision 1, paragraph (b), an education program applying for
210.24 approval to teach AEMTs and paramedics must:

210.25 (1) be administered by an educational institution accredited by the Commission of
210.26 Accreditation of Allied Health Education Programs (CAAHEP);

210.27 (2) include in the application prescribed by the board the names and addresses of clinical
210.28 sites, including a contact person and telephone number; and

210.29 (3) maintain a written agreement with a licensed hospital or licensed ambulance service
210.30 designating a clinical training site.

211.1 (b) An AEMT and paramedic education program that is administered by an educational
 211.2 institution not accredited by CAAHEP, but that is in the process of completing the
 211.3 accreditation process, may be granted provisional approval by the board upon verification
 211.4 of submission of its self-study report and the appropriate review fee to CAAHEP.

211.5 (c) An educational institution that discontinues its participation in the accreditation
 211.6 process must notify the board immediately and provisional approval shall be withdrawn.

211.7 ~~(d) This subdivision does not apply to a paramedic education program when the program
 211.8 is operated by an advanced life support ambulance service licensed by the Emergency
 211.9 Medical Services Regulatory Board under this chapter, and the ambulance service meets
 211.10 the following criteria:~~

211.11 ~~(1) covers a rural primary service area that does not contain a hospital within the primary
 211.12 service area or contains a hospital within the primary service area that has been designated
 211.13 as a critical access hospital under section 144.1483, clause (9);~~

211.14 ~~(2) has tax-exempt status in accordance with the Internal Revenue Code, section
 211.15 501(c)(3);~~

211.16 ~~(3) received approval before 1991 from the commissioner of health to operate a paramedic
 211.17 education program;~~

211.18 ~~(4) operates an AEMT and paramedic education program exclusively to train paramedics
 211.19 for the local ambulance service; and~~

211.20 ~~(5) limits enrollment in the AEMT and paramedic program to five candidates per
 211.21 biennium.~~

211.22 Sec. 31. Minnesota Statutes 2022, section 144E.285, subdivision 4, is amended to read:

211.23 Subd. 4. **Reapproval.** An education program shall apply to the board for reapproval at
 211.24 least ~~three months~~ 30 days prior to the expiration date of its approval and must:

211.25 (1) submit an application prescribed by the board specifying any changes from the
 211.26 information provided for prior approval and any other information requested by the board
 211.27 to clarify incomplete or ambiguous information presented in the application; ~~and~~

211.28 (2) comply with the requirements under subdivision 1, paragraph (b), clauses (2) to ~~(10)~~.
 211.29 (7);

211.30 (3) be subject to a site visit by the board;

- 212.1 (4) for education programs that teach EMRs, comply with the requirements in subdivision
212.2 1a;
- 212.3 (5) for education programs that teach EMTs, comply with the requirements in subdivision
212.4 1b; and
- 212.5 (6) for education programs that teach AEMTs and paramedics, comply with the
212.6 requirements in subdivision 2 and maintain accreditation with CAAHEP.

212.7 Sec. 32. Minnesota Statutes 2022, section 144E.285, subdivision 6, is amended to read:

212.8 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,
212.9 the ~~board~~ director may temporarily suspend approval of the education program after
212.10 conducting a preliminary inquiry to determine whether the ~~board~~ director believes that the
212.11 education program has violated a statute or rule that the ~~board~~ director is empowered to
212.12 enforce and determining that the continued provision of service by the education program
212.13 would create an imminent risk to public health or harm to others.

212.14 (b) A temporary suspension order prohibiting the education program from providing
212.15 emergency medical care training shall give notice of the right to a preliminary hearing
212.16 according to paragraph (d) and shall state the reasons for the entry of the temporary
212.17 suspension order.

212.18 (c) Service of a temporary suspension order is effective when the order is served on the
212.19 education program personally or by certified mail, which is complete upon receipt, refusal,
212.20 or return for nondelivery to the most recent address provided to the ~~board~~ director for the
212.21 education program.

212.22 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director
212.23 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~
212.24 that shall begin within 60 days after issuance of the temporary suspension order or within
212.25 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from
212.26 the education program, whichever is sooner. The hearing shall be on the sole issue of whether
212.27 there is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing
212.28 under this paragraph is not subject to chapter 14.

212.29 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an
212.30 affidavit. The education program or counsel of record may appear for oral argument.

212.31 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,
212.32 if the suspension is continued, notify the education program of the right to a contested case
212.33 hearing under chapter 14.

213.1 (g) If an education program requests a contested case hearing within 30 days of receiving
213.2 notice under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according
213.3 to chapter 14. The administrative law judge shall issue a report and recommendation within
213.4 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue
213.5 a final order within 30 days after receipt of the administrative law judge's report.

213.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

213.7 Sec. 33. Minnesota Statutes 2022, section 144E.287, is amended to read:

213.8 **144E.287 DIVERSION PROGRAM.**

213.9 The ~~board~~ director shall either conduct a health professionals ~~service~~ services program
213.10 ~~under sections 214.31 to 214.37~~ or contract for a diversion program ~~under section 214.28~~
213.11 for professionals regulated ~~by the board~~ under this chapter who are unable to perform their
213.12 duties with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals,
213.13 or any other materials, or as a result of any mental, physical, or psychological condition.

213.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

213.15 Sec. 34. Minnesota Statutes 2022, section 144E.305, subdivision 3, is amended to read:

213.16 Subd. 3. **Immunity.** (a) An individual, licensee, health care facility, business, or
213.17 organization is immune from civil liability or criminal prosecution for submitting in good
213.18 faith a report to the ~~board~~ director under subdivision 1 or 2 or for otherwise reporting in
213.19 good faith to the ~~board~~ director violations or alleged violations of sections 144E.001 to
213.20 144E.33. Reports are classified as confidential data on individuals or protected nonpublic
213.21 data under section 13.02 while an investigation is active. Except for the ~~board's~~ director's
213.22 final determination, all communications or information received by or disclosed to the ~~board~~
213.23 director relating to disciplinary matters of any person or entity subject to the ~~board's~~ director's
213.24 regulatory jurisdiction are confidential and privileged and any disciplinary hearing shall be
213.25 closed to the public.

213.26 (b) ~~Members of the board~~ The director, persons employed by the ~~board~~ director, persons
213.27 engaged in the investigation of violations and in the preparation and management of charges
213.28 of violations of sections 144E.001 to 144E.33 on behalf of the ~~board~~ director, and persons
213.29 participating in the investigation regarding charges of violations are immune from civil
213.30 liability and criminal prosecution for any actions, transactions, or publications, made in
213.31 good faith, in the execution of, or relating to, their duties under sections 144E.001 to 144E.33.

214.1 ~~(e) For purposes of this section, a member of the board is considered a state employee~~
214.2 ~~under section 3.736, subdivision 9.~~

214.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

214.4 Sec. 35. Minnesota Statutes 2023 Supplement, section 152.126, subdivision 6, is amended
214.5 to read:

214.6 **Subd. 6. Access to reporting system data.** (a) Except as indicated in this subdivision,
214.7 the data submitted to the board under subdivision 4 is private data on individuals as defined
214.8 in section 13.02, subdivision 12, and not subject to public disclosure.

214.9 (b) Except as specified in subdivision 5, the following persons shall be considered
214.10 permissible users and may access the data submitted under subdivision 4 in the same or
214.11 similar manner, and for the same or similar purposes, as those persons who are authorized
214.12 to access similar private data on individuals under federal and state law:

214.13 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
214.14 delegated the task of accessing the data, to the extent the information relates specifically to
214.15 a current patient, to whom the prescriber is:

214.16 (i) prescribing or considering prescribing any controlled substance;

214.17 (ii) providing emergency medical treatment for which access to the data may be necessary;

214.18 (iii) providing care, and the prescriber has reason to believe, based on clinically valid
214.19 indications, that the patient is potentially abusing a controlled substance; or

214.20 (iv) providing other medical treatment for which access to the data may be necessary
214.21 for a clinically valid purpose and the patient has consented to access to the submitted data,
214.22 and with the provision that the prescriber remains responsible for the use or misuse of data
214.23 accessed by a delegated agent or employee;

214.24 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
214.25 delegated the task of accessing the data, to the extent the information relates specifically to
214.26 a current patient to whom that dispenser is dispensing or considering dispensing any
214.27 controlled substance and with the provision that the dispenser remains responsible for the
214.28 use or misuse of data accessed by a delegated agent or employee;

214.29 (3) a licensed dispensing practitioner or licensed pharmacist to the extent necessary to
214.30 determine whether corrections made to the data reported under subdivision 4 are accurate;

214.31 (4) a licensed pharmacist who is providing pharmaceutical care for which access to the
214.32 data may be necessary to the extent that the information relates specifically to a current

215.1 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has
215.2 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber
215.3 who is requesting data in accordance with clause (1);

215.4 (5) an individual who is the recipient of a controlled substance prescription for which
215.5 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian
215.6 of a minor, or health care agent of the individual acting under a health care directive under
215.7 chapter 145C. For purposes of this clause, access by individuals includes persons in the
215.8 definition of an individual under section 13.02;

215.9 (6) personnel or designees of a health-related licensing board listed in section 214.01,
215.10 subdivision 2, or of the Office of Emergency Medical Services Regulatory Board, assigned
215.11 to conduct a bona fide investigation of a complaint received by that board or office that
215.12 alleges that a specific licensee is impaired by use of a drug for which data is collected under
215.13 subdivision 4, has engaged in activity that would constitute a crime as defined in section
215.14 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

215.15 (7) personnel of the board engaged in the collection, review, and analysis of controlled
215.16 substance prescription information as part of the assigned duties and responsibilities under
215.17 this section;

215.18 (8) authorized personnel under contract with the board, or under contract with the state
215.19 of Minnesota and approved by the board, who are engaged in the design, evaluation,
215.20 implementation, operation, or maintenance of the prescription monitoring program as part
215.21 of the assigned duties and responsibilities of their employment, provided that access to data
215.22 is limited to the minimum amount necessary to carry out such duties and responsibilities,
215.23 and subject to the requirement of de-identification and time limit on retention of data specified
215.24 in subdivision 5, paragraphs (d) and (e);

215.25 (9) federal, state, and local law enforcement authorities acting pursuant to a valid search
215.26 warrant;

215.27 (10) personnel of the Minnesota health care programs assigned to use the data collected
215.28 under this section to identify and manage recipients whose usage of controlled substances
215.29 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and
215.30 a single hospital;

215.31 (11) personnel of the Department of Human Services assigned to access the data pursuant
215.32 to paragraph (k);

216.1 (12) personnel of the health professionals services program established under section
216.2 214.31, to the extent that the information relates specifically to an individual who is currently
216.3 enrolled in and being monitored by the program, and the individual consents to access to
216.4 that information. The health professionals services program personnel shall not provide this
216.5 data to a health-related licensing board ~~or the Emergency Medical Services Regulatory~~
216.6 ~~Board~~, except as permitted under section 214.33, subdivision 3;

216.7 (13) personnel or designees of a health-related licensing board other than the Board of
216.8 Pharmacy listed in section 214.01, subdivision 2, assigned to conduct a bona fide
216.9 investigation of a complaint received by that board that alleges that a specific licensee is
216.10 inappropriately prescribing controlled substances as defined in this section. For the purposes
216.11 of this clause, the health-related licensing board may also obtain utilization data; and

216.12 (14) personnel of the board specifically assigned to conduct a bona fide investigation
216.13 of a specific licensee or registrant. For the purposes of this clause, the board may also obtain
216.14 utilization data.

216.15 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed
216.16 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe
216.17 controlled substances for humans and who holds a current registration issued by the federal
216.18 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing
216.19 within the state, shall register and maintain a user account with the prescription monitoring
216.20 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration
216.21 application process, other than their name, license number, and license type, is classified
216.22 as private pursuant to section 13.02, subdivision 12.

216.23 (d) Notwithstanding paragraph (b), beginning January 1, 2021, a prescriber or an agent
216.24 or employee of the prescriber to whom the prescriber has delegated the task of accessing
216.25 the data, must access the data submitted under subdivision 4 to the extent the information
216.26 relates specifically to the patient:

216.27 (1) before the prescriber issues an initial prescription order for a Schedules II through
216.28 IV opiate controlled substance to the patient; and

216.29 (2) at least once every three months for patients receiving an opiate for treatment of
216.30 chronic pain or participating in medically assisted treatment for an opioid addiction.

216.31 (e) Paragraph (d) does not apply if:

216.32 (1) the patient is receiving palliative care, or hospice or other end-of-life care;

216.33 (2) the patient is being treated for pain due to cancer or the treatment of cancer;

217.1 (3) the prescription order is for a number of doses that is intended to last the patient five
217.2 days or less and is not subject to a refill;

217.3 (4) the prescriber and patient have a current or ongoing provider/patient relationship of
217.4 a duration longer than one year;

217.5 (5) the prescription order is issued within 14 days following surgery or three days
217.6 following oral surgery or follows the prescribing protocols established under the opioid
217.7 prescribing improvement program under section 256B.0638;

217.8 (6) the controlled substance is prescribed or administered to a patient who is admitted
217.9 to an inpatient hospital;

217.10 (7) the controlled substance is lawfully administered by injection, ingestion, or any other
217.11 means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a
217.12 prescriber and in the presence of the prescriber or pharmacist;

217.13 (8) due to a medical emergency, it is not possible for the prescriber to review the data
217.14 before the prescriber issues the prescription order for the patient; or

217.15 (9) the prescriber is unable to access the data due to operational or other technological
217.16 failure of the program so long as the prescriber reports the failure to the board.

217.17 (f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),
217.18 (10), and (11), may directly access the data electronically. No other permissible users may
217.19 directly access the data electronically. If the data is directly accessed electronically, the
217.20 permissible user shall implement and maintain a comprehensive information security program
217.21 that contains administrative, technical, and physical safeguards that are appropriate to the
217.22 user's size and complexity, and the sensitivity of the personal information obtained. The
217.23 permissible user shall identify reasonably foreseeable internal and external risks to the
217.24 security, confidentiality, and integrity of personal information that could result in the
217.25 unauthorized disclosure, misuse, or other compromise of the information and assess the
217.26 sufficiency of any safeguards in place to control the risks.

217.27 (g) The board shall not release data submitted under subdivision 4 unless it is provided
217.28 with evidence, satisfactory to the board, that the person requesting the information is entitled
217.29 to receive the data.

217.30 (h) The board shall maintain a log of all persons who access the data for a period of at
217.31 least three years and shall ensure that any permissible user complies with paragraph (c)
217.32 prior to attaining direct access to the data.

218.1 (i) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant
218.2 to subdivision 2. A vendor shall not use data collected under this section for any purpose
218.3 not specified in this section.

218.4 (j) The board may participate in an interstate prescription monitoring program data
218.5 exchange system provided that permissible users in other states have access to the data only
218.6 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract
218.7 or memorandum of understanding that the board enters into under this paragraph.

218.8 (k) With available appropriations, the commissioner of human services shall establish
218.9 and implement a system through which the Department of Human Services shall routinely
218.10 access the data for the purpose of determining whether any client enrolled in an opioid
218.11 treatment program licensed according to chapter 245A has been prescribed or dispensed a
218.12 controlled substance in addition to that administered or dispensed by the opioid treatment
218.13 program. When the commissioner determines there have been multiple prescribers or multiple
218.14 prescriptions of controlled substances, the commissioner shall:

218.15 (1) inform the medical director of the opioid treatment program only that the
218.16 commissioner determined the existence of multiple prescribers or multiple prescriptions of
218.17 controlled substances; and

218.18 (2) direct the medical director of the opioid treatment program to access the data directly,
218.19 review the effect of the multiple prescribers or multiple prescriptions, and document the
218.20 review.

218.21 If determined necessary, the commissioner of human services shall seek a federal waiver
218.22 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section
218.23 2.34, paragraph (c), prior to implementing this paragraph.

218.24 (l) The board shall review the data submitted under subdivision 4 on at least a quarterly
218.25 basis and shall establish criteria, in consultation with the advisory task force, for referring
218.26 information about a patient to prescribers and dispensers who prescribed or dispensed the
218.27 prescriptions in question if the criteria are met.

218.28 (m) The board shall conduct random audits, on at least a quarterly basis, of electronic
218.29 access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),
218.30 (10), and (11), to the data in subdivision 4, to ensure compliance with permissible use as
218.31 defined in this section. A permissible user whose account has been selected for a random
218.32 audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice
218.33 that an audit is being conducted. Failure to respond may result in deactivation of access to
218.34 the electronic system and referral to the appropriate health licensing board, or the

219.1 commissioner of human services, for further action. The board shall report the results of
219.2 random audits to the chairs and ranking minority members of the legislative committees
219.3 with jurisdiction over health and human services policy and finance and government data
219.4 practices.

219.5 (n) A permissible user who has delegated the task of accessing the data in subdivision
219.6 4 to an agent or employee shall audit the use of the electronic system by delegated agents
219.7 or employees on at least a quarterly basis to ensure compliance with permissible use as
219.8 defined in this section. When a delegated agent or employee has been identified as
219.9 inappropriately accessing data, the permissible user must immediately remove access for
219.10 that individual and notify the board within seven days. The board shall notify all permissible
219.11 users associated with the delegated agent or employee of the alleged violation.

219.12 (o) A permissible user who delegates access to the data submitted under subdivision 4
219.13 to an agent or employee shall terminate that individual's access to the data within three
219.14 business days of the agent or employee leaving employment with the permissible user. The
219.15 board may conduct random audits to determine compliance with this requirement.

219.16 **EFFECTIVE DATE.** This section is effective January 1, 2025.

219.17 Sec. 36. Minnesota Statutes 2022, section 214.025, is amended to read:

219.18 **214.025 COUNCIL OF HEALTH BOARDS.**

219.19 The health-related licensing boards may establish a Council of Health Boards consisting
219.20 of representatives of the health-related licensing boards ~~and the Emergency Medical Services~~
219.21 ~~Regulatory Board~~. When reviewing legislation or legislative proposals relating to the
219.22 regulation of health occupations, the council shall include the commissioner of health or a
219.23 designee and the director of the Office of Emergency Medical Services or a designee.

219.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

219.25 Sec. 37. Minnesota Statutes 2022, section 214.04, subdivision 2a, is amended to read:

219.26 Subd. 2a. **Performance of executive directors.** The governor may request that a
219.27 health-related licensing board ~~or the Emergency Medical Services Regulatory Board~~ review
219.28 the performance of the board's executive director. Upon receipt of the request, the board
219.29 must respond by establishing a performance improvement plan or taking disciplinary or
219.30 other corrective action, including dismissal. The board shall include the governor's
219.31 representative as a voting member of the board in the board's discussions and decisions

220.1 regarding the governor's request. The board shall report to the governor on action taken by
220.2 the board, including an explanation if no action is deemed necessary.

220.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

220.4 Sec. 38. Minnesota Statutes 2022, section 214.29, is amended to read:

220.5 **214.29 PROGRAM REQUIRED.**

220.6 Each health-related licensing board, ~~including the Emergency Medical Services~~
220.7 ~~Regulatory Board under chapter 144E,~~ shall either conduct a health professionals service
220.8 program under sections 214.31 to 214.37 or contract for a diversion program under section
220.9 214.28.

220.10 **EFFECTIVE DATE.** This section is effective January 1, 2025.

220.11 Sec. 39. Minnesota Statutes 2022, section 214.31, is amended to read:

220.12 **214.31 AUTHORITY.**

220.13 Two or more of the health-related licensing boards listed in section 214.01, subdivision
220.14 2, may jointly conduct a health professionals services program to protect the public from
220.15 persons regulated by the boards who are unable to practice with reasonable skill and safety
220.16 by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result
220.17 of any mental, physical, or psychological condition. The program does not affect a board's
220.18 authority to discipline violations of a board's practice act. ~~For purposes of sections 214.31~~
220.19 ~~to 214.37, the emergency medical services regulatory board shall be included in the definition~~
220.20 ~~of a health-related licensing board under chapter 144E.~~

220.21 **EFFECTIVE DATE.** This section is effective January 1, 2025.

220.22 Sec. 40. Minnesota Statutes 2022, section 214.355, is amended to read:

220.23 **214.355 GROUNDS FOR DISCIPLINARY ACTION.**

220.24 Each health-related licensing board, ~~including the Emergency Medical Services~~
220.25 ~~Regulatory Board under chapter 144E,~~ shall consider it grounds for disciplinary action if a
220.26 regulated person violates the terms of the health professionals services program participation
220.27 agreement or leaves the program except upon fulfilling the terms for successful completion
220.28 of the program as set forth in the participation agreement.

220.29 **EFFECTIVE DATE.** This section is effective January 1, 2025.

221.1 Sec. 41. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**
221.2 **SERVICES ADVISORY COUNCIL.**

221.3 (a) Initial appointments of members to the Emergency Medical Services Advisory
221.4 Council must be made by January 1, 2025. The terms of initial appointees must be determined
221.5 by lot by the secretary of state and must be as follows:

221.6 (1) eight members shall serve two-year terms; and

221.7 (2) eight members shall serve three-year terms.

221.8 (b) The medical director appointee must convene the first meeting of the Emergency
221.9 Medical Services Advisory Council by February 1, 2025.

221.10 Sec. 42. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**
221.11 **SERVICES PHYSICIAN ADVISORY COUNCIL.**

221.12 (a) Initial appointments of members to the Emergency Medical Services Physician
221.13 Advisory Council must be made by January 1, 2025. The terms of initial appointees must
221.14 be determined by lot by the secretary of state and must be as follows:

221.15 (1) five members shall serve two-year terms;

221.16 (2) five members shall serve three-year terms; and

221.17 (3) the term for the medical director appointee to the Emergency Medical Services
221.18 Physician Advisory Council must coincide with that member's term on the Emergency
221.19 Medical Services Advisory Council.

221.20 (b) The medical director appointee must convene the first meeting of the Emergency
221.21 Medical Services Physician Advisory Council by February 1, 2025.

221.22 Sec. 43. **INITIAL MEMBERS AND FIRST MEETING; LABOR AND EMERGENCY**
221.23 **MEDICAL SERVICE PROVIDERS ADVISORY COUNCIL.**

221.24 (a) Initial appointments of members to the Labor and Emergency Medical Service
221.25 Providers Advisory Council must be made by January 1, 2025. The terms of initial appointees
221.26 must be determined by lot by the secretary of state and must be as follows:

221.27 (1) six members shall serve two-year terms; and

221.28 (2) seven members shall serve three-year terms.

222.1 (b) The emergency medical technician instructor appointee must convene the first meeting
222.2 of the Labor and Emergency Medical Service Providers Advisory Council by February 1,
222.3 2025.

222.4 Sec. 44. **TRANSITION.**

222.5 Subdivision 1. **Appointment of director; operation of office.** No later than October
222.6 1, 2024, the governor shall appoint a director-designee of the Office of Emergency Medical
222.7 Services. The individual appointed as the director-designee of the Office of Emergency
222.8 Medical Services shall become the governor's appointee as director of the Office of
222.9 Emergency Medical Services on January 1, 2025. Effective January 1, 2025, the
222.10 responsibilities to regulate emergency medical services in the state under Minnesota Statutes,
222.11 chapter 144E, and Minnesota Rules, chapter 4690, are transferred from the Emergency
222.12 Medical Services Regulatory Board to the Office of Emergency Medical Services and the
222.13 director of the Office of Emergency Medical Services.

222.14 Subd. 2. **Transfer of responsibilities.** Minnesota Statutes, section 15.039, applies to
222.15 the transfer of responsibilities from the Emergency Medical Services Regulatory Board to
222.16 the Office of Emergency Medical Services required by this act. The commissioner of
222.17 administration, with the approval of the governor, may issue reorganization orders under
222.18 Minnesota Statutes, section 16B.37, as necessary to carry out the transfer of responsibilities
222.19 required by this act. The provision of Minnesota Statutes, section 16B.37, subdivision 1,
222.20 which states that transfers under that section may be made only to an agency that has been
222.21 in existence for at least one year, does not apply to transfers in this act to the Office of
222.22 Emergency Medical Services.

222.23 Sec. 45. **REVISOR INSTRUCTION.**

222.24 (a) In Minnesota Statutes, chapter 144E, the revisor of statutes shall replace "board"
222.25 with "director"; "board's" with "director's"; "Emergency Medical Services Regulatory Board"
222.26 or "Minnesota Emergency Medical Services Regulatory Board" with "director"; and
222.27 "board-approved" with "director-approved," except that:

222.28 (1) in Minnesota Statutes, section 144E.11, the revisor of statutes shall not modify the
222.29 term "county board," "community health board," or "community health boards";

222.30 (2) in Minnesota Statutes, sections 144E.40, subdivision 2; 144E.42, subdivision 2;
222.31 144E.44; and 144E.45, subdivision 2, the revisor of statutes shall not modify the term "State
222.32 Board of Investment"; and

223.1 (3) in Minnesota Statutes, sections 144E.50 and 144E.52, the revisor of statutes shall
223.2 not modify the term "regional emergency medical services board," "regional board," "regional
223.3 emergency medical services board's," or "regional boards."

223.4 (b) In the following sections of Minnesota Statutes, the revisor of statutes shall replace
223.5 "Emergency Medical Services Regulatory Board" with "director of the Office of Emergency
223.6 Medical Services": sections 13.717, subdivision 10; 62J.49, subdivision 2; 144.604; 144.608;
223.7 147.09; 156.12, subdivision 2; 169.686, subdivision 3; and 299A.41, subdivision 4.

223.8 (c) In the following sections of Minnesota Statutes, the revisor of statutes shall replace
223.9 "Emergency Medical Services Regulatory Board" with "Office of Emergency Medical
223.10 Services": sections 144.603 and 161.045, subdivision 3.

223.11 (d) In making the changes specified in this section, the revisor of statutes may make
223.12 technical and other necessary changes to sentence structure to preserve the meaning of the
223.13 text.

223.14 Sec. 46. **REPEALER.**

223.15 (a) Minnesota Statutes 2022, sections 144E.001, subdivision 5; 144E.01; 144E.123,
223.16 subdivision 5; and 144E.50, subdivision 3, are repealed.

223.17 (b) Minnesota Statutes 2022, section 144E.27, subdivisions 1 and 1a, are repealed.

223.18 **EFFECTIVE DATE.** Paragraph (a) is effective January 1, 2025.

223.19 **ARTICLE 8**

223.20 **PHARMACY PRACTICE**

223.21 Section 1. Minnesota Statutes 2023 Supplement, section 62Q.46, subdivision 1, is amended
223.22 to read:

223.23 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and
223.24 services" has the meaning specified in the Affordable Care Act. Preventive items and services
223.25 includes:

223.26 (1) evidence-based items or services that have in effect a rating of A or B in the current
223.27 recommendations of the United States Preventive Services Task Force with respect to the
223.28 individual involved;

223.29 (2) immunizations for routine use in children, adolescents, and adults that have in effect
223.30 a recommendation from the Advisory Committee on Immunization Practices of the Centers
223.31 for Disease Control and Prevention with respect to the individual involved. For purposes

224.1 of this clause, a recommendation from the Advisory Committee on Immunization Practices
224.2 of the Centers for Disease Control and Prevention is considered in effect after the
224.3 recommendation has been adopted by the Director of the Centers for Disease Control and
224.4 Prevention, and a recommendation is considered to be for routine use if the recommendation
224.5 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

224.6 (3) with respect to infants, children, and adolescents, evidence-informed preventive care
224.7 and screenings provided for in comprehensive guidelines supported by the Health Resources
224.8 and Services Administration;

224.9 (4) with respect to women, additional preventive care and screenings that are not listed
224.10 with a rating of A or B by the United States Preventive Services Task Force but that are
224.11 provided for in comprehensive guidelines supported by the Health Resources and Services
224.12 Administration;

224.13 (5) all contraceptive methods established in guidelines published by the United States
224.14 Food and Drug Administration;

224.15 (6) screenings for human immunodeficiency virus for:

224.16 (i) all individuals at least 15 years of age but less than 65 years of age; and

224.17 (ii) all other individuals with increased risk of human immunodeficiency virus infection
224.18 according to guidance from the Centers for Disease Control;

224.19 (7) all preexposure prophylaxis when used for the prevention or treatment of human
224.20 immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined
224.21 in any guidance by the United States Preventive Services Task Force or the Centers for
224.22 Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention
224.23 of HIV Infection United States Preventive Services Task Force Recommendation Statement;
224.24 and

224.25 (8) all postexposure prophylaxis when used for the prevention or treatment of human
224.26 immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined
224.27 in any guidance by the United States Preventive Services Task Force or the Centers for
224.28 Disease Control.

224.29 (b) A health plan company must provide coverage for preventive items and services at
224.30 a participating provider without imposing cost-sharing requirements, including a deductible,
224.31 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that
224.32 has a network of providers from excluding coverage or imposing cost-sharing requirements
224.33 for preventive items or services that are delivered by an out-of-network provider.

225.1 (c) A health plan company is not required to provide coverage for any items or services
225.2 specified in any recommendation or guideline described in paragraph (a) if the
225.3 recommendation or guideline is no longer included as a preventive item or service as defined
225.4 in paragraph (a). Annually, a health plan company must determine whether any additional
225.5 items or services must be covered without cost-sharing requirements or whether any items
225.6 or services are no longer required to be covered.

225.7 (d) Nothing in this section prevents a health plan company from using reasonable medical
225.8 management techniques to determine the frequency, method, treatment, or setting for a
225.9 preventive item or service to the extent not specified in the recommendation or guideline.

225.10 (e) A health plan shall not require prior authorization or step therapy for preexposure
225.11 prophylaxis, except that if the United States Food and Drug Administration has approved
225.12 one or more therapeutic equivalents of a drug, device, or product for the prevention of HIV,
225.13 this paragraph does not require a health plan to cover all of the therapeutically equivalent
225.14 versions without prior authorization or step therapy, if at least one therapeutically equivalent
225.15 version is covered without prior authorization or step therapy.

225.16 ~~(e)~~ (f) This section does not apply to grandfathered plans.

225.17 ~~(f)~~ (g) This section does not apply to plans offered by the Minnesota Comprehensive
225.18 Health Association.

225.19 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health
225.20 plans offered, issued, or renewed on or after that date.

225.21 Sec. 2. Minnesota Statutes 2022, section 151.01, subdivision 23, is amended to read:

225.22 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed
225.23 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of
225.24 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed
225.25 advanced practice registered nurse, or licensed physician assistant. For purposes of sections
225.26 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision
225.27 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to
225.28 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision
225.29 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe
225.30 self-administered hormonal contraceptives, nicotine replacement medications, or opiate
225.31 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs
225.32 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,
225.33 subdivision 17.

226.1 **EFFECTIVE DATE.** This section is effective January 1, 2026.

226.2 Sec. 3. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

226.3 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

226.4 (1) interpretation and evaluation of prescription drug orders;

226.5 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a
226.6 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs
226.7 and devices);

226.8 (3) participation in clinical interpretations and monitoring of drug therapy for assurance
226.9 of safe and effective use of drugs, including ~~the performance of~~ ordering and performing
226.10 laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of
226.11 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may
226.12 interpret the results of laboratory tests but may modify A pharmacist may collect specimens,
226.13 interpret results, notify the patient of results, and refer the patient to other health care
226.14 providers for follow-up care and may initiate, modify, or discontinue drug therapy only
226.15 pursuant to a protocol or collaborative practice agreement. A pharmacist may delegate the
226.16 authority to administer tests under this clause to a pharmacy technician or pharmacy intern.
226.17 A pharmacy technician or pharmacy intern may perform tests authorized under this clause
226.18 if the technician or intern is working under the direct supervision of a pharmacist;

226.19 (4) participation in drug and therapeutic device selection; drug administration for first
226.20 dosage and medical emergencies; intramuscular and subcutaneous drug administration under
226.21 a prescription drug order; drug regimen reviews; and drug or drug-related research;

226.22 (5) drug administration, through intramuscular and subcutaneous administration used
226.23 to treat mental illnesses as permitted under the following conditions:

226.24 (i) upon the order of a prescriber and the prescriber is notified after administration is
226.25 complete; or

226.26 (ii) pursuant to a protocol or collaborative practice agreement as defined by section
226.27 151.01, subdivisions 27b and 27c, and participation in the initiation, management,
226.28 modification, administration, and discontinuation of drug therapy is according to the protocol
226.29 or collaborative practice agreement between the pharmacist and a dentist, optometrist,
226.30 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered
226.31 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes
226.32 in drug therapy or medication administration made pursuant to a protocol or collaborative

227.1 practice agreement must be documented by the pharmacist in the patient's medical record
227.2 or reported by the pharmacist to a practitioner responsible for the patient's care;

227.3 ~~(6) participation in administration of influenza vaccines and~~ initiating, ordering, and
227.4 administering influenza and COVID-19 or SARS-CoV-2 vaccines authorized or approved
227.5 by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2
227.6 to all eligible individuals six ~~three~~ years of age and older and all other United States Food
227.7 and Drug Administration-approved vaccines to patients ~~13~~ six years of age and older by
227.8 written protocol with a physician licensed under chapter 147, a physician assistant authorized
227.9 to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized
227.10 to prescribe drugs under section 148.235, provided that according to the federal Advisory
227.11 Committee on Immunization Practices recommendations. A pharmacist may delegate the
227.12 authority to administer vaccines under this clause to a pharmacy technician or pharmacy
227.13 intern who has completed training in vaccine administration if:

227.14 ~~(i) the protocol includes, at a minimum:~~

227.15 ~~(A) the name, dose, and route of each vaccine that may be given;~~

227.16 ~~(B) the patient population for whom the vaccine may be given;~~

227.17 ~~(C) contraindications and precautions to the vaccine;~~

227.18 ~~(D) the procedure for handling an adverse reaction;~~

227.19 ~~(E) the name, signature, and address of the physician, physician assistant, or advanced~~
227.20 ~~practice registered nurse;~~

227.21 ~~(F) a telephone number at which the physician, physician assistant, or advanced practice~~
227.22 ~~registered nurse can be contacted; and~~

227.23 ~~(G) the date and time period for which the protocol is valid;~~

227.24 ~~(ii) (i) the pharmacist has~~ (i) the pharmacist has and the pharmacy technician or pharmacy intern have
227.25 successfully completed a program approved by the Accreditation Council for Pharmacy
227.26 Education (ACPE) specifically for the administration of immunizations or a program
227.27 approved by the board;

227.28 ~~(iii) (ii) the pharmacist utilizes the Minnesota Immunization Information Connection to~~
227.29 assess the immunization status of individuals prior to the administration of vaccines, except
227.30 when administering influenza vaccines to individuals age nine and older;

227.31 ~~(iv) (iii) the pharmacist reports the administration of the immunization to the Minnesota~~
227.32 Immunization Information Connection; and

228.1 ~~(v) the pharmacist complies with guidelines for vaccines and immunizations established~~
228.2 ~~by the federal Advisory Committee on Immunization Practices, except that a pharmacist~~
228.3 ~~does not need to comply with those portions of the guidelines that establish immunization~~
228.4 ~~schedules when administering a vaccine pursuant to a valid, patient-specific order issued~~
228.5 ~~by a physician licensed under chapter 147, a physician assistant authorized to prescribe~~
228.6 ~~drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe~~
228.7 ~~drugs under section 148.235, provided that the order is consistent with the United States~~
228.8 ~~Food and Drug Administration approved labeling of the vaccine;~~

228.9 (iv) if the patient is 18 years of age or younger, the pharmacist, pharmacy technician,
228.10 or pharmacy intern informs the patient and any adult caregiver accompanying the patient
228.11 of the importance of a well-child visit with a pediatrician or other licensed primary care
228.12 provider; and

228.13 (v) in the case of a pharmacy technician administering vaccinations while being
228.14 supervised by a licensed pharmacist:

228.15 (A) the supervision is in-person and must not be done through telehealth as defined
228.16 under section 62A.673, subdivision 2;

228.17 (B) the pharmacist is readily and immediately available to the immunizing pharmacy
228.18 technician;

228.19 (C) the pharmacy technician has a current certificate in basic cardiopulmonary
228.20 resuscitation;

228.21 (D) the pharmacy technician has completed a minimum of two hours of ACPE-approved,
228.22 immunization-related continuing pharmacy education as part of the pharmacy technician's
228.23 two-year continuing education schedule; and

228.24 (E) the pharmacy technician has completed one of two training programs listed under
228.25 Minnesota Rules, part 6800.3850, subpart 1h, item B;

228.26 (7) participation in the initiation, management, modification, and discontinuation of
228.27 drug therapy according to a written protocol or collaborative practice agreement between:
228.28 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician
228.29 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more
228.30 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,
228.31 or advanced practice registered nurses authorized to prescribe, dispense, and administer
228.32 under section 148.235. Any changes in drug therapy made pursuant to a protocol or
228.33 collaborative practice agreement must be documented by the pharmacist in the patient's

229.1 medical record or reported by the pharmacist to a practitioner responsible for the patient's
229.2 care;

229.3 (8) participation in the storage of drugs and the maintenance of records;

229.4 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and
229.5 devices;

229.6 (10) offering or performing those acts, services, operations, or transactions necessary
229.7 in the conduct, operation, management, and control of a pharmacy;

229.8 (11) participation in the initiation, management, modification, and discontinuation of
229.9 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

229.10 (i) a written protocol as allowed under clause (7); or

229.11 (ii) a written protocol with a community health board medical consultant or a practitioner
229.12 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

229.13 (12) prescribing self-administered hormonal contraceptives; nicotine replacement
229.14 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant
229.15 to section 151.37, subdivision 14, 15, or 16; ~~and~~

229.16 (13) participation in the placement of drug monitoring devices according to a prescription,
229.17 protocol, or collaborative practice agreement;

229.18 (14) prescribing, dispensing, and administering drugs for preventing the acquisition of
229.19 human immunodeficiency virus (HIV) if the pharmacist meets the requirements in section
229.20 151.37, subdivision 17; and

229.21 (15) ordering, conducting, and interpreting laboratory tests necessary for therapies that
229.22 use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements
229.23 in section 151.37, subdivision 17.

229.24 **EFFECTIVE DATE.** This section is effective July 1, 2024, except that clauses (14)
229.25 and (15) are effective January 1, 2026.

229.26 Sec. 4. Minnesota Statutes 2022, section 151.37, is amended by adding a subdivision to
229.27 read:

229.28 **Subd. 17. Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized
229.29 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency
229.30 virus (HIV) in accordance with this subdivision.

230.1 (b) By January 1, 2025, the Board of Pharmacy shall develop a standardized protocol
230.2 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing
230.3 the protocol, the board may consult with community health advocacy groups, the Board of
230.4 Medical Practice, the Board of Nursing, the commissioner of health, professional pharmacy
230.5 associations, and professional associations for physicians, physician assistants, and advanced
230.6 practice registered nurses.

230.7 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the
230.8 pharmacist must successfully complete a training program specifically developed for
230.9 prescribing drugs for preventing the acquisition of HIV that is offered by a college of
230.10 pharmacy, a continuing education provider that is accredited by the Accreditation Council
230.11 for Pharmacy Education, or a program approved by the board. To maintain authorization
230.12 to prescribe, the pharmacist shall complete continuing education requirements as specified
230.13 by the board.

230.14 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the
230.15 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may
230.16 dispense to a patient a drug described in paragraph (a).

230.17 (e) Before dispensing a drug described in paragraph (a) that is prescribed by the
230.18 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs
230.19 and must provide the patient with a fact sheet that includes the indications and
230.20 contraindications for the use of these drugs, the appropriate method for using these drugs,
230.21 the need for medical follow up, and any additional information listed in Minnesota Rules,
230.22 part 6800.0910, subpart 2, that is required to be provided to a patient during the counseling
230.23 process.

230.24 (f) A pharmacist is prohibited from delegating the prescribing authority provided under
230.25 this subdivision to any other person. A pharmacist intern registered under section 151.101
230.26 may prepare the prescription, but before the prescription is processed or dispensed, a
230.27 pharmacist authorized to prescribe under this subdivision must review, approve, and sign
230.28 the prescription.

230.29 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,
230.30 management, modification, and discontinuation of drug therapy according to a protocol as
230.31 authorized in this section and in section 151.01, subdivision 27.

230.32 **EFFECTIVE DATE.** This section is effective January 1, 2026, except that paragraph
230.33 (b) is effective the day following final enactment.

231.1 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13f, is
231.2 amended to read:

231.3 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and
231.4 recommend drugs which require prior authorization. The Formulary Committee shall
231.5 establish general criteria to be used for the prior authorization of brand-name drugs for
231.6 which generically equivalent drugs are available, but the committee is not required to review
231.7 each brand-name drug for which a generically equivalent drug is available.

231.8 (b) Prior authorization may be required by the commissioner before certain formulary
231.9 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior
231.10 authorization directly to the commissioner. The commissioner may also request that the
231.11 Formulary Committee review a drug for prior authorization. Before the commissioner may
231.12 require prior authorization for a drug:

231.13 (1) the commissioner must provide information to the Formulary Committee on the
231.14 impact that placing the drug on prior authorization may have on the quality of patient care
231.15 and on program costs, information regarding whether the drug is subject to clinical abuse
231.16 or misuse, and relevant data from the state Medicaid program if such data is available;

231.17 (2) the Formulary Committee must review the drug, taking into account medical and
231.18 clinical data and the information provided by the commissioner; and

231.19 (3) the Formulary Committee must hold a public forum and receive public comment for
231.20 an additional 15 days.

231.21 The commissioner must provide a 15-day notice period before implementing the prior
231.22 authorization.

231.23 (c) Except as provided in subdivision 13j, prior authorization shall not be required or
231.24 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness
231.25 if:

231.26 (1) there is no generically equivalent drug available; and

231.27 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

231.28 (3) the drug is part of the recipient's current course of treatment.

231.29 This paragraph applies to any multistate preferred drug list or supplemental drug rebate
231.30 program established or administered by the commissioner. Prior authorization shall
231.31 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental
231.32 illness within 60 days of when a generically equivalent drug becomes available, provided

232.1 that the brand name drug was part of the recipient's course of treatment at the time the
232.2 generically equivalent drug became available.

232.3 (d) Prior authorization must not be required for liquid methadone if only one version of
232.4 liquid methadone is available. If more than one version of liquid methadone is available,
232.5 the commissioner shall ensure that at least one version of liquid methadone is available
232.6 without prior authorization.

232.7 (e) Prior authorization may be required for an oral liquid form of a drug, except as
232.8 described in paragraph (d). A prior authorization request under this paragraph must be
232.9 automatically approved within 24 hours if the drug is being prescribed for a Food and Drug
232.10 Administration-approved condition for a patient who utilizes an enteral tube for feedings
232.11 or medication administration, even if the patient has current or prior claims for pills for that
232.12 condition. If more than one version of the oral liquid form of a drug is available, the
232.13 commissioner may select the version that is able to be approved for a Food and Drug
232.14 Administration-approved condition for a patient who utilizes an enteral tube for feedings
232.15 or medication administration. This paragraph applies to any multistate preferred drug list
232.16 or supplemental drug rebate program established or administered by the commissioner. The
232.17 commissioner shall design and implement a streamlined prior authorization form for patients
232.18 who utilize an enteral tube for feedings or medication administration and are prescribed an
232.19 oral liquid form of a drug. The commissioner may require prior authorization for brand
232.20 name drugs whenever a generically equivalent product is available, even if the prescriber
232.21 specifically indicates "dispense as written-brand necessary" on the prescription as required
232.22 by section 151.21, subdivision 2.

232.23 (f) Notwithstanding this subdivision, the commissioner may automatically require prior
232.24 authorization, for a period not to exceed 180 days, for any drug that is approved by the
232.25 United States Food and Drug Administration on or after July 1, 2005. The 180-day period
232.26 begins no later than the first day that a drug is available for shipment to pharmacies within
232.27 the state. The Formulary Committee shall recommend to the commissioner general criteria
232.28 to be used for the prior authorization of the drugs, but the committee is not required to
232.29 review each individual drug. In order to continue prior authorizations for a drug after the
232.30 180-day period has expired, the commissioner must follow the provisions of this subdivision.

232.31 (g) Prior authorization under this subdivision shall comply with section 62Q.184.

232.32 (h) Any step therapy protocol requirements established by the commissioner must comply
232.33 with section 62Q.1841.

233.1 (i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not
233.2 be required or utilized for any class of drugs that is approved by the United States Food and
233.3 Drug Administration for preexposure prophylaxis of HIV and AIDS, except under the
233.4 conditions specified in section 62Q.46, subdivision 1, paragraph (e).

233.5 **EFFECTIVE DATE.** This section is effective January 1, 2026.

233.6 Sec. 6. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision
233.7 to read:

233.8 Subd. 13l. **Vaccines and laboratory tests provided by pharmacists.** (a) Medical
233.9 assistance covers vaccines initiated, ordered, or administered by a licensed pharmacist,
233.10 according to the requirements of section 151.01, subdivision 27, clause (6), at no less than
233.11 the rate for which the same services are covered when provided by any other licensed
233.12 practitioner.

233.13 (b) Medical assistance covers laboratory tests ordered and performed by a licensed
233.14 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at
233.15 no less than the rate for which the same services are covered when provided by any other
233.16 licensed practitioner.

233.17 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
233.18 whichever is later. The commissioner of human services shall notify the revisor of statutes
233.19 when federal approval is obtained.

233.20 **ARTICLE 9**

233.21 **MENTAL HEALTH**

233.22 Section 1. Minnesota Statutes 2022, section 245.462, subdivision 6, is amended to read:

233.23 **Subd. 6. Community support services program.** "Community support services program"
233.24 means services, other than inpatient or residential treatment services, provided or coordinated
233.25 by an identified program and staff under the treatment supervision of a mental health
233.26 professional designed to help adults with serious and persistent mental illness to function
233.27 and remain in the community. A community support services program includes:

233.28 (1) client outreach,

233.29 (2) medication monitoring,

233.30 (3) assistance in independent living skills,

233.31 (4) development of employability and work-related opportunities,

- 234.1 (5) crisis assistance,
234.2 (6) psychosocial rehabilitation,
234.3 (7) help in applying for government benefits, and
234.4 (8) housing support services.

234.5 The community support services program must be coordinated with the case management
234.6 services specified in section 245.4711. A program that meets the accreditation standards
234.7 for Clubhouse International model programs meets the requirements of this subdivision.

234.8 Sec. 2. Minnesota Statutes 2022, section 245.4663, subdivision 2, is amended to read:

234.9 Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental
234.10 health provider must:

234.11 (1) provide at least 25 percent of the provider's yearly patient encounters to state public
234.12 program enrollees or patients receiving sliding fee schedule discounts through a formal
234.13 sliding fee schedule meeting the standards established by the United States Department of
234.14 Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;
234.15 ~~or~~

234.16 (2) primarily serve underrepresented communities as defined in section 148E.010,
234.17 subdivision 20; or

234.18 (3) provide services to people in a city or township that is not within the seven-county
234.19 metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth,
234.20 Mankato, Moorhead, Rochester, or St. Cloud.

234.21 Sec. 3. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended
234.22 to read:

234.23 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
234.24 make grants from available appropriations to assist:

- 234.25 (1) counties;
234.26 (2) Indian tribes;
234.27 (3) children's collaboratives under section 124D.23 or 245.493; or
234.28 (4) mental health service providers.

234.29 (b) The following services are eligible for grants under this section:

- 235.1 (1) services to children with emotional disturbances as defined in section 245.4871,
235.2 subdivision 15, and their families;
- 235.3 (2) transition services under section 245.4875, subdivision 8, for young adults under
235.4 age 21 and their families;
- 235.5 (3) respite care services for children with emotional disturbances or severe emotional
235.6 disturbances who are at risk of ~~out-of-home placement~~ or residential treatment or
235.7 hospitalization, who are already in out-of-home placement in family foster settings as defined
235.8 in chapter 245A and at risk of change in out-of-home placement or placement in a residential
235.9 facility or other higher level of care, who have utilized crisis services or emergency room
235.10 services, or who have experienced a loss of in-home staffing support. Allowable activities
235.11 and expenses for respite care services are defined under subdivision 4. A child is not required
235.12 to have case management services to receive respite care services. Counties must work to
235.13 provide access to regularly scheduled respite care;
- 235.14 (4) children's mental health crisis services;
- 235.15 (5) child-, youth-, and family-specific mobile response and stabilization services models;
- 235.16 (6) mental health services for people from cultural and ethnic minorities, including
235.17 supervision of clinical trainees who are Black, indigenous, or people of color;
- 235.18 (7) children's mental health screening and follow-up diagnostic assessment and treatment;
- 235.19 (8) services to promote and develop the capacity of providers to use evidence-based
235.20 practices in providing children's mental health services;
- 235.21 (9) school-linked mental health services under section 245.4901;
- 235.22 (10) building evidence-based mental health intervention capacity for children birth to
235.23 age five;
- 235.24 (11) suicide prevention and counseling services that use text messaging statewide;
- 235.25 (12) mental health first aid training;
- 235.26 (13) training for parents, collaborative partners, and mental health providers on the
235.27 impact of adverse childhood experiences and trauma and development of an interactive
235.28 website to share information and strategies to promote resilience and prevent trauma;
- 235.29 (14) transition age services to develop or expand mental health treatment and supports
235.30 for adolescents and young adults 26 years of age or younger;
- 235.31 (15) early childhood mental health consultation;

236.1 (16) evidence-based interventions for youth at risk of developing or experiencing a first
236.2 episode of psychosis, and a public awareness campaign on the signs and symptoms of
236.3 psychosis;

236.4 (17) psychiatric consultation for primary care practitioners; and

236.5 (18) providers to begin operations and meet program requirements when establishing a
236.6 new children's mental health program. These may be start-up grants.

236.7 (c) Services under paragraph (b) must be designed to help each child to function and
236.8 remain with the child's family in the community and delivered consistent with the child's
236.9 treatment plan. Transition services to eligible young adults under this paragraph must be
236.10 designed to foster independent living in the community.

236.11 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party
236.12 reimbursement sources, if applicable.

236.13 (e) The commissioner may establish and design a pilot program to expand the mobile
236.14 response and stabilization services model for children, youth, and families. The commissioner
236.15 may use grant funding to consult with a qualified expert entity to assist in the formulation
236.16 of measurable outcomes and explore and position the state to submit a Medicaid state plan
236.17 amendment to scale the model statewide.

236.18 Sec. 4. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

236.19 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a
236.20 client's current level of functioning relative to functioning that is appropriate for someone
236.21 the client's age. ~~For a client five years of age or younger, a functional assessment is the~~
236.22 ~~Early Childhood Service Intensity Instrument (ESCI).~~ ~~For a client six to 17 years of age,~~
236.23 ~~a functional assessment is the Child and Adolescent Service Intensity Instrument (CASH).~~
236.24 ~~For a client 18 years of age or older, a functional assessment is the functional assessment~~
236.25 ~~described in section 245I.10, subdivision 9.~~

236.26 Sec. 5. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

236.27 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care
236.28 decision support tool appropriate to the client's age. ~~For a client five years of age or younger,~~
236.29 ~~a level of care assessment is the Early Childhood Service Intensity Instrument (ESCI).~~ ~~For~~
236.30 ~~a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service~~
236.31 ~~Intensity Instrument (CASH).~~ ~~For a client 18 years of age or older, a level of care assessment~~

237.1 ~~is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)~~
237.2 ~~or another tool authorized by the commissioner.~~

237.3 Sec. 6. Minnesota Statutes 2022, section 245I.04, subdivision 6, is amended to read:

237.4 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1)
237.5 is enrolled in an accredited graduate program of study to prepare the staff person for
237.6 independent licensure as a mental health professional and who is participating in a practicum
237.7 or internship with the license holder through the individual's graduate program; ~~or~~ (2) has
237.8 completed an accredited graduate program of study to prepare the staff person for independent
237.9 licensure as a mental health professional and who is in compliance with the requirements
237.10 of the applicable health-related licensing board, including requirements for supervised
237.11 practice; or (3) has completed an accredited graduate program of study to prepare the staff
237.12 person for independent licensure as a mental health professional, has completed a practicum
237.13 or internship and has not yet taken or received the results from the required test or is waiting
237.14 for the final licensure decision.

237.15 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing
237.16 board to ensure that the trainee meets the requirements of the health-related licensing board.
237.17 As permitted by a health-related licensing board, treatment supervision under this chapter
237.18 may be integrated into a plan to meet the supervisory requirements of the health-related
237.19 licensing board but does not supersede those requirements.

237.20 Sec. 7. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

237.21 Subd. 9. **Functional assessment; required elements.** (a) When a license holder is
237.22 completing a functional assessment for an adult client, the license holder must:

237.23 (1) complete a functional assessment of the client after completing the client's diagnostic
237.24 assessment;

237.25 (2) use a collaborative process that allows the client and the client's family and other
237.26 natural supports, the client's referral sources, and the client's providers to provide information
237.27 about how the client's symptoms of mental illness impact the client's functioning;

237.28 (3) if applicable, document the reasons that the license holder did not contact the client's
237.29 family and other natural supports;

237.30 (4) assess and document how the client's symptoms of mental illness impact the client's
237.31 functioning in the following areas:

237.32 (i) the client's mental health symptoms;

- 238.1 (ii) the client's mental health service needs;
- 238.2 (iii) the client's substance use;
- 238.3 (iv) the client's vocational and educational functioning;
- 238.4 (v) the client's social functioning, including the use of leisure time;
- 238.5 (vi) the client's interpersonal functioning, including relationships with the client's family
- 238.6 and other natural supports;
- 238.7 (vii) the client's ability to provide self-care and live independently;
- 238.8 (viii) the client's medical and dental health;
- 238.9 (ix) the client's financial assistance needs; and
- 238.10 (x) the client's housing and transportation needs;
- 238.11 ~~(5) include a narrative summarizing the client's strengths, resources, and all areas of~~
- 238.12 ~~functional impairment;~~
- 238.13 ~~(6)~~ (5) complete the client's functional assessment before the client's initial individual
- 238.14 treatment plan unless a service specifies otherwise; and
- 238.15 ~~(7)~~ (6) update the client's functional assessment with the client's current functioning
- 238.16 whenever there is a significant change in the client's functioning or at least every ~~180~~ 365
- 238.17 days, unless a service specifies otherwise.
- 238.18 (b) A license holder may use any available, validated measurement tool, including but
- 238.19 not limited to the Daily Living Activities-20, when completing the required elements of a
- 238.20 functional assessment under this subdivision.

238.21 Sec. 8. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

238.22 Subdivision 1. **Generally.** (a) If a license holder is licensed as a residential program,

238.23 stores or administers client medications, or observes clients self-administer medications,

238.24 the license holder must ensure that a staff person who is a registered nurse or licensed

238.25 prescriber is responsible for overseeing storage and administration of client medications

238.26 and observing as a client self-administers medications, including training according to

238.27 section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08,

238.28 subdivision 5.

238.29 (b) For purposes of this section, "observed self-administration" means the preparation

238.30 and administration of a medication by a client to themselves under the direct supervision

238.31 of a registered nurse or a staff member to whom a registered nurse delegates supervision

239.1 duty. Observed self-administration does not include a client's use of a medication that they
239.2 keep in their own possession while participating in a program.

239.3 Sec. 9. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision to
239.4 read:

239.5 **Subd. 6. Medication administration in children's day treatment settings.** (a) For a
239.6 program providing children's day treatment services under section 256B.0943, the license
239.7 holder must maintain policies and procedures that state whether the program will store
239.8 medication and administer or allow observed self-administration.

239.9 (b) For a program providing children's day treatment services under section 256B.0943
239.10 that does not store medications but allows clients to use a medication that they keep in their
239.11 own possession while participating in a program, the license holder must maintain
239.12 documentation from a licensed prescriber regarding the safety of medications held by clients,
239.13 including:

239.14 (1) an evaluation that the client is capable of holding and administering the medication
239.15 safely;

239.16 (2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury;
239.17 and

239.18 (3) any conditions under which the license holder should no longer allow the client to
239.19 maintain the medication in their own possession.

239.20 Sec. 10. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

239.21 **Subd. 4. Minimum staffing standards.** (a) A certification holder's treatment team must
239.22 consist of at least four mental health professionals. At least two of the mental health
239.23 professionals must be employed by or under contract with the mental health clinic for a
239.24 minimum of 35 hours per week each. ~~Each of the two mental health professionals must~~
239.25 ~~specialize in a different mental health discipline.~~

239.26 (b) The treatment team must include:

239.27 (1) a physician qualified as a mental health professional according to section 245I.04,
239.28 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to
239.29 section 245I.04, subdivision 2, clause (1); and

239.30 (2) a psychologist qualified as a mental health professional according to section 245I.04,
239.31 subdivision 2, clause (3).

240.1 (c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical
240.2 services at least:

240.3 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time
240.4 equivalent treatment team members;

240.5 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent
240.6 treatment team members;

240.7 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent
240.8 treatment team members; or

240.9 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent
240.10 treatment team members or only provides in-home services to clients.

240.11 (d) The certification holder must maintain a record that demonstrates compliance with
240.12 this subdivision.

240.13 Sec. 11. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

240.14 Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings
240.15 and ancillary meetings according to this subdivision.

240.16 (b) A mental health professional or certified rehabilitation specialist must hold at least
240.17 one team meeting each calendar week ~~and~~. The mental health professional or certified
240.18 rehabilitation specialist must lead and be physically present at the team meeting, except as
240.19 permitted under paragraph (e). All treatment team members, including treatment team
240.20 members who work on a part-time or intermittent basis, must participate in a minimum of
240.21 one team meeting during each calendar week when the treatment team member is working
240.22 for the license holder. The license holder must document all weekly team meetings, including
240.23 the names of meeting attendees, and indicate whether the meeting was conducted remotely
240.24 under paragraph (e).

240.25 (c) If a treatment team member cannot participate in a weekly team meeting, the treatment
240.26 team member must participate in an ancillary meeting. A mental health professional, certified
240.27 rehabilitation specialist, clinical trainee, or mental health practitioner who participated in
240.28 the most recent weekly team meeting may lead the ancillary meeting. During the ancillary
240.29 meeting, the treatment team member leading the ancillary meeting must review the
240.30 information that was shared at the most recent weekly team meeting, including revisions
240.31 to client treatment plans and other information that the treatment supervisors exchanged
240.32 with treatment team members. The license holder must document all ancillary meetings,
240.33 including the names of meeting attendees.

241.1 (d) If a treatment team member working only one shift during a week cannot participate
241.2 in a weekly team meeting or participate in an ancillary meeting, the treatment team member
241.3 must read the minutes of the weekly team meeting required to be documented in paragraph
241.4 (b). The treatment team member must sign to acknowledge receipt of this information, and
241.5 document pertinent information or questions. The mental health professional or certified
241.6 rehabilitation specialist must review any documented questions or pertinent information
241.7 before the next weekly team meeting.

241.8 (e) A license holder may permit a mental health professional or certified rehabilitation
241.9 specialist to lead the weekly meeting remotely due to medical or weather conditions. If the
241.10 conditions that do not permit physical presence persist for longer than one week, the license
241.11 holder must request a variance to conduct additional meetings remotely.

241.12 **Sec. 12. [256B.0617] MENTAL HEALTH SERVICES PROVIDER**
241.13 **CERTIFICATION.**

241.14 (a) The commissioner of human services shall establish an initial provider entity
241.15 application and certification and recertification processes to determine whether a provider
241.16 entity has administrative and clinical infrastructures that meet the certification requirements.
241.17 This process applies to providers of the following services:

- 241.18 (1) children's intensive behavioral health services under section 256B.0946; and
241.19 (2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

241.20 (b) The commissioner shall recertify a provider entity every three years using the
241.21 individual provider's certification anniversary or the calendar year end. The commissioner
241.22 may approve a recertification extension in the interest of sustaining services when a certain
241.23 date for recertification is identified.

241.24 (c) The commissioner shall establish a process for decertification of a provider entity
241.25 and shall require corrective action, medical assistance repayment, or decertification of a
241.26 provider entity that no longer meets the requirements in this section or that fails to meet the
241.27 clinical quality standards or administrative standards provided by the commissioner in the
241.28 application and certification process.

241.29 (d) The commissioner must provide the following to provider entities for the certification,
241.30 recertification, and decertification processes:

- 241.31 (1) a structured listing of required provider certification criteria;

242.1 (2) a formal written letter with a determination of certification, recertification, or
242.2 decertification signed by the commissioner or the appropriate division director; and

242.3 (3) a formal written communication outlining the process for necessary corrective action
242.4 and follow-up by the commissioner signed by the commissioner or their designee, if
242.5 applicable. In the case of corrective action, the commissioner may schedule interim
242.6 recertification site reviews to confirm certification or decertification.

242.7 **EFFECTIVE DATE.** This section is effective July 1, 2024, and the commissioner of
242.8 human services must implement all requirements of this section by September 1, 2024.

242.9 Sec. 13. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

242.10 Subd. 2a. **Eligibility for assertive community treatment.** (a) An eligible client for
242.11 assertive community treatment is an individual who meets the following criteria as assessed
242.12 by an ACT team:

242.13 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the
242.14 commissioner;

242.15 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive
242.16 disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals
242.17 with other psychiatric illnesses may qualify for assertive community treatment if they have
242.18 a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more
242.19 than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals
242.20 with a primary diagnosis of a substance use disorder, intellectual developmental disabilities,
242.21 borderline personality disorder, antisocial personality disorder, traumatic brain injury, or
242.22 an autism spectrum disorder are not eligible for assertive community treatment;

242.23 (3) has significant functional impairment as demonstrated by at least one of the following
242.24 conditions:

242.25 (i) significant difficulty consistently performing the range of routine tasks required for
242.26 basic adult functioning in the community or persistent difficulty performing daily living
242.27 tasks without significant support or assistance;

242.28 (ii) significant difficulty maintaining employment at a self-sustaining level or significant
242.29 difficulty consistently carrying out the head-of-household responsibilities; or

242.30 (iii) significant difficulty maintaining a safe living situation;

242.31 (4) has a need for continuous high-intensity services as evidenced by at least two of the
242.32 following:

- 243.1 (i) two or more psychiatric hospitalizations or residential crisis stabilization services in
243.2 the previous 12 months;
- 243.3 (ii) frequent utilization of mental health crisis services in the previous six months;
- 243.4 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;
- 243.5 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;
- 243.6 (v) coexisting mental health and substance use disorders lasting at least six months;
- 243.7 (vi) recent history of involvement with the criminal justice system or demonstrated risk
243.8 of future involvement;
- 243.9 (vii) significant difficulty meeting basic survival needs;
- 243.10 (viii) residing in substandard housing, experiencing homelessness, or facing imminent
243.11 risk of homelessness;
- 243.12 (ix) significant impairment with social and interpersonal functioning such that basic
243.13 needs are in jeopardy;
- 243.14 (x) coexisting mental health and physical health disorders lasting at least six months;
- 243.15 (xi) residing in an inpatient or supervised community residence but clinically assessed
243.16 to be able to live in a more independent living situation if intensive services are provided;
- 243.17 (xii) requiring a residential placement if more intensive services are not available; or
- 243.18 (xiii) difficulty effectively using traditional office-based outpatient services;
- 243.19 (5) there are no indications that other available community-based services would be
243.20 equally or more effective as evidenced by consistent and extensive efforts to treat the
243.21 individual; and
- 243.22 (6) in the written opinion of a licensed mental health professional, has the need for mental
243.23 health services that cannot be met with other available community-based services, or is
243.24 likely to experience a mental health crisis or require a more restrictive setting if assertive
243.25 community treatment is not provided.
- 243.26 (b) An individual meets the criteria for assertive community treatment under this section
243.27 immediately following participation in a first episode of psychosis program if the individual:
- 243.28 (1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and
243.29 (6);

244.1 (2) is currently participating in a first episode of psychosis program under section
244.2 245.4905; and

244.3 (3) needs the level of intensity provided by an ACT team, in the opinion of the individual's
244.4 first episode of psychosis program, in order to prevent crisis services, hospitalization,
244.5 homelessness, and involvement with the criminal justice system.

244.6 Sec. 14. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

244.7 Subd. 3a. **Provider certification and contract requirements for assertive community**
244.8 **treatment.** (a) The assertive community treatment provider must:

244.9 ~~(1) have a contract with the host county to provide assertive community treatment~~
244.10 ~~services; and~~

244.11 ~~(2)~~ have each ACT team be certified by the state following the certification process and
244.12 procedures developed by the commissioner. The certification process determines whether
244.13 the ACT team meets the standards for assertive community treatment under this section,
244.14 the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum
244.15 program fidelity standards as measured by a nationally recognized fidelity tool approved
244.16 by the commissioner. Recertification must occur at least every three years.

244.17 (b) An ACT team certified under this subdivision must meet the following standards:

244.18 (1) have capacity to recruit, hire, manage, and train required ACT team members;

244.19 (2) have adequate administrative ability to ensure availability of services;

244.20 (3) ensure flexibility in service delivery to respond to the changing and intermittent care
244.21 needs of a client as identified by the client and the individual treatment plan;

244.22 (4) keep all necessary records required by law;

244.23 (5) be an enrolled Medicaid provider; and

244.24 (6) establish and maintain a quality assurance plan to determine specific service outcomes
244.25 and the client's satisfaction with services.

244.26 (c) The commissioner may intervene at any time and decertify an ACT team with cause.
244.27 The commissioner shall establish a process for decertification of an ACT team and shall
244.28 require corrective action, medical assistance repayment, or decertification of an ACT team
244.29 that no longer meets the requirements in this section or that fails to meet the clinical quality
244.30 standards or administrative standards provided by the commissioner in the application and
244.31 certification process. The decertification is subject to appeal to the state.

245.1 Sec. 15. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

245.2 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

245.3 The required treatment staff qualifications and roles for an ACT team are:

245.4 (1) the team leader:

245.5 (i) shall be a mental health professional. Individuals who are not licensed but who are
245.6 eligible for licensure and are otherwise qualified may also fulfill this role ~~but must obtain~~
245.7 ~~full licensure within 24 months of assuming the role of team leader;~~

245.8 (ii) must be an active member of the ACT team and provide some direct services to
245.9 clients;

245.10 (iii) must be a single full-time staff member, dedicated to the ACT team, who is
245.11 responsible for overseeing the administrative operations of the team, ~~providing treatment~~
245.12 ~~supervision of services in conjunction with the psychiatrist or psychiatric care provider,~~ and
245.13 supervising team members to ensure delivery of best and ethical practices; and

245.14 (iv) must be available to ~~provide~~ ensure that overall treatment supervision to the ACT
245.15 team is available after regular business hours and on weekends and holidays. ~~The team~~
245.16 ~~leader may delegate this duty to another~~ and is provided by a qualified member of the ACT
245.17 team;

245.18 (2) the psychiatric care provider:

245.19 (i) must be a mental health professional permitted to prescribe psychiatric medications
245.20 as part of the mental health professional's scope of practice. The psychiatric care provider
245.21 must have demonstrated clinical experience working with individuals with serious and
245.22 persistent mental illness;

245.23 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for
245.24 screening and admitting clients; monitoring clients' treatment and team member service
245.25 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,
245.26 and health-related conditions; actively collaborating with nurses; and helping provide
245.27 treatment supervision to the team;

245.28 (iii) shall fulfill the following functions for assertive community treatment clients:
245.29 provide assessment and treatment of clients' symptoms and response to medications, including
245.30 side effects; provide brief therapy to clients; provide diagnostic and medication education
245.31 to clients, with medication decisions based on shared decision making; monitor clients'
245.32 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and
245.33 community visits;

246.1 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized
246.2 for mental health treatment and shall communicate directly with the client's inpatient
246.3 psychiatric care providers to ensure continuity of care;

246.4 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per
246.5 50 clients. Part-time psychiatric care providers shall have designated hours to work on the
246.6 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,
246.7 supervisory, and administrative responsibilities. No more than two psychiatric care providers
246.8 may share this role; and

246.9 (vi) shall provide psychiatric backup to the program after regular business hours and on
246.10 weekends and holidays. The psychiatric care provider may delegate this duty to another
246.11 qualified psychiatric provider;

246.12 (3) the nursing staff:

246.13 (i) shall consist of one to three registered nurses or advanced practice registered nurses,
246.14 of whom at least one has a minimum of one-year experience working with adults with
246.15 serious mental illness and a working knowledge of psychiatric medications. No more than
246.16 two individuals can share a full-time equivalent position;

246.17 (ii) are responsible for managing medication, administering and documenting medication
246.18 treatment, and managing a secure medication room; and

246.19 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications
246.20 as prescribed; screen and monitor clients' mental and physical health conditions and
246.21 medication side effects; engage in health promotion, prevention, and education activities;
246.22 communicate and coordinate services with other medical providers; facilitate the development
246.23 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring
246.24 psychiatric and physical health symptoms and medication side effects;

246.25 (4) the co-occurring disorder specialist:

246.26 (i) shall be a full-time equivalent co-occurring disorder specialist who has received
246.27 specific training on co-occurring disorders that is consistent with national evidence-based
246.28 practices. The training must include practical knowledge of common substances and how
246.29 they affect mental illnesses, the ability to assess substance use disorders and the client's
246.30 stage of treatment, motivational interviewing, and skills necessary to provide counseling to
246.31 clients at all different stages of change and treatment. The co-occurring disorder specialist
246.32 may also be an individual who is a licensed alcohol and drug counselor as described in
246.33 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,

247.1 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring
247.2 disorder specialists may occupy this role; and

247.3 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.

247.4 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT
247.5 team members on co-occurring disorders;

247.6 (5) the vocational specialist:

247.7 (i) shall be a full-time vocational specialist who has at least one-year experience providing
247.8 employment services or advanced education that involved field training in vocational services
247.9 to individuals with mental illness. An individual who does not meet these qualifications
247.10 may also serve as the vocational specialist upon completing a training plan approved by the
247.11 commissioner;

247.12 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational
247.13 specialist serves as a consultant and educator to fellow ACT team members on these services;

247.14 and

247.15 (iii) must not refer individuals to receive any type of vocational services or linkage by
247.16 providers outside of the ACT team;

247.17 (6) the mental health certified peer specialist:

247.18 (i) shall be a full-time equivalent. No more than two individuals can share this position.
247.19 The mental health certified peer specialist is a fully integrated team member who provides
247.20 highly individualized services in the community and promotes the self-determination and
247.21 shared decision-making abilities of clients. This requirement may be waived due to workforce
247.22 shortages upon approval of the commissioner;

247.23 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,
247.24 self-advocacy, and self-direction, promote wellness management strategies, and assist clients
247.25 in developing advance directives; and

247.26 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage
247.27 wellness and resilience, provide consultation to team members, promote a culture where
247.28 the clients' points of view and preferences are recognized, understood, respected, and
247.29 integrated into treatment, and serve in a manner equivalent to other team members;

247.30 (7) the program administrative assistant shall be a full-time office-based program
247.31 administrative assistant position assigned to solely work with the ACT team, providing a
247.32 range of supports to the team, clients, and families; and

248.1 (8) additional staff:

248.2 (i) shall be based on team size. Additional treatment team staff may include mental
248.3 health professionals; clinical trainees; certified rehabilitation specialists; mental health
248.4 practitioners; or mental health rehabilitation workers. These individuals shall have the
248.5 knowledge, skills, and abilities required by the population served to carry out rehabilitation
248.6 and support functions; and

248.7 (ii) shall be selected based on specific program needs or the population served.

248.8 (b) Each ACT team must clearly document schedules for all ACT team members.

248.9 (c) Each ACT team member must serve as a primary team member for clients assigned
248.10 by the team leader and are responsible for facilitating the individual treatment plan process
248.11 for those clients. The primary team member for a client is the responsible team member
248.12 knowledgeable about the client's life and circumstances and writes the individual treatment
248.13 plan. The primary team member provides individual supportive therapy or counseling, and
248.14 provides primary support and education to the client's family and support system.

248.15 (d) Members of the ACT team must have strong clinical skills, professional qualifications,
248.16 experience, and competency to provide a full breadth of rehabilitation services. Each staff
248.17 member shall be proficient in their respective discipline and be able to work collaboratively
248.18 as a member of a multidisciplinary team to deliver the majority of the treatment,
248.19 rehabilitation, and support services clients require to fully benefit from receiving assertive
248.20 community treatment.

248.21 (e) Each ACT team member must fulfill training requirements established by the
248.22 commissioner.

248.23 Sec. 16. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is
248.24 amended to read:

248.25 Subd. 7b. **Assertive community treatment program size and opportunities scores.** (a)
248.26 Each ACT team ~~shall maintain an annual average caseload that does not exceed 100 clients.~~
248.27 ~~Staff to client ratios shall be based on team size as follows:~~ must demonstrate that the team
248.28 attained a passing score according to the most recently issued Tool for Measurement of
248.29 Assertive Community Treatment (TMACT).

248.30 ~~(1) a small ACT team must:~~

248.31 ~~(i) employ at least six but no more than seven full-time treatment team staff, excluding~~
248.32 ~~the program assistant and the psychiatric care provider;~~

- 249.1 ~~(ii) serve an annual average maximum of no more than 50 clients;~~
- 249.2 ~~(iii) ensure at least one full-time equivalent position for every eight clients served;~~
- 249.3 ~~(iv) schedule ACT team staff on weekdays and on-call duty to provide crisis services~~
- 249.4 ~~and deliver services after hours when staff are not working;~~
- 249.5 ~~(v) provide crisis services during business hours if the small ACT team does not have~~
- 249.6 ~~sufficient staff numbers to operate an after-hours on-call system. During all other hours,~~
- 249.7 ~~the ACT team may arrange for coverage for crisis assessment and intervention services~~
- 249.8 ~~through a reliable crisis-intervention provider as long as there is a mechanism by which the~~
- 249.9 ~~ACT team communicates routinely with the crisis-intervention provider and the on-call~~
- 249.10 ~~ACT team staff are available to see clients face-to-face when necessary or if requested by~~
- 249.11 ~~the crisis-intervention services provider;~~
- 249.12 ~~(vi) adjust schedules and provide staff to carry out the needed service activities in the~~
- 249.13 ~~evenings or on weekend days or holidays, when necessary;~~
- 249.14 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
- 249.15 ~~provider is not regularly scheduled to work. If availability of the ACT team's psychiatric~~
- 249.16 ~~care provider during all hours is not feasible, alternative psychiatric prescriber backup must~~
- 249.17 ~~be arranged and a mechanism of timely communication and coordination established in~~
- 249.18 ~~writing; and~~
- 249.19 ~~(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each~~
- 249.20 ~~week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time~~
- 249.21 ~~equivalent nursing, one full-time co-occurring disorder specialist, one full-time equivalent~~
- 249.22 ~~mental health certified peer specialist, one full-time vocational specialist, one full-time~~
- 249.23 ~~program assistant, and at least one additional full-time ACT team member who has mental~~
- 249.24 ~~health professional, certified rehabilitation specialist, clinical trainee, or mental health~~
- 249.25 ~~practitioner status; and~~
- 249.26 ~~(2) a midsize ACT team shall:~~
- 249.27 ~~(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry~~
- 249.28 ~~time for 51 clients, with an additional two hours for every six clients added to the team, 1.5~~
- 249.29 ~~to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one~~
- 249.30 ~~full-time equivalent mental health certified peer specialist, one full-time vocational specialist,~~
- 249.31 ~~one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT~~
- 249.32 ~~members, with at least one dedicated full-time staff member with mental health professional~~

- 250.1 ~~status. Remaining team members may have mental health professional, certified rehabilitation~~
250.2 ~~specialist, clinical trainee, or mental health practitioner status;~~
- 250.3 ~~(ii) employ seven or more treatment team full-time equivalents, excluding the program~~
250.4 ~~assistant and the psychiatric care provider;~~
- 250.5 ~~(iii) serve an annual average maximum caseload of 51 to 74 clients;~~
- 250.6 ~~(iv) ensure at least one full-time equivalent position for every nine clients served;~~
- 250.7 ~~(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays~~
250.8 ~~and six to eight-hour shift coverage on weekends and holidays. In addition to these minimum~~
250.9 ~~specifications, staff are regularly scheduled to provide the necessary services on a~~
250.10 ~~client-by-client basis in the evenings and on weekends and holidays;~~
- 250.11 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~
250.12 ~~when staff are not working;~~
- 250.13 ~~(vii) have the authority to arrange for coverage for crisis assessment and intervention~~
250.14 ~~services through a reliable crisis intervention provider as long as there is a mechanism by~~
250.15 ~~which the ACT team communicates routinely with the crisis intervention provider and the~~
250.16 ~~on-call ACT team staff are available to see clients face-to-face when necessary or if requested~~
250.17 ~~by the crisis intervention services provider; and~~
- 250.18 ~~(viii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
250.19 ~~provider is not regularly scheduled to work. If availability of the psychiatric care provider~~
250.20 ~~during all hours is not feasible, alternative psychiatric prescriber backup must be arranged~~
250.21 ~~and a mechanism of timely communication and coordination established in writing;~~
- 250.22 ~~(3) a large ACT team must:~~
- 250.23 ~~(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week~~
250.24 ~~per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,~~
250.25 ~~one full-time co-occurring disorder specialist, one full-time equivalent mental health certified~~
250.26 ~~peer specialist, one full-time vocational specialist, one full-time program assistant, and at~~
250.27 ~~least two additional full-time equivalent ACT team members, with at least one dedicated~~
250.28 ~~full-time staff member with mental health professional status. Remaining team members~~
250.29 ~~may have mental health professional or mental health practitioner status;~~
- 250.30 ~~(ii) employ nine or more treatment team full-time equivalents, excluding the program~~
250.31 ~~assistant and psychiatric care provider;~~
- 250.32 ~~(iii) serve an annual average maximum caseload of 75 to 100 clients;~~

- 251.1 ~~(iv) ensure at least one full-time equivalent position for every nine individuals served;~~
251.2 ~~(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the~~
251.3 ~~second shift providing services at least 12 hours per day weekdays. For weekends and~~
251.4 ~~holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,~~
251.5 ~~with a minimum of two staff each weekend day and every holiday;~~
251.6 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~
251.7 ~~when staff are not working; and~~
251.8 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
251.9 ~~provider is not regularly scheduled to work. If availability of the ACT team psychiatric care~~
251.10 ~~provider during all hours is not feasible, alternative psychiatric backup must be arranged~~
251.11 ~~and a mechanism of timely communication and coordination established in writing.~~
251.12 ~~(b) An ACT team of any size may have a staff-to-client ratio that is lower than the~~
251.13 ~~requirements described in paragraph (a) upon approval by the commissioner, but may not~~
251.14 ~~exceed a one-to-ten staff-to-client ratio.~~

251.15 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

251.16 Subd. 7d. **Assertive community treatment assessment and individual treatment**
251.17 **plan.** (a) An initial assessment shall be completed the day of the client's admission to
251.18 assertive community treatment by the ACT team leader or the psychiatric care provider,
251.19 with participation by designated ACT team members and the client. The initial assessment
251.20 must include obtaining or completing a standard diagnostic assessment according to section
251.21 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,
251.22 psychiatric care provider, or other mental health professional designated by the team leader
251.23 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~
251.24 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

251.25 (b) A functional assessment must be completed according to section 245I.10, subdivision
251.26 9. Each part of the functional assessment areas shall be completed by each respective team
251.27 specialist or an ACT team member with skill and knowledge in the area being assessed.

251.28 (c) Between 30 and 45 days after the client's admission to assertive community treatment,
251.29 the entire ACT team must hold a comprehensive case conference, where all team members,
251.30 including the psychiatric provider, present information discovered from the completed
251.31 assessments and provide treatment recommendations. The conference must serve as the
251.32 basis for the first individual treatment plan, which must be written by the primary team
251.33 member.

252.1 (d) The client's psychiatric care provider, primary team member, and individual treatment
252.2 team members shall assume responsibility for preparing the written narrative of the results
252.3 from the psychiatric and social functioning history timeline and the comprehensive
252.4 assessment.

252.5 (e) The primary team member and individual treatment team members shall be assigned
252.6 by the team leader in collaboration with the psychiatric care provider by the time of the first
252.7 treatment planning meeting or 30 days after admission, whichever occurs first.

252.8 (f) Individual treatment plans must be developed through the following treatment planning
252.9 process:

252.10 (1) The individual treatment plan shall be developed in collaboration with the client and
252.11 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT
252.12 team shall evaluate, together with each client, the client's needs, strengths, and preferences
252.13 and develop the individual treatment plan collaboratively. The ACT team shall make every
252.14 effort to ensure that the client and the client's family and natural supports, with the client's
252.15 consent, are in attendance at the treatment planning meeting, are involved in ongoing
252.16 meetings related to treatment, and have the necessary supports to fully participate. The
252.17 client's participation in the development of the individual treatment plan shall be documented.

252.18 (2) The client and the ACT team shall work together to formulate and prioritize the
252.19 issues, set goals, research approaches and interventions, and establish the plan. The plan is
252.20 individually tailored so that the treatment, rehabilitation, and support approaches and
252.21 interventions achieve optimum symptom reduction, help fulfill the personal needs and
252.22 aspirations of the client, take into account the cultural beliefs and realities of the individual,
252.23 and improve all the aspects of psychosocial functioning that are important to the client. The
252.24 process supports strengths, rehabilitation, and recovery.

252.25 (3) Each client's individual treatment plan shall identify service needs, strengths and
252.26 capacities, and barriers, and set specific and measurable short- and long-term goals for each
252.27 service need. The individual treatment plan must clearly specify the approaches and
252.28 interventions necessary for the client to achieve the individual goals, when the interventions
252.29 shall happen, and identify which ACT team member shall carry out the approaches and
252.30 interventions.

252.31 (4) The primary team member and the individual treatment team, together with the client
252.32 and the client's family and natural supports with the client's consent, are responsible for
252.33 reviewing and rewriting the treatment goals and individual treatment plan whenever there
252.34 is a major decision point in the client's course of treatment or at least every six months.

253.1 (5) The primary team member shall prepare a summary that thoroughly describes in
253.2 writing the client's and the individual treatment team's evaluation of the client's progress
253.3 and goal attainment, the effectiveness of the interventions, and the satisfaction with services
253.4 since the last individual treatment plan. The client's most recent diagnostic assessment must
253.5 be included with the treatment plan summary.

253.6 (6) The individual treatment plan and review must be approved or acknowledged by the
253.7 client, the primary team member, the team leader, the psychiatric care provider, and all
253.8 individual treatment team members. A copy of the approved individual treatment plan must
253.9 be made available to the client.

253.10 Sec. 18. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is
253.11 amended to read:

253.12 Subd. 8. **Medical assistance payment for assertive community treatment and**
253.13 **intensive residential treatment services.** (a) Payment for intensive residential treatment
253.14 services and assertive community treatment in this section shall be based on one daily rate
253.15 per provider inclusive of the following services received by an eligible client in a given
253.16 calendar day: all rehabilitative services under this section, staff travel time to provide
253.17 rehabilitative services under this section, and nonresidential crisis stabilization services
253.18 under section 256B.0624.

253.19 (b) Except as indicated in paragraph (c), payment will not be made to more than one
253.20 entity for each client for services provided under this section on a given day. If services
253.21 under this section are provided by a team that includes staff from more than one entity, the
253.22 team must determine how to distribute the payment among the members.

253.23 (c) The commissioner shall determine one rate for each provider that will bill medical
253.24 assistance for residential services under this section and one rate for each assertive community
253.25 treatment provider. If a single entity provides both services, one rate is established for the
253.26 entity's residential services and another rate for the entity's nonresidential services under
253.27 this section. A provider is not eligible for payment under this section without authorization
253.28 from the commissioner. The commissioner shall develop rates using the following criteria:

253.29 (1) the provider's cost for services shall include direct services costs, other program
253.30 costs, and other costs determined as follows:

253.31 (i) the direct services costs must be determined using actual costs of salaries, benefits,
253.32 payroll taxes, and training of direct service staff and service-related transportation;

254.1 (ii) other program costs not included in item (i) must be determined as a specified
254.2 percentage of the direct services costs as determined by item (i). The percentage used shall
254.3 be determined by the commissioner based upon the average of percentages that represent
254.4 the relationship of other program costs to direct services costs among the entities that provide
254.5 similar services;

254.6 (iii) physical plant costs calculated based on the percentage of space within the program
254.7 that is entirely devoted to treatment and programming. This does not include administrative
254.8 or residential space;

254.9 (iv) assertive community treatment physical plant costs must be reimbursed as part of
254.10 the costs described in item (ii); and

254.11 (v) subject to federal approval, up to an additional five percent of the total rate may be
254.12 added to the program rate as a quality incentive based upon the entity meeting performance
254.13 criteria specified by the commissioner;

254.14 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and
254.15 consistent with federal reimbursement requirements under Code of Federal Regulations,
254.16 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and
254.17 Budget Circular Number A-122, relating to nonprofit entities;

254.18 (3) the number of service units;

254.19 (4) the degree to which clients will receive services other than services under this section;
254.20 and

254.21 (5) the costs of other services that will be separately reimbursed.

254.22 (d) The rate for intensive residential treatment services and assertive community treatment
254.23 must exclude the medical assistance room and board rate, as defined in section 256B.056,
254.24 subdivision 5d, and services not covered under this section, such as partial hospitalization,
254.25 home care, and inpatient services.

254.26 (e) Physician services that are not separately billed may be included in the rate to the
254.27 extent that a psychiatrist, or other health care professional providing physician services
254.28 within their scope of practice, is a member of the intensive residential treatment services
254.29 treatment team. Physician services, whether billed separately or included in the rate, may
254.30 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning
254.31 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth
254.32 is used to provide intensive residential treatment services.

255.1 (f) When services under this section are provided by an assertive community treatment
255.2 provider, case management functions must be an integral part of the team.

255.3 (g) The rate for a provider must not exceed the rate charged by that provider for the
255.4 same service to other payors.

255.5 (h) The rates for existing programs must be established prospectively based upon the
255.6 expenditures and utilization over a prior 12-month period using the criteria established in
255.7 paragraph (c). The rates for new programs must be established based upon estimated
255.8 expenditures and estimated utilization using the criteria established in paragraph (c).

255.9 (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive
255.10 community treatment, adult residential crisis stabilization services, and intensive residential
255.11 treatment services must be annually adjusted for inflation using the Centers for Medicare
255.12 and Medicaid Services Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter
255.13 of the calendar year before the rate year. The inflation adjustment must be based on the
255.14 12-month period from the midpoint of the previous rate year to the midpoint of the rate year
255.15 for which the rate is being determined.

255.16 (j) Entities who discontinue providing services must be subject to a settle-up process
255.17 whereby actual costs and reimbursement for the previous 12 months are compared. In the
255.18 event that the entity was paid more than the entity's actual costs plus any applicable
255.19 performance-related funding due the provider, the excess payment must be reimbursed to
255.20 the department. If a provider's revenue is less than actual allowed costs due to lower
255.21 utilization than projected, the commissioner may reimburse the provider to recover its actual
255.22 allowable costs. The resulting adjustments by the commissioner must be proportional to the
255.23 percent of total units of service reimbursed by the commissioner and must reflect a difference
255.24 of greater than five percent.

255.25 (k) A provider may request of the commissioner a review of any rate-setting decision
255.26 made under this subdivision.

255.27 Sec. 19. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

255.28 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services
255.29 must be provided by qualified individual provider staff of a certified provider entity.

255.30 Individual provider staff must be qualified as:

255.31 (1) a mental health professional who is qualified according to section 245I.04, subdivision
255.32 2;

256.1 (2) a certified rehabilitation specialist who is qualified according to section 245I.04,
256.2 subdivision 8;

256.3 (3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

256.4 (4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

256.5 (5) a mental health certified peer specialist who is qualified according to section 245I.04,
256.6 subdivision 10; ~~or~~

256.7 (6) a mental health rehabilitation worker who is qualified according to section 245I.04,
256.8 subdivision 14; or

256.9 (7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

256.10 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
256.11 of human services must notify the revisor of statutes when federal approval is obtained.

256.12 Sec. 20. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is
256.13 amended to read:

256.14 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
256.15 assistance covers services provided by a not-for-profit certified community behavioral health
256.16 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

256.17 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an
256.18 eligible service is delivered using the CCBHC daily bundled rate system for medical
256.19 assistance payments as described in paragraph (c). The commissioner shall include a quality
256.20 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).
256.21 There is no county share for medical assistance services when reimbursed through the
256.22 CCBHC daily bundled rate system.

256.23 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC
256.24 payments under medical assistance meets the following requirements:

256.25 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
256.26 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
256.27 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
256.28 payment rate, total annual visits include visits covered by medical assistance and visits not
256.29 covered by medical assistance. Allowable costs include but are not limited to the salaries
256.30 and benefits of medical assistance providers; the cost of CCBHC services provided under
256.31 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as
256.32 insurance or supplies needed to provide CCBHC services;

257.1 (2) payment shall be limited to one payment per day per medical assistance enrollee
257.2 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
257.3 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph
257.4 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or
257.5 licensed agency employed by or under contract with a CCBHC;

257.6 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,
257.7 subdivision 3, shall be established by the commissioner using a provider-specific rate based
257.8 on the newly certified CCBHC's audited historical cost report data adjusted for the expected
257.9 cost of delivering CCBHC services. Estimates are subject to review by the commissioner
257.10 and must include the expected cost of providing the full scope of CCBHC services and the
257.11 expected number of visits for the rate period;

257.12 (4) the commissioner shall rebase CCBHC rates once every two years following the last
257.13 rebasing and no less than 12 months following an initial rate or a rate change due to a change
257.14 in the scope of services. For CCBHCs certified after September 31, 2020, and before January
257.15 1, 2021, the commissioner shall rebase rates according to this clause beginning for dates of
257.16 service provided on January 1, 2024;

257.17 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
257.18 of the rebasing;

257.19 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
257.20 Medicaid rate is not eligible for the CCBHC rate methodology;

257.21 (7) payments for CCBHC services to individuals enrolled in managed care shall be
257.22 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
257.23 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
257.24 of the CCBHC daily bundled rate system in the Medicaid Management Information System
257.25 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
257.26 due made payable to CCBHCs no later than 18 months thereafter;

257.27 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
257.28 provider-specific rate by the Medicare Economic Index for primary care services. This
257.29 update shall occur each year in between rebasing periods determined by the commissioner
257.30 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
257.31 annually using the CCBHC cost report established by the commissioner; and

257.32 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
257.33 services when such changes are expected to result in an adjustment to the CCBHC payment
257.34 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information

258.1 regarding the changes in the scope of services, including the estimated cost of providing
258.2 the new or modified services and any projected increase or decrease in the number of visits
258.3 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
258.4 adjustments for changes in scope shall occur no more than once per year in between rebasing
258.5 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

258.6 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
258.7 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
258.8 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
258.9 any contract year, federal approval is not received for this paragraph, the commissioner
258.10 must adjust the capitation rates paid to managed care plans and county-based purchasing
258.11 plans for that contract year to reflect the removal of this provision. Contracts between
258.12 managed care plans and county-based purchasing plans and providers to whom this paragraph
258.13 applies must allow recovery of payments from those providers if capitation rates are adjusted
258.14 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
258.15 to any increase in rates that results from this provision. This paragraph expires if federal
258.16 approval is not received for this paragraph at any time.

258.17 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
258.18 that meets the following requirements:

258.19 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
258.20 thresholds for performance metrics established by the commissioner, in addition to payments
258.21 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
258.22 paragraph (c);

258.23 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement
258.24 year to be eligible for incentive payments;

258.25 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
258.26 receive quality incentive payments at least 90 days prior to the measurement year; and

258.27 (4) a CCBHC must provide the commissioner with data needed to determine incentive
258.28 payment eligibility within six months following the measurement year. The commissioner
258.29 shall notify CCBHC providers of their performance on the required measures and the
258.30 incentive payment amount within 12 months following the measurement year.

258.31 (f) All claims to managed care plans for CCBHC services as provided under this section
258.32 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
258.33 than January 1 of the following calendar year, if:

259.1 (1) one or more managed care plans does not comply with the federal requirement for
259.2 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
259.3 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
259.4 days of noncompliance; and

259.5 (2) the total amount of clean claims not paid in accordance with federal requirements
259.6 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
259.7 eligible for payment by managed care plans.

259.8 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
259.9 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
259.10 the following year. If the conditions in this paragraph are met between July 1 and December
259.11 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
259.12 on July 1 of the following year.

259.13 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered
259.14 service under medical assistance when a licensed mental health professional or alcohol and
259.15 drug counselor determines that peer services are medically necessary. Eligibility under this
259.16 subdivision for peer services provided by a CCBHC supersede eligibility standards under
259.17 sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8).

259.18 Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 20, is amended to read:

259.19 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
259.20 state agency, medical assistance covers case management services to persons with serious
259.21 and persistent mental illness and children with severe emotional disturbance. Services
259.22 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
259.23 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
259.24 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

259.25 (b) Entities meeting program standards set out in rules governing family community
259.26 support services as defined in section 245.4871, subdivision 17, are eligible for medical
259.27 assistance reimbursement for case management services for children with severe emotional
259.28 disturbance when these services meet the program standards in Minnesota Rules, parts
259.29 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

259.30 (c) Medical assistance and MinnesotaCare payment for mental health case management
259.31 shall be made on a monthly basis. In order to receive payment for an eligible child, the
259.32 provider must document at least a face-to-face contact either in person or by interactive
259.33 video that meets the requirements of subdivision 20b with the child, the child's parents, or

260.1 the child's legal representative. To receive payment for an eligible adult, the provider must
260.2 document:

260.3 (1) at least a face-to-face contact with the adult or the adult's legal representative either
260.4 in person or by interactive video that meets the requirements of subdivision 20b; or

260.5 (2) at least a telephone contact or contact via secure electronic message, if preferred by
260.6 the adult client, with the adult or the adult's legal representative and document a face-to-face
260.7 contact either in person or by interactive video that meets the requirements of subdivision
260.8 20b with the adult or the adult's legal representative within the preceding two months.

260.9 (d) Payment for mental health case management provided by county or state staff shall
260.10 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
260.11 (b), with separate rates calculated for child welfare and mental health, and within mental
260.12 health, separate rates for children and adults.

260.13 (e) Payment for mental health case management provided by Indian health services or
260.14 by agencies operated by Indian tribes may be made according to this section or other relevant
260.15 federally approved rate setting methodology.

260.16 (f) Payment for mental health case management provided by vendors who contract with
260.17 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
260.18 for mental health case management provided by vendors who contract with a Tribe must
260.19 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
260.20 by the vendor for the same service to other payers. If the service is provided by a team of
260.21 contracted vendors, the team shall determine how to distribute the rate among its members.
260.22 No reimbursement received by contracted vendors shall be returned to the county or tribe,
260.23 except to reimburse the county or tribe for advance funding provided by the county or tribe
260.24 to the vendor.

260.25 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
260.26 and county or state staff, the costs for county or state staff participation in the team shall be
260.27 included in the rate for county-provided services. In this case, the contracted vendor, the
260.28 tribal agency, and the county may each receive separate payment for services provided by
260.29 each entity in the same month. In order to prevent duplication of services, each entity must
260.30 document, in the recipient's file, the need for team case management and a description of
260.31 the roles of the team members.

260.32 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
260.33 mental health case management shall be provided by the recipient's county of responsibility,
260.34 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds

261.1 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
261.2 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
261.3 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
261.4 the recipient's county of responsibility.

261.5 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
261.6 and MinnesotaCare include mental health case management. When the service is provided
261.7 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
261.8 share.

261.9 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
261.10 that does not meet the reporting or other requirements of this section. The county of
261.11 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
261.12 is responsible for any federal disallowances. The county or tribe may share this responsibility
261.13 with its contracted vendors.

261.14 (k) The commissioner shall set aside a portion of the federal funds earned for county
261.15 expenditures under this section to repay the special revenue maximization account under
261.16 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

261.17 (1) the costs of developing and implementing this section; and

261.18 (2) programming the information systems.

261.19 (l) Payments to counties and tribal agencies for case management expenditures under
261.20 this section shall only be made from federal earnings from services provided under this
261.21 section. When this service is paid by the state without a federal share through fee-for-service,
261.22 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
261.23 shall include the federal earnings, the state share, and the county share.

261.24 (m) Case management services under this subdivision do not include therapy, treatment,
261.25 legal, or outreach services.

261.26 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
261.27 and the recipient's institutional care is paid by medical assistance, payment for case
261.28 management services under this subdivision is limited to the lesser of:

261.29 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
261.30 than six months in a calendar year; or

261.31 (2) the limits and conditions which apply to federal Medicaid funding for this service.

262.1 (o) Payment for case management services under this subdivision shall not duplicate
262.2 payments made under other program authorities for the same purpose.

262.3 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
262.4 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
262.5 mental health targeted case management services must actively support identification of
262.6 community alternatives for the recipient and discharge planning.

262.7 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 5, is
262.8 amended to read:

262.9 Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers
262.10 child and family psychoeducation services provided to a child up to under age 21 with and
262.11 the child's family members when determined to be medically necessary due to a diagnosed
262.12 mental health condition when or diagnosed mental illness identified in the child's individual
262.13 treatment plan and provided by a mental health professional who is qualified under section
262.14 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04,
262.15 subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision
262.16 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a
262.17 clinical trainee who has determined it medically necessary to involve family members in
262.18 the child's care is qualified under section 245I.04, subdivision 6, and practicing within the
262.19 scope of practice under section 245I.04, subdivision 7.

262.20 (b) "Child and family psychoeducation services" means information or demonstration
262.21 provided to an individual or family as part of an individual, family, multifamily group, or
262.22 peer group session to explain, educate, and support the child and family in understanding
262.23 a child's symptoms of mental illness, the impact on the child's development, and needed
262.24 components of treatment and skill development so that the individual, family, or group can
262.25 help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve
262.26 optimal mental health and long-term resilience.

262.27 (c) Child and family psychoeducation services include individual, family, or group skills
262.28 development or training to:

262.29 (1) support the development of psychosocial skills that are medically necessary to support
262.30 the child to an age-appropriate developmental trajectory when the child's development was
262.31 disrupted by a mental health condition or diagnosed mental illness; or

263.1 (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace
263.2 skills deficits or maladaptive skills acquired over the course of the child's mental health
263.3 condition or mental illness.

263.4 (d) Skills development or training delivered to a child or the child's family under this
263.5 subdivision must be targeted to the specific deficits related to the child's mental health
263.6 condition or mental illness and must be prescribed in the child's individual treatment plan.
263.7 Group skills training may be provided to multiple recipients who, because of the nature of
263.8 their emotional, behavioral, or social functional ability, may benefit from interaction in a
263.9 group setting.

263.10 Sec. 23. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

263.11 Subd. 12. **Excluded services.** The following services are not eligible for medical
263.12 assistance payment as children's therapeutic services and supports:

263.13 (1) service components of children's therapeutic services and supports simultaneously
263.14 provided by more than one provider entity unless prior authorization is obtained;

263.15 (2) treatment by multiple providers within the same agency at the same clock time,
263.16 unless one service is delivered to the child and the other service is delivered to the child's
263.17 family or treatment team without the child present;

263.18 (3) children's therapeutic services and supports provided in violation of medical assistance
263.19 policy in Minnesota Rules, part 9505.0220;

263.20 (4) mental health behavioral aide services provided by a personal care assistant who is
263.21 not qualified as a mental health behavioral aide and employed by a certified children's
263.22 therapeutic services and supports provider entity;

263.23 (5) service components of CTSS that are the responsibility of a residential or program
263.24 license holder, including foster care providers under the terms of a service agreement or
263.25 administrative rules governing licensure; and

263.26 (6) adjunctive activities that may be offered by a provider entity but are not otherwise
263.27 covered by medical assistance, including:

263.28 (i) a service that is primarily recreation oriented or that is provided in a setting that is
263.29 not medically supervised. This includes sports activities, exercise groups, activities such as
263.30 craft hours, leisure time, social hours, meal or snack time, trips to community activities,
263.31 and tours;

- 264.1 (ii) a social or educational service that does not have or cannot reasonably be expected
264.2 to have a therapeutic outcome related to the client's emotional disturbance;
- 264.3 (iii) prevention or education programs provided to the community; and
- 264.4 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

264.5 Sec. 24. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

264.6 **Subd. 5. Standards for intensive nonresidential rehabilitative providers.** (a) Services
264.7 must meet the standards in this section and chapter 245I as required in section 245I.011,
264.8 subdivision 5.

264.9 (b) The treatment team must have specialized training in providing services to the specific
264.10 age group of youth that the team serves. An individual treatment team must serve youth
264.11 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14
264.12 years of age or older and under 21 years of age.

264.13 (c) The treatment team for intensive nonresidential rehabilitative mental health services
264.14 comprises both permanently employed core team members and client-specific team members
264.15 as follows:

264.16 (1) Based on professional qualifications and client needs, clinically qualified core team
264.17 members are assigned on a rotating basis as the client's lead worker to coordinate a client's
264.18 care. The core team must comprise at least four full-time equivalent direct care staff and
264.19 must minimally include:

264.20 (i) a mental health professional who serves as team leader to provide administrative
264.21 direction and treatment supervision to the team;

264.22 (ii) an advanced-practice registered nurse with certification in psychiatric or mental
264.23 health care or a board-certified child and adolescent psychiatrist, either of which must be
264.24 credentialed to prescribe medications;

264.25 ~~(iii) a licensed alcohol and drug counselor who is also trained in mental health~~
264.26 ~~interventions; and~~

264.27 ~~(iv)~~ (iii) a mental health certified peer specialist who is qualified according to section
264.28 245I.04, subdivision 10, and is also a former children's mental health consumer; and

264.29 (iv) a co-occurring disorder specialist who meets the requirements under section
264.30 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the
264.31 provision of co-occurring disorder treatment to clients.

- 265.1 (2) The core team may also include any of the following:
- 265.2 (i) additional mental health professionals;
- 265.3 (ii) a vocational specialist;
- 265.4 (iii) an educational specialist with knowledge and experience working with youth
- 265.5 regarding special education requirements and goals, special education plans, and coordination
- 265.6 of educational activities with health care activities;
- 265.7 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;
- 265.8 (v) a clinical trainee qualified according to section 245I.04, subdivision 6;
- 265.9 (vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;
- 265.10 (vii) a case management service provider, as defined in section 245.4871, subdivision
- 265.11 4;
- 265.12 (viii) a housing access specialist; and
- 265.13 (ix) a family peer specialist as defined in subdivision 2, paragraph (j).
- 265.14 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc
- 265.15 members not employed by the team who consult on a specific client and who must accept
- 265.16 overall clinical direction from the treatment team for the duration of the client's placement
- 265.17 with the treatment team and must be paid by the provider agency at the rate for a typical
- 265.18 session by that provider with that client or at a rate negotiated with the client-specific
- 265.19 member. Client-specific treatment team members may include:
- 265.20 (i) the mental health professional treating the client prior to placement with the treatment
- 265.21 team;
- 265.22 (ii) the client's current substance use counselor, if applicable;
- 265.23 (iii) a lead member of the client's individualized education program team or school-based
- 265.24 mental health provider, if applicable;
- 265.25 (iv) a representative from the client's health care home or primary care clinic, as needed
- 265.26 to ensure integration of medical and behavioral health care;
- 265.27 (v) the client's probation officer or other juvenile justice representative, if applicable;
- 265.28 and
- 265.29 (vi) the client's current vocational or employment counselor, if applicable.

266.1 (d) The treatment supervisor shall be an active member of the treatment team and shall
266.2 function as a practicing clinician at least on a part-time basis. The treatment team shall meet
266.3 with the treatment supervisor at least weekly to discuss recipients' progress and make rapid
266.4 adjustments to meet recipients' needs. The team meeting must include client-specific case
266.5 reviews and general treatment discussions among team members. Client-specific case
266.6 reviews and planning must be documented in the individual client's treatment record.

266.7 (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment
266.8 team position.

266.9 (f) The treatment team shall serve no more than 80 clients at any one time. Should local
266.10 demand exceed the team's capacity, an additional team must be established rather than
266.11 exceed this limit.

266.12 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental
266.13 health practitioner, clinical trainee, or mental health professional. The provider shall have
266.14 the capacity to promptly and appropriately respond to emergent needs and make any
266.15 necessary staffing adjustments to ensure the health and safety of clients.

266.16 (h) The intensive nonresidential rehabilitative mental health services provider shall
266.17 participate in evaluation of the assertive community treatment for youth (Youth ACT) model
266.18 as conducted by the commissioner, including the collection and reporting of data and the
266.19 reporting of performance measures as specified by contract with the commissioner.

266.20 (i) A regional treatment team may serve multiple counties.

266.21 Sec. 25. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is
266.22 amended to read:

266.23 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this
266.24 section must be based on one daily encounter rate per provider inclusive of the following
266.25 services received by an eligible client in a given calendar day: all rehabilitative services,
266.26 supports, and ancillary activities under this section, staff travel time to provide rehabilitative
266.27 services under this section, and crisis response services under section 256B.0624.

266.28 (b) Payment must not be made to more than one entity for each client for services
266.29 provided under this section on a given day. If services under this section are provided by a
266.30 team that includes staff from more than one entity, the team shall determine how to distribute
266.31 the payment among the members.

267.1 (c) The commissioner shall establish regional cost-based rates for entities that will bill
267.2 medical assistance for nonresidential intensive rehabilitative mental health services. In
267.3 developing these rates, the commissioner shall consider:

267.4 (1) the cost for similar services in the health care trade area;

267.5 (2) actual costs incurred by entities providing the services;

267.6 (3) the intensity and frequency of services to be provided to each client;

267.7 (4) the degree to which clients will receive services other than services under this section;

267.8 and

267.9 (5) the costs of other services that will be separately reimbursed.

267.10 (d) The rate for a provider must not exceed the rate charged by that provider for the
267.11 same service to other payers.

267.12 (e) Effective for the rate years beginning on and after January 1, 2024, rates must be
267.13 annually adjusted for inflation using the Centers for Medicare and Medicaid Services
267.14 Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter of the calendar year
267.15 before the rate year. The inflation adjustment must be based on the 12-month period from
267.16 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is
267.17 being determined.

267.18 **Sec. 26. DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**

267.19 **CHILDREN'S RESIDENTIAL FACILITY RULEMAKING.**

267.20 (a) The commissioner of human services must use the expedited rulemaking process
267.21 and comply with all requirements under Minnesota Statutes, section 14.389, to adopt the
267.22 amendments required under this section. Notwithstanding Laws 1995, chapter 226, article
267.23 3, sections 50, 51, and 60, or any other law to the contrary, joint rulemaking authority with
267.24 the commissioner of corrections does not apply to rule amendments applicable only to the
267.25 commissioner of human services. An amendment to jointly administered rule parts must be
267.26 related to requirements under this section or to amendments that are necessary for consistency
267.27 with this section.

267.28 (b) The commissioner of human services must amend Minnesota Rules, chapter 2960,
267.29 to replace all instances of the term "clinical supervision" with the term "treatment
267.30 supervision."

267.31 (c) The commissioner of human services must amend Minnesota Rules, part 2960.0020,
267.32 to replace all instances of the term "clinical supervisor" with the term "treatment supervisor."

268.1 (d) The commissioner of human services must amend Minnesota Rules, part 2960.0020,
268.2 to add the definition of "licensed prescriber" to mean an individual who is authorized to
268.3 prescribe legend drugs under Minnesota Statutes, section 151.37.

268.4 (e) The commissioner of human services must amend Minnesota Rules, parts 2960.0020
268.5 to 2960.0710, to replace all instances of "physician" with "licensed prescriber." Amendments
268.6 to rules under this paragraph must apply only to the Department of Human Services.

268.7 (f) The commissioner of human services must amend Minnesota Rules, part 2960.0620,
268.8 subpart 2, to strike all of the current language and insert the following language: "If a resident
268.9 is prescribed a psychotropic medication, the license holder must monitor for side effects of
268.10 the medication. Within 24 hours of admission, a registered nurse or licensed prescriber must
268.11 assess the resident for and document any current side effects and document instructions for
268.12 how frequently the license holder must monitor for side effects of the psychotropic
268.13 medications the resident is taking. When a resident begins taking a new psychotropic
268.14 medication or stops taking a psychotropic medication, the license holder must monitor for
268.15 side effects according to the instructions of the registered nurse or licensed prescriber. The
268.16 license holder must monitor for side effects using standardized checklists, rating scales, or
268.17 other tools according to the instructions of the registered nurse or licensed prescriber. The
268.18 license holder must provide the results of the checklist, rating scale, or other tool to the
268.19 licensed prescriber for review."

268.20 (g) The commissioner of human services must amend Minnesota Rules, part 2960.0630,
268.21 subpart 2, to allow license holders to use the ancillary meeting process under Minnesota
268.22 Statutes, section 245I.23, subdivision 14, paragraph (c), if a staff member cannot participate
268.23 in a weekly clinical supervision session.

268.24 (h) The commissioner of human services must amend Minnesota Rules, part 2960.0630,
268.25 subpart 3, to strike item D.

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

268.27 Sec. 27. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MEDICAL**
268.28 **ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL HEALTH CRISIS**
268.29 **STABILIZATION.**

268.30 (a) The commissioner of human services must consult with providers, advocates, Tribal
268.31 Nations, counties, people with lived experience as or with a child in a mental health crisis,
268.32 and other interested community members to develop a covered benefit under medical

269.1 assistance to provide residential mental health crisis stabilization for children. The benefit
269.2 must:

269.3 (1) consist of evidence-based promising practices or culturally responsive treatment
269.4 services for children under the age of 21 experiencing a mental health crisis;

269.5 (2) embody an integrative care model that supports individuals experiencing a mental
269.6 health crisis who may also be experiencing co-occurring conditions;

269.7 (3) qualify for federal financial participation; and

269.8 (4) include services that support children and families, including but not limited to:

269.9 (i) an assessment of the child's immediate needs and factors that led to the mental health
269.10 crisis;

269.11 (ii) individualized care to address immediate needs and restore the child to a precrisis
269.12 level of functioning;

269.13 (iii) 24-hour on-site staff and assistance;

269.14 (iv) supportive counseling and clinical services;

269.15 (v) skills training and positive support services, as identified in the child's individual
269.16 crisis stabilization plan;

269.17 (vi) referrals to other service providers in the community as needed and to support the
269.18 child's transition from residential crisis stabilization services;

269.19 (vii) development of an individualized and culturally responsive crisis response action
269.20 plan; and

269.21 (viii) assistance to access and store medication.

269.22 (b) When developing the new benefit, the commissioner must make recommendations
269.23 for providers to be reimbursed for room and board.

269.24 (c) The commissioner must consult with or contract with rate-setting experts to develop
269.25 a prospective data-based rate methodology for the children's residential mental health crisis
269.26 stabilization benefit.

269.27 (d) No later than January 15, 2025, the commissioner must submit to the chairs and
269.28 ranking minority members of the legislative committees with jurisdiction over human
269.29 services policy and finance a report detailing for the children's residential mental health
269.30 crisis stabilization benefit the proposed:

270.1 (1) eligibility criteria, clinical and service requirements, provider standards, licensing
270.2 requirements, and reimbursement rates;

270.3 (2) the process for community engagement, community input, and crisis models studied
270.4 in other states;

270.5 (3) a deadline for the commissioner to submit a state plan amendment to the Centers for
270.6 Medicare and Medicaid Services; and

270.7 (4) draft legislation with the statutory changes necessary to implement the benefit.

270.8 **EFFECTIVE DATE.** This section is effective July 1, 2024.

270.9 Sec. 28. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL**
270.10 **HEALTH PROCEDURE CODES.**

270.11 The commissioner of human services must develop recommendations, in consultation
270.12 with external partners and medical coding and compliance experts, on simplifying mental
270.13 health procedure codes and the feasibility of converting mental health procedure codes to
270.14 the current procedural terminology (CPT) code structure. By October 1, 2025, the
270.15 commissioner must submit a report to the chairs and ranking minority members of the
270.16 legislative committees with jurisdiction over mental health on the recommendations and
270.17 methodology to simplify and restructure mental health procedure codes with corresponding
270.18 resource-based relative value scale (RBRVS) values.

270.19 **EFFECTIVE DATE.** This section is effective July 1, 2024.

270.20 Sec. 29. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; RESPITE**
270.21 **CARE ACCESS.**

270.22 The commissioner of human services, in coordination with interested parties, must
270.23 develop proposals by December 31, 2025, to increase access to licensed respite foster care
270.24 homes that take into consideration the new rule directing title IV-E agencies to adopt one
270.25 set of licensing or approval standards for all relative or kinship foster family homes that is
270.26 different from the licensing or approval standards used for nonrelative or nonkinship foster
270.27 family homes, as provided by the Federal Register, volume 88, page 66700.

270.28 Sec. 30. **MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

270.29 The commissioner of human services shall consult with the commissioner of management
270.30 and budget, counties, Tribes, mental health providers, and advocacy organizations to develop
270.31 recommendations for moving from the children's and adult mental health grant funding

271.1 structure to a formula-based allocation structure for mental health services. The
271.2 recommendations must consider formula-based allocations for grants for respite care,
271.3 school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

271.4 Sec. 31. **REVISOR INSTRUCTION.**

271.5 The revisor of statutes, in consultation with the Office of Senate Counsel, Research and
271.6 Fiscal Analysis; the House Research Department; and the commissioner of human services,
271.7 shall prepare legislation for the 2025 legislative session to recodify Minnesota Statutes,
271.8 section 256B.0622, to move provisions related to assertive community treatment and intensive
271.9 residential treatment services into separate sections of statute. The revisor shall correct any
271.10 cross-references made necessary by this recodification.

271.11 Sec. 32. **REPEALER.**

271.12 Minnesota Rules, part 2960.0620, subpart 3, is repealed.

271.13 **ARTICLE 10**

271.14 **DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL**

271.15 Section 1. Minnesota Statutes 2023 Supplement, section 13.46, subdivision 4, as amended
271.16 by Laws 2024, chapter 80, article 8, section 4, is amended to read:

271.17 Subd. 4. **Licensing data.** (a) As used in this subdivision:

271.18 (1) "licensing data" are all data collected, maintained, used, or disseminated by the
271.19 welfare system pertaining to persons licensed or registered or who apply for licensure or
271.20 registration or who formerly were licensed or registered under the authority of the
271.21 commissioner of human services;

271.22 (2) "client" means a person who is receiving services from a licensee or from an applicant
271.23 for licensure; and

271.24 (3) "personal and personal financial data" are Social Security numbers, identity of and
271.25 letters of reference, insurance information, reports from the Bureau of Criminal
271.26 Apprehension, health examination reports, and social/home studies.

271.27 (b)(1)(i) Except as provided in paragraph (c), the following data on applicants,
271.28 certification holders, license holders, and former licensees are public: name, address,
271.29 telephone number of licensees, email addresses except for family child foster care, date of
271.30 receipt of a completed application, dates of licensure, licensed capacity, type of client
271.31 preferred, variances granted, record of training and education in child care and child

272.1 development, type of dwelling, name and relationship of other family members, previous
272.2 license history, class of license, the existence and status of complaints, and the number of
272.3 serious injuries to or deaths of individuals in the licensed program as reported to the
272.4 commissioner of human services; the commissioner of children, youth, and families; the
272.5 local social services agency; or any other county welfare agency. For purposes of this clause,
272.6 a serious injury is one that is treated by a physician.

272.7 (ii) Except as provided in item (v), when a correction order, an order to forfeit a fine,
272.8 an order of license suspension, an order of temporary immediate suspension, an order of
272.9 license revocation, an order of license denial, or an order of conditional license has been
272.10 issued, or a complaint is resolved, the following data on current and former licensees and
272.11 applicants are public: the general nature of the complaint or allegations leading to the
272.12 temporary immediate suspension; the substance and investigative findings of the licensing
272.13 or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence
272.14 of settlement negotiations; the record of informal resolution of a licensing violation; orders
272.15 of hearing; findings of fact; conclusions of law; specifications of the final correction order,
272.16 fine, suspension, temporary immediate suspension, revocation, denial, or conditional license
272.17 contained in the record of licensing action; whether a fine has been paid; and the status of
272.18 any appeal of these actions.

272.19 (iii) When a license denial under section 142A.15 or 245A.05 or a sanction under section
272.20 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling
272.21 individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity
272.22 of the applicant, license holder, or controlling individual as the individual responsible for
272.23 maltreatment is public data at the time of the issuance of the license denial or sanction.

272.24 (iv) When a license denial under section 142A.15 or 245A.05 or a sanction under section
272.25 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling
272.26 individual is disqualified under chapter 245C, the identity of the license holder, applicant,
272.27 or controlling individual as the disqualified individual is public data at the time of the
272.28 issuance of the licensing sanction or denial. If the applicant, license holder, or controlling
272.29 individual requests reconsideration of the disqualification and the disqualification is affirmed,
272.30 the reason for the disqualification and the reason to not set aside the disqualification are
272.31 private data.

272.32 (v) A correction order or fine issued to a child care provider for a licensing violation is
272.33 private data on individuals under section 13.02, subdivision 12, or nonpublic data under
272.34 section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

273.1 (2) For applicants who withdraw their application prior to licensure or denial of a license,
273.2 the following data are public: the name of the applicant, the city and county in which the
273.3 applicant was seeking licensure, the dates of the commissioner's receipt of the initial
273.4 application and completed application, the type of license sought, and the date of withdrawal
273.5 of the application.

273.6 (3) For applicants who are denied a license, the following data are public: the name and
273.7 address of the applicant, the city and county in which the applicant was seeking licensure,
273.8 the dates of the commissioner's receipt of the initial application and completed application,
273.9 the type of license sought, the date of denial of the application, the nature of the basis for
273.10 the denial, the existence of settlement negotiations, the record of informal resolution of a
273.11 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final
273.12 order of denial, and the status of any appeal of the denial.

273.13 (4) When maltreatment is substantiated under section 626.557 or chapter 260E and the
273.14 victim and the substantiated perpetrator are affiliated with a program licensed under chapter
273.15 142B or 245A; the commissioner of human services; commissioner of children, youth, and
273.16 families; local social services agency; or county welfare agency may inform the license
273.17 holder where the maltreatment occurred of the identity of the substantiated perpetrator and
273.18 the victim.

273.19 (5) Notwithstanding clause (1), for child foster care, only the name of the license holder
273.20 and the status of the license are public if the county attorney has requested that data otherwise
273.21 classified as public data under clause (1) be considered private data based on the best interests
273.22 of a child in placement in a licensed program.

273.23 (c) The following are private data on individuals under section 13.02, subdivision 12,
273.24 or nonpublic data under section 13.02, subdivision 9: personal and personal financial data
273.25 on family day care program and family foster care program applicants and licensees and
273.26 their family members who provide services under the license.

273.27 (d) The following are private data on individuals: the identity of persons who have made
273.28 reports concerning licensees or applicants that appear in inactive investigative data, and the
273.29 records of clients or employees of the licensee or applicant for licensure whose records are
273.30 received by the licensing agency for purposes of review or in anticipation of a contested
273.31 matter. The names of reporters of complaints or alleged violations of licensing standards
273.32 under chapters 142B, 245A, 245B, 245C, and 245D, and applicable rules and alleged
273.33 maltreatment under section 626.557 and chapter 260E, are confidential data and may be

274.1 disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557,
274.2 subdivision 12b.

274.3 (e) Data classified as private, confidential, nonpublic, or protected nonpublic under this
274.4 subdivision become public data if submitted to a court or administrative law judge as part
274.5 of a disciplinary proceeding in which there is a public hearing concerning a license which
274.6 has been suspended, immediately suspended, revoked, or denied.

274.7 (f) Data generated in the course of licensing investigations that relate to an alleged
274.8 violation of law are investigative data under subdivision 3.

274.9 (g) Data that are not public data collected, maintained, used, or disseminated under this
274.10 subdivision that relate to or are derived from a report as defined in section 260E.03, or
274.11 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35,
274.12 subdivision 6, and 626.557, subdivision 12b.

274.13 (h) Upon request, not public data collected, maintained, used, or disseminated under
274.14 this subdivision that relate to or are derived from a report of substantiated maltreatment as
274.15 defined in section 626.557 or chapter 260E may be exchanged with the Department of
274.16 Health for purposes of completing background studies pursuant to section 144.057 and with
274.17 the Department of Corrections for purposes of completing background studies pursuant to
274.18 section 241.021.

274.19 (i) Data on individuals collected according to licensing activities under chapters 142B,
274.20 245A, and 245C, data on individuals collected by the commissioner of human services
274.21 according to investigations under section 626.557 and chapters 142B, 245A, 245B, 245C,
274.22 245D, and 260E may be shared with the Department of Human Rights, the Department of
274.23 Health, the Department of Corrections, the ombudsman for mental health and developmental
274.24 disabilities, and the individual's professional regulatory board when there is reason to believe
274.25 that laws or standards under the jurisdiction of those agencies may have been violated or
274.26 the information may otherwise be relevant to the board's regulatory jurisdiction. Background
274.27 study data on an individual who is the subject of a background study under chapter 245C
274.28 for a licensed service for which the commissioner of human services or children, youth,
274.29 and families is the license holder may be shared with the commissioner and the
274.30 commissioner's delegate by the licensing division. Unless otherwise specified in this chapter,
274.31 the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

274.32 (j) In addition to the notice of determinations required under sections 260E.24,
274.33 subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the
274.34 commissioner of children, youth, and families or the local social services agency has

275.1 determined that an individual is a substantiated perpetrator of maltreatment of a child based
275.2 on sexual abuse, as defined in section 260E.03, and the commissioner or local social services
275.3 agency knows that the individual is a person responsible for a child's care in another facility,
275.4 the commissioner or local social services agency shall notify the head of that facility of this
275.5 determination. The notification must include an explanation of the individual's available
275.6 appeal rights and the status of any appeal. If a notice is given under this paragraph, the
275.7 government entity making the notification shall provide a copy of the notice to the individual
275.8 who is the subject of the notice.

275.9 (k) All not public data collected, maintained, used, or disseminated under this subdivision
275.10 and subdivision 3 may be exchanged between the Department of Human Services, Licensing
275.11 Division, and the Department of Corrections for purposes of regulating services for which
275.12 the Department of Human Services and the Department of Corrections have regulatory
275.13 authority.

275.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

275.15 Sec. 2. Minnesota Statutes 2023 Supplement, section 245A.03, subdivision 2, as amended
275.16 by Laws 2024, chapter 80, article 2, section 35, and Laws 2024, chapter 85, section 52, is
275.17 amended to read:

275.18 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

275.19 (1) residential or nonresidential programs that are provided to a person by an individual
275.20 who is related;

275.21 (2) nonresidential programs that are provided by an unrelated individual to persons from
275.22 a single related family;

275.23 (3) residential or nonresidential programs that are provided to adults who do not misuse
275.24 substances or have a substance use disorder, a mental illness, a developmental disability, a
275.25 functional impairment, or a physical disability;

275.26 (4) sheltered workshops or work activity programs that are certified by the commissioner
275.27 of employment and economic development;

275.28 (5) programs operated by a public school for children 33 months or older;

275.29 (6) nonresidential programs primarily for children that provide care or supervision for
275.30 periods of less than three hours a day while the child's parent or legal guardian is in the
275.31 same building as the nonresidential program or present within another building that is
275.32 directly contiguous to the building in which the nonresidential program is located;

- 276.1 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
276.2 under section 245A.02;
- 276.3 (8) board and lodge facilities licensed by the commissioner of health that do not provide
276.4 children's residential services under Minnesota Rules, chapter 2960, mental health or
276.5 substance use disorder treatment;
- 276.6 (9) programs licensed by the commissioner of corrections;
- 276.7 (10) recreation programs for children or adults that are operated or approved by a park
276.8 and recreation board whose primary purpose is to provide social and recreational activities;
- 276.9 (11) noncertified boarding care homes unless they provide services for five or more
276.10 persons whose primary diagnosis is mental illness or a developmental disability;
- 276.11 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
276.12 programs, and nonresidential programs for children provided for a cumulative total of less
276.13 than 30 days in any 12-month period;
- 276.14 (13) residential programs for persons with mental illness, that are located in hospitals;
- 276.15 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
276.16 4630;
- 276.17 (15) mental health outpatient services for adults with mental illness or children with
276.18 emotional disturbance;
- 276.19 (16) residential programs serving school-age children whose sole purpose is cultural or
276.20 educational exchange, until the commissioner adopts appropriate rules;
- 276.21 (17) community support services programs as defined in section 245.462, subdivision
276.22 6, and family community support services as defined in section 245.4871, subdivision 17;
- 276.23 (18) ~~settings registered under chapter 144G that provide home care services licensed by~~
276.24 ~~the commissioner of health to fewer than seven adults~~ assisted living facilities licensed by
276.25 the commissioner of health under chapter 144G;
- 276.26 (19) substance use disorder treatment activities of licensed professionals in private
276.27 practice as defined in section 245G.01, subdivision 17;
- 276.28 (20) consumer-directed community support service funded under the Medicaid waiver
276.29 for persons with developmental disabilities when the individual who provided the service
276.30 is:

277.1 (i) the same individual who is the direct payee of these specific waiver funds or paid by
277.2 a fiscal agent, fiscal intermediary, or employer of record; and

277.3 (ii) not otherwise under the control of a residential or nonresidential program that is
277.4 required to be licensed under this chapter when providing the service;

277.5 (21) a county that is an eligible vendor under section 254B.05 to provide care coordination
277.6 and comprehensive assessment services;

277.7 (22) a recovery community organization that is an eligible vendor under section 254B.05
277.8 to provide peer recovery support services; or

277.9 (23) programs licensed by the commissioner of children, youth, and families in chapter
277.10 142B.

277.11 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
277.12 building in which a nonresidential program is located if it shares a common wall with the
277.13 building in which the nonresidential program is located or is attached to that building by
277.14 skyway, tunnel, atrium, or common roof.

277.15 (c) Except for the home and community-based services identified in section 245D.03,
277.16 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
277.17 provided and funded according to an approved federal waiver plan where licensure is
277.18 specifically identified as not being a condition for the services and funding.

277.19 Sec. 3. Minnesota Statutes 2022, section 245A.04, is amended by adding a subdivision to
277.20 read:

277.21 **Subd. 7b. Notification to commissioner of changes in key staff positions; children's**
277.22 **residential facilities and detoxification programs.** (a) A license holder must notify the
277.23 commissioner within five business days of a change or vacancy in a key staff position under
277.24 paragraph (b) or (c). The license holder must notify the commissioner of the staffing change
277.25 on a form approved by the commissioner and include the name of the staff person now
277.26 assigned to the key staff position and the staff person's qualifications for the position. The
277.27 license holder must notify the program licensor of a vacancy to discuss how the duties of
277.28 the key staff position will be fulfilled during the vacancy.

277.29 (b) The key staff position for a children's residential facility licensed according to
277.30 Minnesota Rules, parts 2960.0130 to 2960.0220, is a program director; and

277.31 (c) The key staff positions for a detoxification program licensed according to Minnesota
277.32 Rules, parts 9530.6510 to 9530.6590, are:

- 278.1 (1) a program director as required by Minnesota Rules, part 9530.6560, subpart 1;
278.2 (2) a registered nurse as required by Minnesota Rules, part 9530.6560, subpart 4; and
278.3 (3) a medical director as required by Minnesota Rules, part 9530.6560, subpart 5.

278.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

278.5 Sec. 4. Minnesota Statutes 2022, section 245A.043, subdivision 2, is amended to read:

278.6 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change
278.7 in ownership, the commissioner shall require submission of a new license application. This
278.8 subdivision does not apply to a licensed program or service located in a home where the
278.9 license holder resides. A change in ownership occurs when:

278.10 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent
278.11 of the property, stock, or assets;

278.12 (2) the license holder merges with another organization;

278.13 (3) the license holder consolidates with two or more organizations, resulting in the
278.14 creation of a new organization;

278.15 (4) there is a change to the federal tax identification number associated with the license
278.16 holder; or

278.17 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for
278.18 the original ~~application~~ license have changed.

278.19 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses (1) and or (5), no change
278.20 in ownership has occurred and a new license application is not required if at least one
278.21 controlling individual has been listed affiliated as a controlling individual for the license
278.22 for at least the previous 12 months immediately preceding the change.

278.23 **EFFECTIVE DATE.** This section is effective January 1, 2025.

278.24 Sec. 5. Minnesota Statutes 2023 Supplement, section 245A.043, subdivision 3, is amended
278.25 to read:

278.26 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is
278.27 proposed and the party intends to assume operation without an interruption in service longer
278.28 than 60 days after acquiring the program or service, the license holder must provide the
278.29 commissioner with written notice of the proposed change on a form provided by the
278.30 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.

279.1 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that
279.2 intends to operate the service or program.

279.3 (b) The party must submit a license application under this chapter on the form and in
279.4 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in
279.5 ownership is anticipated to be complete; and must include documentation to support the
279.6 upcoming change. The party must comply with background study requirements under chapter
279.7 245C and shall pay the application fee required under section 245A.10.

279.8 (c) A party that intends to assume operation without an interruption in service longer
279.9 than 60 days after acquiring the program or service is exempt from the requirements of
279.10 sections 245G.03, subdivision 2, paragraph (b), and 254B.03, subdivision 2, paragraphs (c)
279.11 and (d).

279.12 ~~(e)~~ (d) The commissioner may streamline application procedures when the party is an
279.13 existing license holder under this chapter and is acquiring a program licensed under this
279.14 chapter or service in the same service class as one or more licensed programs or services
279.15 the party operates and those licenses are in substantial compliance. For purposes of this
279.16 subdivision, "substantial compliance" means within the previous 12 months the commissioner
279.17 did not (1) issue a sanction under section 245A.07 against a license held by the party, or
279.18 (2) make a license held by the party conditional according to section 245A.06.

279.19 ~~(d) Except when a temporary change in ownership license is issued pursuant to~~
279.20 ~~subdivision 4~~ (e) While the standard change of ownership process is pending, the existing
279.21 license holder ~~is solely~~ remains responsible for operating the program according to applicable
279.22 laws and rules until a license under this chapter is issued to the party.

279.23 ~~(e)~~ (f) If a licensing inspection of the program or service was conducted within the
279.24 previous 12 months and the existing license holder's license record demonstrates substantial
279.25 compliance with the applicable licensing requirements, the commissioner may waive the
279.26 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
279.27 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire
279.28 marshal deemed that an inspection was not warranted, and (2) proof that the premises was
279.29 inspected for compliance with the building code or that no inspection was deemed warranted.

279.30 ~~(f)~~ (g) If the party is seeking a license for a program or service that has an outstanding
279.31 action under section 245A.06 or 245A.07, the party must submit a ~~letter~~ written plan as part
279.32 of the application process identifying how the party has or will come into full compliance
279.33 with the licensing requirements.

280.1 ~~(g)~~ (h) The commissioner shall evaluate the party's application according to section
280.2 245A.04, subdivision 6. If the commissioner determines that the party has remedied or
280.3 demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07
280.4 and has determined that the program otherwise complies with all applicable laws and rules,
280.5 the commissioner shall issue a license or conditional license under this chapter. A conditional
280.6 license issued under this section is final and not subject to reconsideration under section
280.7 245A.06, subdivision 4. The conditional license remains in effect until the commissioner
280.8 determines that the grounds for the action are corrected or no longer exist.

280.9 ~~(h)~~ (i) The commissioner may deny an application as provided in section 245A.05. An
280.10 applicant whose application was denied by the commissioner may appeal the denial according
280.11 to section 245A.05.

280.12 ~~(i)~~ (j) This subdivision does not apply to a licensed program or service located in a home
280.13 where the license holder resides.

280.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

280.15 Sec. 6. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision
280.16 to read:

280.17 **Subd. 3a. Emergency change in ownership process.** (a) In the event of a death of a
280.18 license holder or sole controlling individual or a court order or other event that results in
280.19 the license holder being inaccessible or unable to operate the program or service, a party
280.20 may submit a request to the commissioner to allow the party to assume operation of the
280.21 program or service under an emergency change in ownership process to ensure persons
280.22 continue to receive services while the commissioner evaluates the party's license application.

280.23 (b) To request the emergency change of ownership process, the party must immediately:

280.24 (1) notify the commissioner of the event resulting in the inability of the license holder
280.25 to operate the program and of the party's intent to assume operations; and

280.26 (2) provide the commissioner with documentation that demonstrates the party has a legal
280.27 or legitimate ownership interest in the program or service if applicable and is able to operate
280.28 the program or service.

280.29 (c) If the commissioner approves the party to continue operating the program or service
280.30 under an emergency change in ownership process, the party must:

280.31 (1) request to be added as a controlling individual or license holder to the existing license;

281.1 (2) notify persons receiving services of the emergency change in ownership in a manner
281.2 approved by the commissioner;

281.3 (3) submit an application for a new license within 30 days of approval;

281.4 (4) comply with the background study requirements under chapter 245C; and

281.5 (5) pay the application fee required under section 245A.10.

281.6 (d) While the emergency change of ownership process is pending, a party approved
281.7 under this subdivision is responsible for operating the program under the existing license
281.8 according to applicable laws and rules until a new license under this chapter is issued.

281.9 (e) The provisions in subdivision 3, paragraphs (c), (d), and (f) to (i) apply to this
281.10 subdivision.

281.11 (f) Once a party is issued a new license or has decided not to seek a new license, the
281.12 commissioner must close the existing license.

281.13 (g) This subdivision applies to any program or service licensed under this chapter.

281.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

281.15 Sec. 7. Minnesota Statutes 2022, section 245A.043, subdivision 4, is amended to read:

281.16 Subd. 4. **Temporary change in ownership transitional license.** ~~(a) After receiving the~~
281.17 ~~party's application pursuant to subdivision 3, upon the written request of the existing license~~
281.18 ~~holder and the party, the commissioner may issue a temporary change in ownership license~~
281.19 ~~to the party while the commissioner evaluates the party's application. Until a decision is~~
281.20 ~~made to grant or deny a license under this chapter, the existing license holder and the party~~
281.21 ~~shall both be responsible for operating the program or service according to applicable laws~~
281.22 ~~and rules, and the sale or transfer of the existing license holder's ownership interest in the~~
281.23 ~~licensed program or service does not terminate the existing license.~~

281.24 ~~(b) The commissioner may issue a temporary change in ownership license when a license~~
281.25 ~~holder's death, divorce, or other event affects the ownership of the program and an applicant~~
281.26 ~~seeks to assume operation of the program or service to ensure continuity of the program or~~
281.27 ~~service while a license application is evaluated.~~

281.28 ~~(c) This subdivision applies to any program or service licensed under this chapter.~~

281.29 If a party's application under subdivision 2 is for a satellite license for a community
281.30 residential setting under section 245D.23 or day services facility under 245D.27 and if the
281.31 party already holds an active license to provide services under chapter 245D, the

282.1 commissioner may issue a temporary transitional license to the party for the community
282.2 residential setting or day services facility while the commissioner evaluates the party's
282.3 application. Until a decision is made to grant or deny a community residential setting or
282.4 day services facility satellite license, the party must be solely responsible for operating the
282.5 program according to applicable laws and rules, and the existing license must be closed.
282.6 The temporary transitional license expires after 12 months from the date it was issued or
282.7 upon issuance of the community residential setting or day services facility satellite license,
282.8 whichever occurs first.

282.9 **EFFECTIVE DATE.** This section is effective January 1, 2025.

282.10 Sec. 8. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision
282.11 to read:

282.12 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder
282.13 has not fully complied with this section, the commissioner may impose a licensing sanction
282.14 under section 245A.05, 245A.06, or 245A.07.

282.15 **EFFECTIVE DATE.** This section is effective January 1, 2025.

282.16 Sec. 9. Minnesota Statutes 2023 Supplement, section 245A.07, subdivision 1, as amended
282.17 by Laws 2024, chapter 80, article 2, section 44, is amended to read:

282.18 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
282.19 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,
282.20 or secure an injunction against the continuing operation of the program of a license holder
282.21 who does not comply with applicable law or rule. When applying sanctions authorized under
282.22 this section, the commissioner shall consider the nature, chronicity, or severity of the violation
282.23 of law or rule and the effect of the violation on the health, safety, or rights of persons served
282.24 by the program.

282.25 (b) If a license holder appeals the suspension or revocation of a license and the license
282.26 holder continues to operate the program pending a final order on the appeal, the commissioner
282.27 shall issue the license holder a temporary provisional license. The commissioner may include
282.28 terms the license holder must follow pending a final order on the appeal. Unless otherwise
282.29 specified by the commissioner, variances in effect on the date of the license sanction under
282.30 appeal continue under the temporary provisional license. If a license holder fails to comply
282.31 with applicable law or rule while operating under a temporary provisional license, the
282.32 commissioner may impose additional sanctions under this section and section 245A.06, and
282.33 may terminate any prior variance. If a temporary provisional license is set to expire, a new

283.1 temporary provisional license shall be issued to the license holder upon payment of any fee
283.2 required under section 245A.10. The temporary provisional license shall expire on the date
283.3 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional
283.4 license shall be issued for the remainder of the current license period.

283.5 (c) If a license holder is under investigation and the license issued under this chapter is
283.6 due to expire before completion of the investigation, the program shall be issued a new
283.7 license upon completion of the reapplication requirements and payment of any applicable
283.8 license fee. Upon completion of the investigation, a licensing sanction may be imposed
283.9 against the new license under this section, section 245A.06, or 245A.08.

283.10 (d) Failure to reapply or closure of a license issued under this chapter by the license
283.11 holder prior to the completion of any investigation shall not preclude the commissioner
283.12 from issuing a licensing sanction under this section or section 245A.06 at the conclusion
283.13 of the investigation.

283.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

283.15 Sec. 10. Minnesota Statutes 2022, section 245A.07, subdivision 6, is amended to read:

283.16 Subd. 6. **Appeal of multiple sanctions.** (a) When the license holder appeals more than
283.17 one licensing action or sanction that were simultaneously issued by the commissioner, the
283.18 license holder shall specify the actions or sanctions that are being appealed.

283.19 (b) If there are different timelines prescribed in statutes for the licensing actions or
283.20 sanctions being appealed, the license holder must submit the appeal within the longest of
283.21 those timelines specified in statutes.

283.22 (c) The appeal must be made in writing by certified mail ~~or~~, personal service, or through
283.23 the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent
283.24 to the commissioner within the prescribed timeline with the first day beginning the day after
283.25 the license holder receives the certified letter. If a request is made by personal service, it
283.26 must be received by the commissioner within the prescribed timeline with the first day
283.27 beginning the day after the license holder receives the certified letter. If the appeal is made
283.28 through the provider hub, the appeal must be received by the commissioner within the
283.29 prescribed timeline with the first day beginning the day after the commissioner issued the
283.30 order through the hub.

283.31 (d) When there are different timelines prescribed in statutes for the appeal of licensing
283.32 actions or sanctions simultaneously issued by the commissioner, the commissioner shall

284.1 specify in the notice to the license holder the timeline for appeal as specified under paragraph
284.2 (b).

284.3 Sec. 11. Minnesota Statutes 2023 Supplement, section 245A.11, subdivision 7, is amended
284.4 to read:

284.5 Subd. 7. **Adult foster care and community residential setting; variance for alternate**
284.6 **overnight supervision.** (a) The commissioner may grant a variance under section 245A.04,
284.7 subdivision 9, to statute or rule parts requiring a caregiver to be present in an adult foster
284.8 care home or a community residential setting during normal sleeping hours to allow for
284.9 alternative methods of overnight supervision. The commissioner may grant the variance if
284.10 the local county licensing agency recommends the variance and the county recommendation
284.11 includes documentation verifying that:

284.12 (1) the county has approved the license holder's plan for alternative methods of providing
284.13 overnight supervision and determined the plan protects the residents' health, safety, and
284.14 rights;

284.15 (2) the license holder has obtained written and signed informed consent from each
284.16 resident or each resident's legal representative documenting the resident's or legal
284.17 representative's agreement with the alternative method of overnight supervision; and

284.18 (3) the alternative method of providing overnight supervision, which may include the
284.19 use of technology, is specified for each resident in the resident's: (i) individualized plan of
284.20 care; (ii) ~~individual service~~ support plan under section 256B.092, subdivision 1b, if required;
284.21 or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,
284.22 subpart 19, if required.

284.23 (b) To be eligible for a variance under paragraph (a), the adult foster care or community
284.24 residential setting license holder must not have had a conditional license issued under section
284.25 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24
284.26 months based on failure to provide adequate supervision, health care services, or resident
284.27 safety in the adult foster care home or a community residential setting.

284.28 (c) A license holder requesting a variance under this subdivision to utilize technology
284.29 as a component of a plan for alternative overnight supervision may request the commissioner's
284.30 review in the absence of a county recommendation. Upon receipt of such a request from a
284.31 license holder, the commissioner shall review the variance request with the county.

284.32 ~~(d) The variance requirements under this subdivision for alternative overnight supervision~~
284.33 ~~do not apply to community residential settings licensed under chapter 245D.~~

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

285.2 Sec. 12. Minnesota Statutes 2023 Supplement, section 245A.16, subdivision 1, as amended
285.3 by Laws 2024, chapter 80, article 2, section 65, is amended to read:

285.4 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been
285.5 designated by the commissioner to perform licensing functions and activities under section
285.6 245A.04; to recommend denial of applicants under section 245A.05; to issue correction
285.7 orders, to issue variances, and recommend a conditional license under section 245A.06; or
285.8 to recommend suspending or revoking a license or issuing a fine under section 245A.07,
285.9 shall comply with rules and directives of the commissioner governing those functions and
285.10 with this section. The following variances are excluded from the delegation of variance
285.11 authority and may be issued only by the commissioner:

285.12 (1) dual licensure of family child foster care and family adult foster care, dual licensure
285.13 of child foster residence setting and community residential setting, and dual licensure of
285.14 family adult foster care and family child care;

285.15 (2) adult foster care or community residential setting maximum capacity;

285.16 (3) adult foster care or community residential setting minimum age requirement;

285.17 (4) child foster care maximum age requirement;

285.18 (5) variances regarding disqualified individuals;

285.19 (6) the required presence of a caregiver in the adult foster care residence during normal
285.20 sleeping hours;

285.21 (7) variances to requirements relating to chemical use problems of a license holder or a
285.22 household member of a license holder; and

285.23 (8) variances to section 142B.46 for the use of a cradleboard for a cultural
285.24 accommodation.

285.25 (b) For family adult day services programs, the commissioner may authorize licensing
285.26 reviews every two years after a licensee has had at least one annual review.

285.27 (c) A license issued under this section may be issued for up to two years.

285.28 (d) During implementation of chapter 245D, the commissioner shall consider:

285.29 (1) the role of counties in quality assurance;

285.30 (2) the duties of county licensing staff; and

286.1 (3) the possible use of joint powers agreements, according to section 471.59, with counties
286.2 through which some licensing duties under chapter 245D may be delegated by the
286.3 commissioner to the counties.

286.4 Any consideration related to this paragraph must meet all of the requirements of the corrective
286.5 action plan ordered by the federal Centers for Medicare and Medicaid Services.

286.6 (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or
286.7 successor provisions; and section 245D.061 or successor provisions, for family child foster
286.8 care programs providing out-of-home respite, as identified in section 245D.03, subdivision
286.9 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

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

286.11 Sec. 13. Minnesota Statutes 2023 Supplement, section 245A.211, subdivision 4, is amended
286.12 to read:

286.13 Subd. 4. **Contraindicated physical restraints.** A license or certification holder must
286.14 not implement a restraint on a person receiving services in a program in a way that is
286.15 contraindicated for any of the person's known medical or psychological conditions. Prior
286.16 to using restraints on a person, ~~the license or certification holder must assess and document~~
286.17 ~~a determination of any~~ with a known medical or psychological conditions that restraints are
286.18 contraindicated for, the license or certification holder must document the contraindication
286.19 and the type of restraints that will not be used on the person based on this determination.

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

286.21 Sec. 14. Minnesota Statutes 2023 Supplement, section 245A.242, subdivision 2, is amended
286.22 to read:

286.23 Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply
286.24 of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency
286.25 treatment of opioid overdose and must have a written standing order protocol by a physician
286.26 who is licensed under chapter 147, advanced practice registered nurse who is licensed under
286.27 chapter 148, or physician assistant who is licensed under chapter 147A, that permits the
286.28 license holder to maintain a supply of opiate antagonists on site. A license holder must
286.29 require staff to undergo training in the specific mode of administration used at the program,
286.30 which may include intranasal administration, intramuscular injection, or both.

286.31 (b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960
286.32 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

287.1 (1) emergency opiate antagonist medications are not required to be stored in a locked
287.2 area and staff and adult clients may carry this medication on them and store it in an unlocked
287.3 location;

287.4 (2) staff persons who only administer emergency opiate antagonist medications only
287.5 require the training required by paragraph (a), which any knowledgeable trainer may provide.
287.6 The trainer is not required to be a registered nurse or part of an accredited educational
287.7 institution; and

287.8 (3) nonresidential substance use disorder treatment programs that do not administer
287.9 client medications beyond emergency opiate antagonist medications are not required to
287.10 have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and
287.11 must instead describe the program's procedures for administering opiate antagonist
287.12 medications in the license holder's description of health care services under section 245G.08,
287.13 subdivision 1.

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

287.15 Sec. 15. Minnesota Statutes 2022, section 245A.52, subdivision 2, is amended to read:

287.16 Subd. 2. **Door to attached garage.** ~~Notwithstanding Minnesota Rules, part 9502.0425,~~
287.17 ~~subpart 5, day care residences with an attached garage are not required to have a self-closing~~
287.18 ~~door to the residence. The door to the residence may be~~ (a) If there is an opening between
287.19 an attached garage and a day care residence, there must be a door that is:

287.20 (1) a solid wood bonded-core door at least 1-3/8 inches thick;

287.21 (2) a steel insulated door if the door is at least 1-3/8 inches thick; or

287.22 (3) a door with a fire protection rating of 20 minutes.

287.23 (b) The separation wall on the garage side between the residence and garage must consist
287.24 of 1/2-inch-thick gypsum wallboard or its equivalent.

287.25 Sec. 16. Minnesota Statutes 2023 Supplement, section 245C.02, subdivision 13e, is
287.26 amended to read:

287.27 Subd. 13e. **NETStudy 2.0.** (a) "NETStudy 2.0" means the commissioner's system that
287.28 replaces both NETStudy and the department's internal background study processing system.
287.29 NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by
287.30 improving the accuracy of background studies through fingerprint-based criminal record
287.31 checks and expanding the background studies to include a review of information from the

288.1 Minnesota Court Information System and the national crime information database. NETStudy
288.2 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

288.3 (1) providing access to and updates from public web-based data related to employment
288.4 eligibility;

288.5 (2) decreasing the need for repeat studies through electronic updates of background
288.6 study subjects' criminal records;

288.7 (3) supporting identity verification using subjects' Social Security numbers and
288.8 photographs;

288.9 (4) using electronic employer notifications;

288.10 (5) issuing immediate verification of subjects' eligibility to provide services as more
288.11 studies are completed under the NETStudy 2.0 system; and

288.12 (6) providing electronic access to certain notices for entities and background study
288.13 subjects.

288.14 (b) Information obtained by entities from public web-based data through NETStudy 2.0
288.15 under paragraph (a), clause (1), or any other source that is not direct correspondence from
288.16 the commissioner is not a notice of disqualification from the commissioner under this
288.17 chapter.

288.18 Sec. 17. Minnesota Statutes 2023 Supplement, section 245C.033, subdivision 3, is amended
288.19 to read:

288.20 Subd. 3. **Procedure; maltreatment and state licensing agency data.** (a) For requests
288.21 paid directly by the guardian or conservator, requests for maltreatment and state licensing
288.22 agency data checks must be submitted by the guardian or conservator to the commissioner
288.23 on the form or in the manner prescribed by the commissioner. Upon receipt of a signed
288.24 informed consent and payment under section 245C.10, the commissioner shall complete
288.25 the maltreatment and state licensing agency checks. Upon completion of the checks, the
288.26 commissioner shall provide the requested information to the courts on the form or in the
288.27 manner prescribed by the commissioner.

288.28 (b) For requests paid by the court based on the in forma pauperis status of the guardian
288.29 or conservator, requests for maltreatment and state licensing agency data checks must be
288.30 submitted by the court to the commissioner on the form or in the manner prescribed by the
288.31 commissioner. The form will serve as certification that the individual has been granted in
288.32 forma pauperis status. Upon receipt of a signed data request consent form from the court,

289.1 the commissioner shall initiate the maltreatment and state licensing agency checks. Upon
289.2 completion of the checks, the commissioner shall provide the requested information to the
289.3 courts on the form or in the manner prescribed by the commissioner.

289.4 Sec. 18. [245C.041] EMERGENCY WAIVER TO TEMPORARILY MODIFY
289.5 BACKGROUND STUDY REQUIREMENTS.

289.6 (a) In the event of an emergency identified by the commissioner, the commissioner may
289.7 temporarily waive or modify provisions in this chapter, except that the commissioner shall
289.8 not waive or modify:

289.9 (1) disqualification standards in section 245C.14 or 245C; or

289.10 (2) any provision regarding the scope of individuals required to be subject to a background
289.11 study conducted under this chapter.

289.12 (b) For the purposes of this section, an emergency may include, but is not limited to a
289.13 public health emergency, environmental emergency, natural disaster, or other unplanned
289.14 event that the commissioner has determined prevents the requirements in this chapter from
289.15 being met. This authority shall not exceed the amount of time needed to respond to the
289.16 emergency and reinstate the requirements of this chapter. The commissioner has the authority
289.17 to establish the process and time frame for returning to full compliance with this chapter.
289.18 The commissioner shall determine the length of time an emergency study is valid.

289.19 (c) At the conclusion of the emergency, entities must submit a new, compliant background
289.20 study application and fee for each individual who was the subject of background study
289.21 affected by the powers created in this section, referred to as an "emergency study" to have
289.22 a new study that fully complies with this chapter within a time frame and notice period
289.23 established by the commissioner.

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

289.25 Sec. 19. Minnesota Statutes 2022, section 245C.05, subdivision 5, is amended to read:

289.26 Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph ~~(b)~~ (c), for
289.27 background studies conducted by the commissioner for child foster care, children's residential
289.28 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the
289.29 subject of the background study, who is 18 years of age or older, shall provide the
289.30 commissioner with a set of classifiable fingerprints obtained from an authorized agency for
289.31 a national criminal history record check.

290.1 (b) Notwithstanding paragraph (c), for background studies conducted by the commissioner
290.2 for Head Start programs, the subject of the background study shall provide the commissioner
290.3 with a set of classifiable fingerprints obtained from an authorized agency for a national
290.4 criminal history record check.

290.5 ~~(b)~~ (c) For background studies initiated on or after the implementation of NETStudy
290.6 2.0, except as provided under subdivision 5a, every subject of a background study must
290.7 provide the commissioner with a set of the background study subject's classifiable fingerprints
290.8 and photograph. The photograph and fingerprints must be recorded at the same time by the
290.9 authorized fingerprint collection vendor or vendors and sent to the commissioner through
290.10 the commissioner's secure data system described in section 245C.32, subdivision 1a,
290.11 paragraph (b).

290.12 ~~(e)~~ (d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
290.13 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
290.14 Investigation for a national criminal history record check.

290.15 ~~(d)~~ (e) The fingerprints must not be retained by the Department of Public Safety, Bureau
290.16 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
290.17 not retain background study subjects' fingerprints.

290.18 ~~(e)~~ (f) The authorized fingerprint collection vendor or vendors shall, for purposes of
290.19 verifying the identity of the background study subject, be able to view the identifying
290.20 information entered into NETStudy 2.0 by the entity that initiated the background study,
290.21 but shall not retain the subject's fingerprints, photograph, or information from NETStudy
290.22 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the
290.23 name and date and time the subject's fingerprints were recorded and sent, only as necessary
290.24 for auditing and billing activities.

290.25 ~~(f)~~ (g) For any background study conducted under this chapter, the subject shall provide
290.26 the commissioner with a set of classifiable fingerprints when the commissioner has reasonable
290.27 cause to require a national criminal history record check as defined in section 245C.02,
290.28 subdivision 15a.

290.29 Sec. 20. Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 1, is amended
290.30 to read:

290.31 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)
290.32 For a background study conducted by the Department of Human Services, the commissioner
290.33 shall review:

291.1 (1) information related to names of substantiated perpetrators of maltreatment of
291.2 vulnerable adults that has been received by the commissioner as required under section
291.3 626.557, subdivision 9c, paragraph (j);

291.4 (2) the commissioner's records relating to the maltreatment of minors in licensed
291.5 programs, and from findings of maltreatment of minors as indicated through the social
291.6 service information system;

291.7 (3) information from juvenile courts as required ~~in subdivision 4 for individuals listed~~
291.8 ~~in section 245C.03, subdivision 1, paragraph (a),~~ for studies under this chapter when there
291.9 is reasonable cause;

291.10 (4) information from the Bureau of Criminal Apprehension, including information
291.11 regarding a background study subject's registration in Minnesota as a predatory offender
291.12 under section 243.166;

291.13 (5) except as provided in clause (6), information received as a result of submission of
291.14 fingerprints for a national criminal history record check, as defined in section 245C.02,
291.15 subdivision 13c, when the commissioner has reasonable cause for a national criminal history
291.16 record check as defined under section 245C.02, subdivision 15a, or as required under section
291.17 144.057, subdivision 1, clause (2);

291.18 (6) for a background study related to a child foster family setting application for licensure,
291.19 foster residence settings, children's residential facilities, a transfer of permanent legal and
291.20 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a
291.21 background study required for family child care, certified license-exempt child care, child
291.22 care centers, and legal nonlicensed child care authorized under chapter 119B, the
291.23 commissioner shall also review:

291.24 (i) information from the child abuse and neglect registry for any state in which the
291.25 background study subject has resided for the past five years;

291.26 (ii) when the background study subject is 18 years of age or older, or a minor under
291.27 section 245C.05, subdivision 5a, paragraph (c), information received following submission
291.28 of fingerprints for a national criminal history record check; and

291.29 (iii) when the background study subject is 18 years of age or older or a minor under
291.30 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified
291.31 license-exempt child care, licensed child care centers, and legal nonlicensed child care
291.32 authorized under chapter 119B, information obtained using non-fingerprint-based data
291.33 including information from the criminal and sex offender registries for any state in which

292.1 the background study subject resided for the past five years and information from the national
292.2 crime information database and the national sex offender registry;

292.3 (7) for a background study required for family child care, certified license-exempt child
292.4 care centers, licensed child care centers, and legal nonlicensed child care authorized under
292.5 chapter 119B, the background study shall also include, to the extent practicable, a name
292.6 and date-of-birth search of the National Sex Offender Public website; and

292.7 (8) for a background study required for treatment programs for sexual psychopathic
292.8 personalities or sexually dangerous persons, the background study shall only include a
292.9 review of the information required under paragraph (a), clauses (1) to (4).

292.10 (b) Except as otherwise provided in this paragraph, notwithstanding expungement by a
292.11 court, the commissioner may consider information obtained under paragraph (a), clauses
292.12 (3) and (4), unless:

292.13 (1) the commissioner received notice of the petition for expungement and the court order
292.14 for expungement is directed specifically to the commissioner; or

292.15 (2) the commissioner received notice of the expungement order issued pursuant to section
292.16 609A.017, 609A.025, or 609A.035, and the order for expungement is directed specifically
292.17 to the commissioner.

292.18 The commissioner may not consider information obtained under paragraph (a), clauses (3)
292.19 and (4), or from any other source that identifies a violation of chapter 152 without
292.20 determining if the offense involved the possession of marijuana or tetrahydrocannabinol
292.21 and, if so, whether the person received a grant of expungement or order of expungement,
292.22 or the person was resentenced to a lesser offense. If the person received a grant of
292.23 expungement or order of expungement, the commissioner may not consider information
292.24 related to that violation but may consider any other relevant information arising out of the
292.25 same incident.

292.26 (c) The commissioner shall also review criminal case information received according
292.27 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates
292.28 to individuals who have already been studied under this chapter and who remain affiliated
292.29 with the agency that initiated the background study.

292.30 (d) When the commissioner has reasonable cause to believe that the identity of a
292.31 background study subject is uncertain, the commissioner may require the subject to provide
292.32 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check
292.33 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph

293.1 shall not be saved by the commissioner after they have been used to verify the identity of
293.2 the background study subject against the particular criminal record in question.

293.3 (e) The commissioner may inform the entity that initiated a background study under
293.4 NETStudy 2.0 of the status of processing of the subject's fingerprints.

293.5 Sec. 21. Minnesota Statutes 2022, section 245C.08, subdivision 4, is amended to read:

293.6 Subd. 4. **Juvenile court records.** (a) For a background study conducted by the
293.7 Department of Human Services, the commissioner shall review records from the juvenile
293.8 courts for an individual studied under ~~section 245C.03, subdivision 1, paragraph (a),~~ this
293.9 chapter when the commissioner has reasonable cause.

293.10 ~~(b) For a background study conducted by a county agency for family child care before~~
293.11 ~~the implementation of NETStudy 2.0, the commissioner shall review records from the~~
293.12 ~~juvenile courts for individuals listed in section 245C.03, subdivision 1, who are ages 13~~
293.13 ~~through 23 living in the household where the licensed services will be provided. The~~
293.14 ~~commissioner shall also review records from juvenile courts for any other individual listed~~
293.15 ~~under section 245C.03, subdivision 1, when the commissioner has reasonable cause.~~

293.16 ~~(e)~~ (b) The juvenile courts shall help with the study by giving the commissioner existing
293.17 juvenile court records relating to delinquency proceedings held on individuals ~~described in~~
293.18 ~~section 245C.03, subdivision 1, paragraph (a),~~ who are subjects of studies under this chapter
293.19 when requested pursuant to this subdivision.

293.20 ~~(d)~~ (c) For purposes of this chapter, a finding that a delinquency petition is proven in
293.21 juvenile court shall be considered a conviction in state district court.

293.22 ~~(e)~~ (d) Juvenile courts shall provide orders of involuntary and voluntary termination of
293.23 parental rights under section 260C.301 to the commissioner upon request for purposes of
293.24 conducting a background study under this chapter.

293.25 Sec. 22. Minnesota Statutes 2023 Supplement, section 245C.10, subdivision 15, is amended
293.26 to read:

293.27 Subd. 15. **Guardians and conservators.** (a) The commissioner shall recover the cost
293.28 of conducting maltreatment and state licensing agency checks for guardians and conservators
293.29 under section 245C.033 through a fee of no more than \$50. The fees collected under this
293.30 subdivision are appropriated to the commissioner for the purpose of conducting maltreatment
293.31 and state licensing agency checks.

294.1 (b) The fee must be paid directly to and in the manner prescribed by the commissioner
294.2 before any maltreatment and state licensing agency checks under section 245C.033 may be
294.3 conducted.

294.4 (c) Notwithstanding paragraph (b), the court shall pay the fee for an applicant who has
294.5 been granted in forma pauperis status upon receipt of the invoice from the commissioner.

294.6 Sec. 23. Minnesota Statutes 2022, section 245C.10, subdivision 18, is amended to read:

294.7 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**
294.8 **of health.** The applicant or license holder is responsible for paying to the Department of
294.9 Human Services all fees associated with the preparation of the fingerprints, the criminal
294.10 records check consent form, and, through a fee of no more than \$44 per study, the criminal
294.11 background check.

294.12 Sec. 24. Minnesota Statutes 2022, section 245C.14, is amended by adding a subdivision
294.13 to read:

294.14 Subd. 5. **Basis for disqualification.** Information obtained by entities from public
294.15 web-based data through NETStudy 2.0 or any other source that is not direct correspondence
294.16 from the commissioner is not a notice of disqualification from the commissioner under this
294.17 chapter.

294.18 Sec. 25. Minnesota Statutes 2022, section 245C.22, subdivision 4, is amended to read:

294.19 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification
294.20 if the commissioner finds that the individual has submitted sufficient information to
294.21 demonstrate that the individual does not pose a risk of harm to any person served by the
294.22 applicant, license holder, or other entities as provided in this chapter.

294.23 (b) In determining whether the individual has met the burden of proof by demonstrating
294.24 the individual does not pose a risk of harm, the commissioner shall consider:

294.25 (1) the nature, severity, and consequences of the event or events that led to the
294.26 disqualification;

294.27 (2) whether there is more than one disqualifying event;

294.28 (3) the age and vulnerability of the victim at the time of the event;

294.29 (4) the harm suffered by the victim;

294.30 (5) vulnerability of persons served by the program;

295.1 (6) the similarity between the victim and persons served by the program;

295.2 (7) the time elapsed without a repeat of the same or similar event;

295.3 (8) documentation of successful completion by the individual studied of training or
295.4 rehabilitation pertinent to the event; and

295.5 (9) any other information relevant to reconsideration.

295.6 (c) For an individual seeking a child foster care license who is a relative of the child,
295.7 the commissioner shall consider the importance of maintaining the child's relationship with
295.8 relatives as an additional significant factor in determining whether a background study
295.9 disqualification should be set aside.

295.10 ~~(e)~~ (d) If the individual requested reconsideration on the basis that the information relied
295.11 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines
295.12 that the information relied upon to disqualify the individual is correct, the commissioner
295.13 must also determine if the individual poses a risk of harm to persons receiving services in
295.14 accordance with paragraph (b).

295.15 ~~(d)~~ (e) For an individual seeking employment in the substance use disorder treatment
295.16 field, the commissioner shall set aside the disqualification if the following criteria are met:

295.17 (1) the individual is not disqualified for a crime of violence as listed under section
295.18 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021,
295.19 subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

295.20 (2) the individual is not disqualified under section 245C.15, subdivision 1;

295.21 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph
295.22 (b);

295.23 (4) the individual provided documentation of successful completion of treatment, at least
295.24 one year prior to the date of the request for reconsideration, at a program licensed under
295.25 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after
295.26 the successful completion of treatment;

295.27 (5) the individual provided documentation demonstrating abstinence from controlled
295.28 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to
295.29 the date of the request for reconsideration; and

295.30 (6) the individual is seeking employment in the substance use disorder treatment field.

296.1 Sec. 26. Minnesota Statutes 2022, section 245C.24, subdivision 2, is amended to read:

296.2 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
296.3 paragraphs (b) to ~~(f)~~ (g), the commissioner may not set aside the disqualification of any
296.4 individual disqualified pursuant to this chapter, regardless of how much time has passed,
296.5 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
296.6 1.

296.7 (b) For an individual in the substance use disorder or corrections field who was
296.8 disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose
296.9 disqualification was set aside prior to July 1, 2005, the commissioner must consider granting
296.10 a variance pursuant to section 245C.30 for the license holder for a program dealing primarily
296.11 with adults. A request for reconsideration evaluated under this paragraph must include a
296.12 letter of recommendation from the license holder that was subject to the prior set-aside
296.13 decision addressing the individual's quality of care to children or vulnerable adults and the
296.14 circumstances of the individual's departure from that service.

296.15 (c) If an individual who requires a background study for nonemergency medical
296.16 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
296.17 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
296.18 passed since the discharge of the sentence imposed, the commissioner may consider granting
296.19 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
296.20 paragraph must include a letter of recommendation from the employer. This paragraph does
296.21 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
296.22 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
296.23 clause (1); 617.246; or 617.247.

296.24 (d) When a licensed foster care provider adopts an individual who had received foster
296.25 care services from the provider for over six months, and the adopted individual is required
296.26 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
296.27 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
296.28 to permit the adopted individual with a permanent disqualification to remain affiliated with
296.29 the license holder under the conditions of the variance when the variance is recommended
296.30 by the county of responsibility for each of the remaining individuals in placement in the
296.31 home and the licensing agency for the home.

296.32 (e) For an individual 18 years of age or older affiliated with a licensed family foster
296.33 setting, the commissioner must not set aside or grant a variance for the disqualification of
296.34 any individual disqualified pursuant to this chapter, regardless of how much time has passed,

297.1 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
297.2 4a, paragraphs (a) and (b).

297.3 (f) In connection with a family foster setting license, the commissioner may grant a
297.4 variance to the disqualification for an individual who is under 18 years of age at the time
297.5 the background study is submitted.

297.6 (g) In connection with foster residence settings and children's residential facilities, the
297.7 commissioner must not set aside or grant a variance for the disqualification of any individual
297.8 disqualified pursuant to this chapter, regardless of how much time has passed, if the individual
297.9 was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph
297.10 (a) or (b).

297.11 Sec. 27. Minnesota Statutes 2022, section 245C.24, subdivision 5, is amended to read:

297.12 Subd. 5. **Five-year bar to set aside or variance disqualification; children's residential**
297.13 **facilities, foster residence settings.** The commissioner shall not set aside or grant a variance
297.14 for the disqualification of an individual in connection with a license for a children's residential
297.15 facility or foster residence setting who was convicted of a felony within the past five years
297.16 for: (1) physical assault or battery; or (2) a drug-related offense.

297.17 Sec. 28. Minnesota Statutes 2022, section 245C.24, subdivision 6, is amended to read:

297.18 Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The
297.19 commissioner shall not set aside or grant a variance for the disqualification of an individual
297.20 18 years of age or older in connection with a foster family setting license if within five years
297.21 preceding the study the individual is convicted of a felony in section 245C.15, subdivision
297.22 4a, paragraph (d).

297.23 (b) In connection with a foster family setting license, the commissioner may set aside
297.24 or grant a variance to the disqualification for an individual who is under 18 years of age at
297.25 the time the background study is submitted.

297.26 (c) In connection with a foster family setting license, the commissioner may set aside
297.27 or grant a variance to the disqualification for an individual who is under 18 years of age at
297.28 the time the background study is submitted.

298.1 Sec. 29. Minnesota Statutes 2022, section 245C.30, is amended by adding a subdivision
298.2 to read:

298.3 Subd. 1b. **Child foster care variances.** For an individual seeking a child foster care
298.4 license who is a relative of the child, the commissioner shall consider the importance of
298.5 maintaining the child's relationship with relatives as an additional significant factor in
298.6 determining whether the individual should be granted a variance.

298.7 Sec. 30. Minnesota Statutes 2022, section 245F.09, subdivision 2, is amended to read:

298.8 Subd. 2. **Protective procedures plan.** A license holder must have a written policy and
298.9 procedure that establishes the protective procedures that program staff must follow when
298.10 a patient is in imminent danger of harming self or others. The policy must be appropriate
298.11 to the type of facility and the level of staff training. The protective procedures policy must
298.12 include:

298.13 (1) an approval signed and dated by the program director and medical director prior to
298.14 implementation. Any changes to the policy must also be approved, signed, and dated by the
298.15 current program director and the medical director prior to implementation;

298.16 (2) which protective procedures the license holder will use to prevent patients from
298.17 imminent danger of harming self or others;

298.18 (3) the emergency conditions under which the protective procedures are permitted to be
298.19 used, if any;

298.20 (4) the patient's health conditions that limit the specific procedures that may be used and
298.21 alternative means of ensuring safety;

298.22 (5) emergency resources the program staff must contact when a patient's behavior cannot
298.23 be controlled by the procedures established in the policy;

298.24 (6) the training that staff must have before using any protective procedure;

298.25 (7) documentation of approved therapeutic holds;

298.26 (8) the use of law enforcement personnel as described in subdivision 4;

298.27 (9) standards governing emergency use of seclusion. Seclusion must be used only when
298.28 less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii)
298.29 must be met when seclusion is used with a patient:

298.30 (i) seclusion must be employed solely for the purpose of preventing a patient from
298.31 imminent danger of harming self or others;

299.1 (ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm
299.2 using projections, windows, electrical fixtures, or hard objects, and must allow the patient
299.3 to be readily observed without being interrupted;

299.4 (iii) seclusion must be authorized by the program director, a licensed physician, a
299.5 registered nurse, or a licensed physician assistant. If one of these individuals is not present
299.6 in the facility, the program director or a licensed physician, registered nurse, or physician
299.7 assistant must be contacted and authorization must be obtained within 30 minutes of initiating
299.8 seclusion, according to written policies;

299.9 (iv) patients must not be placed in seclusion for more than 12 hours at any one time;

299.10 (v) once the condition of a patient in seclusion has been determined to be safe enough
299.11 to end continuous observation, a patient in seclusion must be observed at a minimum of
299.12 every 15 minutes for the duration of seclusion and must always be within hearing range of
299.13 program staff;

299.14 (vi) a process for program staff to use to remove a patient to other resources available
299.15 to the facility if seclusion does not sufficiently assure patient safety; and

299.16 (vii) a seclusion area may be used for other purposes, such as intensive observation, if
299.17 the room meets normal standards of care for the purpose and if the room is not locked; and

299.18 (10) physical holds may only be used when less restrictive measures are not feasible.
299.19 The standards in items (i) to (iv) must be met when physical holds are used with a patient:

299.20 (i) physical holds must be employed solely for preventing a patient from imminent
299.21 danger of harming self or others;

299.22 (ii) physical holds must be authorized by the program director, a licensed physician, a
299.23 registered nurse, or a physician assistant. If one of these individuals is not present in the
299.24 facility, the program director or a licensed physician, registered nurse, or physician assistant
299.25 must be contacted and authorization must be obtained within 30 minutes of initiating a
299.26 physical hold, according to written policies;

299.27 (iii) the patient's health concerns must be considered in deciding whether to use physical
299.28 holds and which holds are appropriate for the patient; and

299.29 (iv) only approved holds may be utilized. Prone and contraindicated holds are not allowed
299.30 according to section 245A.211 and must not be authorized.

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

300.1 Sec. 31. Minnesota Statutes 2022, section 245F.14, is amended by adding a subdivision
300.2 to read:

300.3 Subd. 8. Notification to commissioner of changes in key staff positions. A license
300.4 holder must notify the commissioner within five business days of a change or vacancy in a
300.5 key staff position. The key positions are a program director as required by subdivision 1, a
300.6 registered nurse as required by subdivision 4, and a medical director as required by
300.7 subdivision 5. The license holder must notify the commissioner of the staffing change on
300.8 a form approved by the commissioner and include the name of the staff person now assigned
300.9 to the key staff position and the staff person's qualifications for the position. The license
300.10 holder must notify the program licenser of a vacancy to discuss how the duties of the key
300.11 staff position will be fulfilled during the vacancy.

300.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

300.13 Sec. 32. Minnesota Statutes 2022, section 245F.17, is amended to read:

300.14 **245F.17 PERSONNEL FILES.**

300.15 A license holder must maintain a separate personnel file for each staff member. At a
300.16 minimum, the file must contain:

300.17 (1) a completed application for employment signed by the staff member that contains
300.18 the staff member's qualifications for employment and documentation related to the applicant's
300.19 background study data, as defined in chapter 245C;

300.20 (2) documentation of the staff member's current professional license or registration, if
300.21 relevant;

300.22 (3) documentation of orientation and subsequent training; and

300.23 ~~(4) documentation of a statement of freedom from substance use problems; and~~

300.24 ~~(5) (4) an annual job performance evaluation.~~

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

300.26 Sec. 33. Minnesota Statutes 2022, section 245G.07, subdivision 4, is amended to read:

300.27 ~~Subd. 4. Location of service provision. The license holder may provide services at any~~
300.28 ~~of the license holder's licensed locations or at another suitable location including a school,~~
300.29 ~~government building, medical or behavioral health facility, or social service organization,~~
300.30 ~~upon notification and approval of the commissioner. If services are provided off site from~~
300.31 ~~the licensed site, the reason for the provision of services remotely must be documented.~~

301.1 ~~The license holder may provide additional services under subdivision 2, clauses (2) to (5),~~
301.2 ~~off-site if the license holder includes a policy and procedure detailing the off-site location~~
301.3 ~~as a part of the treatment service description and the program abuse prevention plan.~~

301.4 (a) The license holder must provide all treatment services a client receives at one of the
301.5 license holder's substance use disorder treatment licensed locations or at a location allowed
301.6 under paragraphs (b) to (f). If the services are provided at the locations in paragraphs (b) to
301.7 (d), the license holder must document in the client record the location services were provided.

301.8 (b) The license holder may provide nonresidential individual treatment services at a
301.9 client's home or place of residence.

301.10 (c) If the license holder provides treatment services by telehealth, the services must be
301.11 provided according to this paragraph:

301.12 (1) the license holder must maintain a licensed physical location in Minnesota where
301.13 the license holder must offer all treatment services in subdivision 1, paragraph (a), clauses
301.14 (1) to (4), physically in-person to each client;

301.15 (2) the license holder must meet all requirements for the provision of telehealth in sections
301.16 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder
301.17 must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client
301.18 receiving services by telehealth, regardless of payment type or whether the client is a medical
301.19 assistance enrollee;

301.20 (3) the license holder may provide treatment services by telehealth to clients individually;

301.21 (4) the license holder may provide treatment services by telehealth to a group of clients
301.22 that are each in a separate physical location;

301.23 (5) the license holder must not provide treatment services remotely by telehealth to a
301.24 group of clients meeting together in person, unless permitted under clause (7);

301.25 (6) clients and staff may join an in-person group by telehealth if a staff member qualified
301.26 to provide the treatment service is physically present with the group of clients meeting
301.27 together in person; and

301.28 (7) the qualified professional providing a residential group treatment service by telehealth
301.29 must be physically present on-site at the licensed residential location while the service is
301.30 being provided. If weather conditions prohibit a qualified professional from traveling to the
301.31 residential program and another qualified professional is not available to provide the service,
301.32 a qualified professional may provide a residential group treatment service by telehealth
301.33 from a location away from the licensed residential location.

302.1 (d) The license holder may provide the additional treatment services under subdivision
302.2 2, clauses (2) to (6) and (8), away from the licensed location at a suitable location appropriate
302.3 to the treatment service.

302.4 (e) Upon written approval from the commissioner for each satellite location, the license
302.5 holder may provide nonresidential treatment services at satellite locations that are in a
302.6 school, jail, or nursing home. A satellite location may only provide services to students of
302.7 the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing
302.8 homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to
302.9 document compliance with building codes, fire and safety codes, health rules, and zoning
302.10 ordinances.

302.11 (f) The commissioner may approve other suitable locations as satellite locations for
302.12 nonresidential treatment services. The commissioner may require satellite locations under
302.13 this paragraph to meet all applicable licensing requirements. The license holder may not
302.14 have more than two satellite locations per license under this paragraph.

302.15 (g) The license holder must provide the commissioner access to all files, documentation,
302.16 staff persons, and any other information the commissioner requires at the main licensed
302.17 location for all clients served at any location under paragraphs (b) to (f).

302.18 (h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a
302.19 program abuse prevention plan is not required for satellite or other locations under paragraphs
302.20 (b) to (e). An individual abuse prevention plan is still required for any client that is a
302.21 vulnerable adult as defined in section 626.5572, subdivision 21.

302.22 **EFFECTIVE DATE.** This section is effective January 1, 2025.

302.23 Sec. 34. Minnesota Statutes 2022, section 245G.08, subdivision 5, is amended to read:

302.24 **Subd. 5. Administration of medication and assistance with self-medication.** (a) A
302.25 license holder must meet the requirements in this subdivision if a service provided includes
302.26 the administration of medication.

302.27 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
302.28 licensed practitioner or a registered nurse the task of administration of medication or assisting
302.29 with self-medication, must:

302.30 (1) successfully complete a medication administration training program for unlicensed
302.31 personnel through an accredited Minnesota postsecondary educational institution. A staff
302.32 member's completion of the course must be documented in writing and placed in the staff
302.33 member's personnel file;

303.1 (2) be trained according to a formalized training program that is taught by a registered
303.2 nurse and offered by the license holder. ~~The training must include the process for~~
303.3 ~~administration of naloxone, if naloxone is kept on-site.~~ A staff member's completion of the
303.4 training must be documented in writing and placed in the staff member's personnel records;
303.5 or

303.6 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
303.7 registered nurse must be employed or contracted to develop the policies and procedures for
303.8 administration of medication or assisting with self-administration of medication, or both.

303.9 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
303.10 23. The registered nurse's supervision must include, at a minimum, monthly on-site
303.11 supervision or more often if warranted by a client's health needs. The policies and procedures
303.12 must include:

303.13 (1) a provision that a delegation of administration of medication is limited to a method
303.14 a staff member has been trained to administer and limited to:

303.15 (i) a medication that is administered orally, topically, or as a suppository, an eye drop,
303.16 an ear drop, an inhalant, or an intranasal; and

303.17 (ii) an intramuscular injection of ~~naloxone~~ an opiate antagonist as defined in section
303.18 604A.04, subdivision 1, or epinephrine;

303.19 (2) a provision that each client's file must include documentation indicating whether
303.20 staff must conduct the administration of medication or the client must self-administer
303.21 medication, or both;

303.22 (3) a provision that a client may carry emergency medication such as nitroglycerin as
303.23 instructed by the client's physician, advanced practice registered nurse, or physician assistant;

303.24 (4) a provision for the client to self-administer medication when a client is scheduled to
303.25 be away from the facility;

303.26 (5) a provision that if a client self-administers medication when the client is present in
303.27 the facility, the client must self-administer medication under the observation of a trained
303.28 staff member;

303.29 (6) a provision that when a license holder serves a client who is a parent with a child,
303.30 the parent may only administer medication to the child under a staff member's supervision;

303.31 (7) requirements for recording the client's use of medication, including staff signatures
303.32 with date and time;

304.1 (8) guidelines for when to inform a nurse of problems with self-administration of
304.2 medication, including a client's failure to administer, refusal of a medication, adverse
304.3 reaction, or error; and

304.4 (9) procedures for acceptance, documentation, and implementation of a prescription,
304.5 whether written, verbal, telephonic, or electronic.

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

304.7 Sec. 35. Minnesota Statutes 2022, section 245G.08, subdivision 6, is amended to read:

304.8 Subd. 6. **Control of drugs.** A license holder must have and implement written policies
304.9 and procedures developed by a registered nurse that contain:

304.10 (1) a requirement that each drug must be stored in a locked compartment. A Schedule
304.11 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked
304.12 compartment, permanently affixed to the physical plant or medication cart;

304.13 (2) a system which accounts for all scheduled drugs each shift;

304.14 (3) a procedure for recording the client's use of medication, including the signature of
304.15 the staff member who completed the administration of the medication with the time and
304.16 date;

304.17 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

304.18 (5) a statement that only authorized personnel are permitted access to the keys to a locked
304.19 compartment;

304.20 (6) a statement that no legend drug supply for one client shall be given to another client;
304.21 and

304.22 (7) a procedure for monitoring the available supply of ~~naloxone~~ an opiate antagonist as
304.23 defined in section 604A.04, subdivision 1, on site, and replenishing the naloxone supply
304.24 when needed, and destroying naloxone according to clause (4).

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

304.26 Sec. 36. Minnesota Statutes 2022, section 245G.10, is amended by adding a subdivision
304.27 to read:

304.28 Subd. 6. **Notification to commissioner of changes in key staff positions.** A license
304.29 holder must notify the commissioner within five business days of a change or vacancy in a
304.30 key staff position. The key positions are a treatment director as required by subdivision 1,

305.1 an alcohol and drug counselor supervisor as required by subdivision 2, and a registered
305.2 nurse as required by section 245G.08, subdivision 5, paragraph (c). The license holder must
305.3 notify the commissioner of the staffing change on a form approved by the commissioner
305.4 and include the name of the staff person now assigned to the key staff position and the staff
305.5 person's qualifications for the position. The license holder must notify the program licensur
305.6 of a vacancy to discuss how the duties of the key staff position will be fulfilled during the
305.7 vacancy.

305.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

305.9 Sec. 37. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 2, is amended
305.10 to read:

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

305.13 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being
305.14 diverted from intended use of the medication.

305.15 (c) "Guest dose" means administration of a medication used for the treatment of opioid
305.16 addiction to a person who is not a client of the program that is administering or dispensing
305.17 the medication.

305.18 (d) "Medical director" means a practitioner licensed to practice medicine in the
305.19 jurisdiction that the opioid treatment program is located who assumes responsibility for
305.20 administering all medical services performed by the program, either by performing the
305.21 services directly or by delegating specific responsibility to a practitioner of the opioid
305.22 treatment program.

305.23 (e) "Medication used for the treatment of opioid use disorder" means a medication
305.24 approved by the Food and Drug Administration for the treatment of opioid use disorder.

305.25 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

305.26 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,
305.27 title 42, section 8.12, and includes programs licensed under this chapter.

305.28 (h) "Practitioner" means a staff member holding a current, unrestricted license to practice
305.29 medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing
305.30 and is currently registered with the Drug Enforcement Administration to order or dispense
305.31 controlled substances in Schedules II to V under the Controlled Substances Act, United
305.32 States Code, title 21, part B, section 821. ~~Practitioner includes an advanced practice registered~~

306.1 ~~nurse and physician assistant if the staff member receives a variance by the state opioid~~
 306.2 ~~treatment authority under section 254A.03 and the federal Substance Abuse and Mental~~
 306.3 ~~Health Services Administration.~~

306.4 (i) "Unsupervised use" or "take-home" means the use of a medication for the treatment
 306.5 of opioid use disorder dispensed for use by a client outside of the program setting.

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

306.7 Sec. 38. Minnesota Statutes 2022, section 245G.22, subdivision 6, is amended to read:

306.8 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
 306.9 medication used for the treatment of opioid use disorder to the illicit market, medication
 306.10 dispensed to a client for unsupervised use shall be subject to the requirements of this
 306.11 subdivision. Any client in an opioid treatment program may receive ~~a single unsupervised~~
 306.12 ~~use dose for a day that the clinic is closed for business, including Sundays and state and~~
 306.13 ~~federal holidays~~ their individualized take-home doses as ordered for days that the clinic is
 306.14 closed for business, on one weekend day (e.g., Sunday) and state and federal holidays, no
 306.15 matter their length of time in treatment, as allowed under Code of Federal Regulations, title
 306.16 42, part 8.12 (i)(1).

306.17 (b) For take-home doses beyond those allowed by paragraph (a), a practitioner with
 306.18 ~~authority to prescribe~~ must review and document the criteria in this paragraph and paragraph
 306.19 ~~(e)~~ the Code of Federal Regulations, title 42, part 8.12 (i)(2), when determining whether
 306.20 dispensing medication for a client's unsupervised use is safe and it is appropriate to
 306.21 implement, increase, or extend the amount of time between visits to the program. The criteria
 306.22 are:

306.23 ~~(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,~~
 306.24 ~~and alcohol;~~

306.25 ~~(2) regularity of program attendance;~~

306.26 ~~(3) absence of serious behavioral problems at the program;~~

306.27 ~~(4) absence of known recent criminal activity such as drug dealing;~~

306.28 ~~(5) stability of the client's home environment and social relationships;~~

306.29 ~~(6) length of time in comprehensive maintenance treatment;~~

306.30 ~~(7) reasonable assurance that unsupervised use medication will be safely stored within~~
 306.31 ~~the client's home; and~~

307.1 ~~(8) whether the rehabilitative benefit the client derived from decreasing the frequency~~
307.2 ~~of program attendance outweighs the potential risks of diversion or unsupervised use.~~

307.3 (c) The determination, including the basis of the determination must be documented by
307.4 a practitioner in the client's medical record.

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

307.6 Sec. 39. Minnesota Statutes 2022, section 245G.22, subdivision 7, is amended to read:

307.7 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
307.8 ~~medical director or prescribing~~ practitioner assesses ~~and~~, determines, and documents that
307.9 a client meets the criteria in subdivision 6 ~~and may be dispensed a medication used for the~~
307.10 ~~treatment of opioid addiction, the restrictions in this subdivision must be followed when~~
307.11 ~~the medication to be dispensed is methadone hydrochloride. The results of the assessment~~
307.12 ~~must be contained in the client file. The number of unsupervised use medication doses per~~
307.13 ~~week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication~~
307.14 ~~doses a client may receive for days the clinic is closed for business as allowed by subdivision~~
307.15 ~~6, paragraph (a) and that a patient is safely able to manage unsupervised doses of methadone,~~
307.16 the number of take-home doses the client receives must be limited by the number allowed
307.17 by the Code of Federal Regulations, title 42, part 8.12 (i)(3).

307.18 ~~(b) During the first 90 days of treatment, the unsupervised use medication supply must~~
307.19 ~~be limited to a maximum of a single dose each week and the client shall ingest all other~~
307.20 ~~doses under direct supervision.~~

307.21 ~~(c) In the second 90 days of treatment, the unsupervised use medication supply must be~~
307.22 ~~limited to two doses per week.~~

307.23 ~~(d) In the third 90 days of treatment, the unsupervised use medication supply must not~~
307.24 ~~exceed three doses per week.~~

307.25 ~~(e) In the remaining months of the first year, a client may be given a maximum six-day~~
307.26 ~~unsupervised use medication supply.~~

307.27 ~~(f) After one year of continuous treatment, a client may be given a maximum two-week~~
307.28 ~~unsupervised use medication supply.~~

307.29 ~~(g) After two years of continuous treatment, a client may be given a maximum one-month~~
307.30 ~~unsupervised use medication supply, but must make monthly visits to the program.~~

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

308.1 Sec. 40. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 17, is amended
308.2 to read:

308.3 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the
308.4 policies and procedures required in this subdivision.

308.5 (b) For a program that is not open every day of the year, the license holder must maintain
308.6 a policy and procedure that covers requirements under section 245G.22, subdivisions 6 and
308.7 7. Unsupervised use of medication used for the treatment of opioid use disorder for days
308.8 that the program is closed for business, ~~including but not limited to Sundays~~ on one weekend
308.9 day and state and federal holidays, must meet the requirements under section 245G.22,
308.10 subdivisions 6 and 7.

308.11 (c) The license holder must maintain a policy and procedure that includes specific
308.12 measures to reduce the possibility of diversion. The policy and procedure must:

308.13 (1) specifically identify and define the responsibilities of the medical and administrative
308.14 staff for performing diversion control measures; and

308.15 (2) include a process for contacting no less than five percent of clients who have
308.16 unsupervised use of medication, excluding clients approved solely under subdivision 6,
308.17 paragraph (a), to require clients to physically return to the program each month. The system
308.18 must require clients to return to the program within a stipulated time frame and turn in all
308.19 unused medication containers related to opioid use disorder treatment. The license holder
308.20 must document all related contacts on a central log and the outcome of the contact for each
308.21 client in the client's record. The medical director must be informed of each outcome that
308.22 results in a situation in which a possible diversion issue was identified.

308.23 (d) Medication used for the treatment of opioid use disorder must be ordered,
308.24 administered, and dispensed according to applicable state and federal regulations and the
308.25 standards set by applicable accreditation entities. If a medication order requires assessment
308.26 by the person administering or dispensing the medication to determine the amount to be
308.27 administered or dispensed, the assessment must be completed by an individual whose
308.28 professional scope of practice permits an assessment. For the purposes of enforcement of
308.29 this paragraph, the commissioner has the authority to monitor the person administering or
308.30 dispensing the medication for compliance with state and federal regulations and the relevant
308.31 standards of the license holder's accreditation agency and may issue licensing actions
308.32 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's
308.33 determination of noncompliance.

308.34 (e) A counselor in an opioid treatment program must not supervise more than 50 clients.

309.1 (f) Notwithstanding paragraph (e), from July 1, 2023, to June 30, 2024, a counselor in
309.2 an opioid treatment program may supervise up to 60 clients. The license holder may continue
309.3 to serve a client who was receiving services at the program on June 30, 2024, at a counselor
309.4 to client ratio of up to one to 60 and is not required to discharge any clients in order to return
309.5 to the counselor to client ratio of one to 50. The license holder may not, however, serve a
309.6 new client after June 30, 2024, unless the counselor who would supervise the new client is
309.7 supervising fewer than 50 existing clients.

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

309.9 Sec. 41. Minnesota Statutes 2023 Supplement, section 256.046, subdivision 3, is amended
309.10 to read:

309.11 Subd. 3. **Administrative disqualification of child care providers caring for children**
309.12 **receiving child care assistance.** (a) The department shall pursue an administrative
309.13 disqualification, if the child care provider is accused of committing an intentional program
309.14 violation, in lieu of a criminal action when it has not been pursued. Intentional program
309.15 violations include intentionally making false or misleading statements; intentionally
309.16 misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating
309.17 program regulations under chapters 119B and 245E. Intent may be proven by demonstrating
309.18 a pattern of conduct that violates program rules under chapters 119B and 245E.

309.19 (b) To initiate an administrative disqualification, the commissioner must ~~mail~~ send
309.20 written notice ~~by certified mail~~ using a signature-verified confirmed delivery method to the
309.21 provider against whom the action is being taken. Unless otherwise specified under chapter
309.22 119B or 245E or Minnesota Rules, chapter 3400, the commissioner must ~~mail~~ send the
309.23 written notice at least 15 calendar days before the adverse action's effective date. The notice
309.24 shall state (1) the factual basis for the agency's determination, (2) the action the agency
309.25 intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known,
309.26 and (4) the provider's right to appeal the agency's proposed action.

309.27 (c) The provider may appeal an administrative disqualification by submitting a written
309.28 request to the Department of Human Services, Appeals Division. A provider's request must
309.29 be received by the Appeals Division no later than 30 days after the date the commissioner
309.30 mails the notice.

309.31 (d) The provider's appeal request must contain the following:

309.32 (1) each disputed item, the reason for the dispute, and, if applicable, an estimate of the
309.33 dollar amount involved for each disputed item;

310.1 (2) the computation the provider believes to be correct, if applicable;

310.2 (3) the statute or rule relied on for each disputed item; and

310.3 (4) the name, address, and telephone number of the person at the provider's place of
310.4 business with whom contact may be made regarding the appeal.

310.5 (e) On appeal, the issuing agency bears the burden of proof to demonstrate by a
310.6 preponderance of the evidence that the provider committed an intentional program violation.

310.7 (f) The hearing is subject to the requirements of sections 256.045 and 256.0451. The
310.8 human services judge may combine a fair hearing and administrative disqualification hearing
310.9 into a single hearing if the factual issues arise out of the same or related circumstances and
310.10 the provider receives prior notice that the hearings will be combined.

310.11 (g) A provider found to have committed an intentional program violation and is
310.12 administratively disqualified shall be disqualified, for a period of three years for the first
310.13 offense and permanently for any subsequent offense, from receiving any payments from
310.14 any child care program under chapter 119B.

310.15 (h) Unless a timely and proper appeal made under this section is received by the
310.16 department, the administrative determination of the department is final and binding.

310.17 **EFFECTIVE DATE.** This section is effective August 1, 2024.

310.18 Sec. 42. Minnesota Statutes 2023 Supplement, section 256B.064, subdivision 4, is amended
310.19 to read:

310.20 Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2
310.21 ~~by certified mail at~~ using a signature-verified confirmed delivery method to the address
310.22 submitted to the department by the individual or entity. Service is complete upon mailing.

310.23 (b) The department shall give notice in writing to a recipient placed in the Minnesota
310.24 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.
310.25 The department shall send the notice by first class mail to the recipient's current address on
310.26 file with the department. A recipient placed in the Minnesota restricted recipient program
310.27 may contest the placement by submitting a written request for a hearing to the department
310.28 within 90 days of the notice being mailed.

311.1 Sec. 43. Minnesota Statutes 2022, section 260E.33, subdivision 2, as amended by Laws
311.2 2024, chapter 80, article 8, section 44, is amended to read:

311.3 Subd. 2. **Request for reconsideration.** (a) Except as provided under subdivision 5, an
311.4 individual or facility that the commissioner of human services; commissioner of children,
311.5 youth, and families; a local welfare agency; or the commissioner of education determines
311.6 has maltreated a child, an interested person acting on behalf of the child, regardless of the
311.7 determination, who contests the investigating agency's final determination regarding
311.8 maltreatment may request the investigating agency to reconsider its final determination
311.9 regarding maltreatment. The request for reconsideration must be submitted in writing or
311.10 submitted in the provider licensing and reporting hub to the investigating agency within 15
311.11 calendar days after receipt of notice of the final determination regarding maltreatment or,
311.12 if the request is made by an interested person who is not entitled to notice, within 15 days
311.13 after receipt of the notice by the parent or guardian of the child. If mailed, the request for
311.14 reconsideration must be postmarked and sent to the investigating agency within 15 calendar
311.15 days of the individual's or facility's receipt of the final determination. If the request for
311.16 reconsideration is made by personal service, it must be received by the investigating agency
311.17 within 15 calendar days after the individual's or facility's receipt of the final determination.
311.18 Upon implementation of the provider licensing and reporting hub, the individual or facility
311.19 must use the hub to request reconsideration. The reconsideration must be received by the
311.20 commissioner within 15 calendar days of the individual's receipt of the notice of
311.21 disqualification.

311.22 (b) An individual who was determined to have maltreated a child under this chapter and
311.23 who was disqualified on the basis of serious or recurring maltreatment under sections
311.24 245C.14 and 245C.15 may request reconsideration of the maltreatment determination and
311.25 the disqualification. The request for reconsideration of the maltreatment determination and
311.26 the disqualification must be submitted within 30 calendar days of the individual's receipt
311.27 of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request
311.28 for reconsideration of the maltreatment determination and the disqualification must be
311.29 postmarked and sent to the investigating agency within 30 calendar days of the individual's
311.30 receipt of the maltreatment determination and notice of disqualification. If the request for
311.31 reconsideration is made by personal service, it must be received by the investigating agency
311.32 within 30 calendar days after the individual's receipt of the notice of disqualification.

312.1 Sec. 44. Laws 2024, chapter 80, article 2, section 6, subdivision 2, is amended to read:

312.2 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change
312.3 in ownership, the commissioner shall require submission of a new license application. This
312.4 subdivision does not apply to a licensed program or service located in a home where the
312.5 license holder resides. A change in ownership occurs when:

312.6 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent
312.7 of the property, stock, or assets;

312.8 (2) the license holder merges with another organization;

312.9 (3) the license holder consolidates with two or more organizations, resulting in the
312.10 creation of a new organization;

312.11 (4) there is a change to the federal tax identification number associated with the license
312.12 holder; or

312.13 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for
312.14 the original ~~application~~ license have changed.

312.15 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses clause (1) and or (5), no
312.16 change in ownership has occurred and a new license application is not required if at least
312.17 one controlling individual has been ~~listed~~ affiliated as a controlling individual for the license
312.18 for at least the previous 12 months immediately preceding the change.

312.19 **EFFECTIVE DATE.** This section is effective January 1, 2025.

312.20 Sec. 45. Laws 2024, chapter 80, article 2, section 6, subdivision 3, is amended to read:

312.21 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is
312.22 proposed and the party intends to assume operation without an interruption in service longer
312.23 than 60 days after acquiring the program or service, the license holder must provide the
312.24 commissioner with written notice of the proposed change on a form provided by the
312.25 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.
312.26 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that
312.27 intends to operate the service or program.

312.28 (b) The party must submit a license application under this chapter on the form and in
312.29 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in
312.30 ownership is anticipated to be complete and must include documentation to support the
312.31 upcoming change. The party must comply with background study requirements under chapter
312.32 245C and shall pay the application fee required under section 245A.10.

313.1 (c) The commissioner may streamline application procedures when the party is an existing
313.2 license holder under this chapter and is acquiring a program licensed under this chapter or
313.3 service in the same service class as one or more licensed programs or services the party
313.4 operates and those licenses are in substantial compliance. For purposes of this subdivision,
313.5 "substantial compliance" means within the previous 12 months the commissioner did not
313.6 (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make
313.7 a license held by the party conditional according to section 245A.06.

313.8 (d) ~~Except when a temporary change in ownership license is issued pursuant to~~
313.9 ~~subdivision 4~~ While the standard change of ownership process is pending, the existing
313.10 license holder ~~is solely~~ remains responsible for operating the program according to applicable
313.11 laws and rules until a license under this chapter is issued to the party.

313.12 (e) If a licensing inspection of the program or service was conducted within the previous
313.13 12 months and the existing license holder's license record demonstrates substantial
313.14 compliance with the applicable licensing requirements, the commissioner may waive the
313.15 party's inspection required by section 245A.04, subdivision 4. The party must submit to the
313.16 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire
313.17 marshal deemed that an inspection was not warranted, and (2) proof that the premises was
313.18 inspected for compliance with the building code or that no inspection was deemed warranted.

313.19 (f) If the party is seeking a license for a program or service that has an outstanding action
313.20 under section 245A.06 or 245A.07, the party must submit a letter as part of the application
313.21 process identifying how the party has or will come into full compliance with the licensing
313.22 requirements.

313.23 (g) The commissioner shall evaluate the party's application according to section 245A.04,
313.24 subdivision 6. If the commissioner determines that the party has remedied or demonstrates
313.25 the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has
313.26 determined that the program otherwise complies with all applicable laws and rules, the
313.27 commissioner shall issue a license or conditional license under this chapter. A conditional
313.28 license issued under this section is final and not subject to reconsideration under section
313.29 142B.16, subdivision 4. The conditional license remains in effect until the commissioner
313.30 determines that the grounds for the action are corrected or no longer exist.

313.31 (h) The commissioner may deny an application as provided in section 245A.05. An
313.32 applicant whose application was denied by the commissioner may appeal the denial according
313.33 to section 245A.05.

314.1 (i) This subdivision does not apply to a licensed program or service located in a home
314.2 where the license holder resides.

314.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

314.4 Sec. 46. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision
314.5 to read:

314.6 **Subd. 3a. Emergency change in ownership process.** (a) In the event of a death of a
314.7 license holder or sole controlling individual or a court order or other event that results in
314.8 the license holder being inaccessible or unable to operate the program or service, a party
314.9 may submit a request to the commissioner to allow the party to assume operation of the
314.10 program or service under an emergency change in ownership process to ensure persons
314.11 continue to receive services while the commissioner evaluates the party's license application.

314.12 (b) To request the emergency change of ownership process, the party must immediately:

314.13 (1) notify the commissioner of the event resulting in the inability of the license holder
314.14 to operate the program and of the party's intent to assume operations; and

314.15 (2) provide the commissioner with documentation that demonstrates the party has a legal
314.16 or legitimate ownership interest in the program or service if applicable and is able to operate
314.17 the program or service.

314.18 (c) If the commissioner approves the party to continue operating the program or service
314.19 under an emergency change in ownership process, the party must:

314.20 (1) request to be added as a controlling individual or license holder to the existing license;

314.21 (2) notify persons receiving services of the emergency change in ownership in a manner
314.22 approved by the commissioner;

314.23 (3) submit an application for a new license within 30 days of approval;

314.24 (4) comply with the background study requirements under chapter 245C; and

314.25 (5) pay the application fee required under section 142B.12.

314.26 (d) While the emergency change of ownership process is pending, a party approved
314.27 under this subdivision is responsible for operating the program under the existing license
314.28 according to applicable laws and rules until a new license under this chapter is issued.

314.29 (e) The provisions in subdivision 3, paragraphs (c), (g), and (h), apply to this subdivision.

314.30 (f) Once a party is issued a new license or has decided not to seek a new license, the
314.31 commissioner must close the existing license.

315.1 (g) This subdivision applies to any program or service licensed under this chapter.

315.2 **EFFECTIVE DATE.** This section is effective January 1, 2025.

315.3 Sec. 47. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision
315.4 to read:

315.5 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder
315.6 has not fully complied with this section, the commissioner may impose a licensing sanction
315.7 under section 142B.15, 142B.16, or 142B.18.

315.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

315.9 Sec. 48. Laws 2024, chapter 80, article 2, section 10, subdivision 1, is amended to read:

315.10 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
315.11 under section 142B.16, the commissioner may suspend or revoke the license, impose a fine,
315.12 or secure an injunction against the continuing operation of the program of a license holder
315.13 who:

315.14 (1) does not comply with applicable law or rule;

315.15 (2) has nondisqualifying background study information, as described in section 245C.05,
315.16 subdivision 4, that reflects on the license holder's ability to safely provide care to foster
315.17 children; or

315.18 (3) has an individual living in the household where the licensed services are provided
315.19 or is otherwise subject to a background study, and the individual has nondisqualifying
315.20 background study information, as described in section 245C.05, subdivision 4, that reflects
315.21 on the license holder's ability to safely provide care to foster children.

315.22 When applying sanctions authorized under this section, the commissioner shall consider
315.23 the nature, chronicity, or severity of the violation of law or rule and the effect of the violation
315.24 on the health, safety, or rights of persons served by the program.

315.25 (b) If a license holder appeals the suspension or revocation of a license and the license
315.26 holder continues to operate the program pending a final order on the appeal, the commissioner
315.27 shall issue the license holder a temporary provisional license. Unless otherwise specified
315.28 by the commissioner, variances in effect on the date of the license sanction under appeal
315.29 continue under the temporary provisional license. The commissioner may include terms the
315.30 license holder must follow pending a final order on the appeal. If a license holder fails to
315.31 comply with applicable law or rule while operating under a temporary provisional license,

316.1 the commissioner may impose additional sanctions under this section and section 142B.16
316.2 and may terminate any prior variance. If a temporary provisional license is set to expire, a
316.3 new temporary provisional license shall be issued to the license holder upon payment of
316.4 any fee required under section 142B.12. The temporary provisional license shall expire on
316.5 the date the final order is issued. If the license holder prevails on the appeal, a new
316.6 nonprovisional license shall be issued for the remainder of the current license period.

316.7 (c) If a license holder is under investigation and the license issued under this chapter is
316.8 due to expire before completion of the investigation, the program shall be issued a new
316.9 license upon completion of the reapplication requirements and payment of any applicable
316.10 license fee. Upon completion of the investigation, a licensing sanction may be imposed
316.11 against the new license under this section or section 142B.16 or 142B.20.

316.12 (d) Failure to reapply or closure of a license issued under this chapter by the license
316.13 holder prior to the completion of any investigation shall not preclude the commissioner
316.14 from issuing a licensing sanction under this section or section 142B.16 at the conclusion of
316.15 the investigation.

316.16 **EFFECTIVE DATE.** This section is effective January 1, 2025.

316.17 Sec. 49. Laws 2024, chapter 80, article 2, section 10, subdivision 6, is amended to read:

316.18 Subd. 6. **Appeal of multiple sanctions.** (a) When the license holder appeals more than
316.19 one licensing action or sanction that were simultaneously issued by the commissioner, the
316.20 license holder shall specify the actions or sanctions that are being appealed.

316.21 (b) If there are different timelines prescribed in statutes for the licensing actions or
316.22 sanctions being appealed, the license holder must submit the appeal within the longest of
316.23 those timelines specified in statutes.

316.24 (c) The appeal must be made in writing by certified mail ~~or~~, personal service, or through
316.25 the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent
316.26 to the commissioner within the prescribed timeline with the first day beginning the day after
316.27 the license holder receives the certified letter. If a request is made by personal service, it
316.28 must be received by the commissioner within the prescribed timeline with the first day
316.29 beginning the day after the license holder receives the certified letter. If the appeal is made
316.30 through the provider hub, the appeal must be received by the commissioner within the
316.31 prescribed timeline with the first day beginning the day after the commissioner issued the
316.32 order through the hub.

317.1 (d) When there are different timelines prescribed in statutes for the appeal of licensing
317.2 actions or sanctions simultaneously issued by the commissioner, the commissioner shall
317.3 specify in the notice to the license holder the timeline for appeal as specified under paragraph
317.4 (b).

317.5 Sec. 50. REPEALER.

317.6 (a) Minnesota Statutes 2022, section 245C.125, is repealed.

317.7 (b) Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 2, is repealed.

317.8 (c) Minnesota Rules, part 9502.0425, subpart 5, is repealed.

317.9 (d) Laws 2024, chapter 80, article 2, section 6, subdivision 4, is repealed.

317.10

ARTICLE 11

317.11

SUBSTANCE USE DISORDER TREATMENT LICENSING

317.12 Section 1. Minnesota Statutes 2022, section 245G.11, subdivision 5, is amended to read:

317.13 Subd. 5. **Alcohol and drug counselor qualifications.** (a) An alcohol and drug counselor
317.14 must either be licensed or exempt from licensure under chapter 148F.

317.15 (b) An individual who is exempt from licensure under chapter 148F, must meet one of
317.16 the following additional requirements:

317.17 (1) completion of at least a baccalaureate degree with a major or concentration in social
317.18 work, nursing, sociology, human services, or psychology, or licensure as a registered nurse;
317.19 successful completion of a minimum of 120 hours of classroom instruction in which each
317.20 of the core functions listed in chapter 148F is covered; and successful completion of 440
317.21 hours of supervised experience as an alcohol and drug counselor, either as a student or a
317.22 staff member;

317.23 (2) completion of at least 270 hours of drug counselor training in which each of the core
317.24 functions listed in chapter 148F is covered, and successful completion of 880 hours of
317.25 supervised experience as an alcohol and drug counselor, either as a student or as a staff
317.26 member;

317.27 (3) current certification as an alcohol and drug counselor or alcohol and drug counselor
317.28 reciprocal, through the evaluation process established by the International Certification and
317.29 Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

318.1 (4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling
318.2 education from an accredited school or educational program and 880 hours of alcohol and
318.3 drug counseling practicum; ~~or~~

318.4 (5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000
318.5 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in
318.6 a licensed program as an alcohol and drug counselor prior to January 1, 2005;

318.7 (6) qualification as a mental health professional under section 245I.04, subdivision 2,
318.8 and completion of training in addiction, co-occurring disorders, or substance use disorder
318.9 diagnosis and treatment as required under section 245G.13, subdivision 2, paragraph (f).

318.10 An individual exempt from licensure under this clause must engage in practice exclusively
318.11 within the scope of practice under the individual's professional licensing statutes. This clause
318.12 expires December 31, 2026;

318.13 (7) qualification as a clinical trainee under section 245I.04, subdivision 6. An individual
318.14 exempt from licensure under this clause must practice under the supervision of a mental
318.15 health professional who is practicing in accordance with this section. This clause expires
318.16 on December 31, 2026; and

318.17 (8) licensure as a registered nurse under section 148.171, subdivision 20, and completion
318.18 of training in addiction, co-occurring disorders, or substance use disorder diagnosis and
318.19 treatment as required under section 245G.13, subdivision 2, paragraph (f). An individual
318.20 exempt from licensure under this clause must engage in practice exclusively within the
318.21 scope of practice under the individual's professional licensing statutes. This clause expires
318.22 on December 31, 2026.

318.23 (c) An alcohol and drug counselor may not provide a treatment service that requires
318.24 professional licensure unless the individual possesses the necessary license. For the purposes
318.25 of enforcing this section, the commissioner has the authority to monitor a service provider's
318.26 compliance with the relevant standards of the service provider's profession and may issue
318.27 licensing actions against the license holder according to sections 245A.05, 245A.06, and
318.28 245A.07, based on the commissioner's determination of noncompliance.

318.29 Sec. 2. Minnesota Statutes 2022, section 245G.11, subdivision 7, is amended to read:

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

- 319.1 (1) is skilled in the process of identifying and assessing a wide range of client needs;
- 319.2 (2) is knowledgeable about local community resources and how to use those resources
- 319.3 for the benefit of the client;
- 319.4 (3) has successfully completed ~~30 hours of classroom instruction on treatment~~
- 319.5 ~~coordination for an individual with substance use disorder~~ 15 hours of training on treatment
- 319.6 coordination for an individual with substance use disorder; and
- 319.7 (4) ~~has either~~ meets one of the following criteria:
- 319.8 (i) has a bachelor's degree in one of the behavioral sciences or related fields and at least
- 319.9 1,000 hours of supervised experience working with individuals with substance use disorder;
- 319.10 ~~or~~
- 319.11 (ii) is a mental health practitioner qualified under section 245I.04, subdivision 4; or
- 319.12 (iii) has a current certification as an alcohol and drug counselor, level I, by the Upper
- 319.13 Midwest Indian Council on Addictive Disorders; and.
- 319.14 ~~(5) has at least 2,000 hours of supervised experience working with individuals with~~
- 319.15 ~~substance use disorder.~~
- 319.16 (b) A treatment coordinator must receive at least one hour of supervision regarding
- 319.17 individual service delivery from an alcohol and drug counselor, or a mental health
- 319.18 professional who has substance use treatment and assessments within the scope of their
- 319.19 practice, on a monthly basis.

319.20 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner

319.21 of human services must notify the revisor of statutes when federal approval is obtained.

319.22 ARTICLE 12

319.23 MISCELLANEOUS

319.24 Section 1. Minnesota Statutes 2022, section 148F.025, subdivision 2, is amended to read:

319.25 Subd. 2. **Education requirements for licensure.** An applicant for licensure must submit

319.26 evidence satisfactory to the board that the applicant has:

319.27 (1) received a bachelor's or master's degree from an accredited school or educational

319.28 program; and

319.29 (2) received 18 semester credits or 270 clock hours of academic course work and 880

319.30 clock hours of supervised alcohol and drug counseling practicum from an accredited school

320.1 or education program. The course work and practicum do not have to be part of the bachelor's
320.2 degree earned under clause (1). The academic course work must be in the following areas:

320.3 (i) an overview of the transdisciplinary foundations of alcohol and drug counseling,
320.4 including theories of chemical dependency, the continuum of care, and the process of change;

320.5 (ii) pharmacology of substance abuse disorders and the dynamics of addiction, including
320.6 substance use disorder treatment with medications for opioid use disorder;

320.7 (iii) professional and ethical responsibilities;

320.8 (iv) multicultural aspects of chemical dependency;

320.9 (v) co-occurring disorders; and

320.10 (vi) the core functions defined in section 148F.01, subdivision 10.

320.11 Sec. 2. Minnesota Statutes 2023 Supplement, section 245.991, subdivision 1, is amended
320.12 to read:

320.13 Subdivision 1. **Establishment.** The commissioner of human services must establish the
320.14 projects for assistance in transition from homelessness program to prevent or end
320.15 homelessness for people with serious mental illness, substance use disorder, or co-occurring
320.16 substance use disorder and ensure the commissioner achieves the goals of the housing
320.17 mission statement in section 245.461, subdivision 4.

320.18 Sec. 3. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended
320.19 to read:

320.20 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal
320.21 Regulations, title 25, part 20, who meet the income standards of section 256B.056,
320.22 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health
320.23 fund services. State money appropriated for this paragraph must be placed in a separate
320.24 account established for this purpose.

320.25 (b) Persons with dependent children who are determined to be in need of substance use
320.26 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in
320.27 need of chemical dependency treatment pursuant to a case plan under section 260C.201,
320.28 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment
320.29 services. Treatment services must be appropriate for the individual or family, which may
320.30 include long-term care treatment or treatment in a facility that allows the dependent children

321.1 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if
321.2 applicable.

321.3 (c) Notwithstanding paragraph (a), persons enrolled in medical assistance are eligible
321.4 for room and board services under section 254B.05, subdivision 5, paragraph (b), clause
321.5 (12).

321.6 (d) A client is eligible to have substance use disorder treatment paid for with funds from
321.7 the behavioral health fund when the client:

321.8 (1) is eligible for MFIP as determined under chapter 256J;

321.9 (2) is eligible for medical assistance as determined under Minnesota Rules, parts
321.10 9505.0010 to 9505.0150;

321.11 (3) is eligible for general assistance, general assistance medical care, or work readiness
321.12 as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

321.13 (4) has income that is within current household size and income guidelines for entitled
321.14 persons, as defined in this subdivision and subdivision 7.

321.15 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have
321.16 a third-party payment source are eligible for the behavioral health fund if the third-party
321.17 payment source pays less than 100 percent of the cost of treatment services for eligible
321.18 clients.

321.19 (f) A client is ineligible to have substance use disorder treatment services paid for with
321.20 behavioral health fund money if the client:

321.21 (1) has an income that exceeds current household size and income guidelines for entitled
321.22 persons as defined in this subdivision and subdivision 7; or

321.23 (2) has an available third-party payment source that will pay the total cost of the client's
321.24 treatment.

321.25 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode
321.26 is eligible for continued treatment service that is paid for by the behavioral health fund until
321.27 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan
321.28 if the client:

321.29 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance
321.30 medical care; or

321.31 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local
321.32 agency under section 254B.04.

322.1 (h) When a county commits a client under chapter 253B to a regional treatment center
322.2 for substance use disorder services and the client is ineligible for the behavioral health fund,
322.3 the county is responsible for the payment to the regional treatment center according to
322.4 section 254B.05, subdivision 4.

322.5 (i) Notwithstanding paragraph (a), persons enrolled in MinnesotaCare are eligible for
322.6 room and board services under section 254B.05, subdivision 1a, paragraph (e).

322.7 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
322.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
322.9 when federal approval is obtained.

322.10 Sec. 4. Minnesota Statutes 2023 Supplement, section 256D.01, subdivision 1a, is amended
322.11 to read:

322.12 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to
322.13 provide for single adults, childless couples, or children as defined in section 256D.02,
322.14 subdivision 2b, ineligible for federal programs who are unable to provide for themselves.
322.15 The minimum standard of assistance determines the total amount of the general assistance
322.16 grant without separate standards for shelter, utilities, or other needs.

322.17 (b) The standard of assistance for an assistance unit consisting of a recipient who is
322.18 childless and unmarried or living apart from children and spouse and who does not live with
322.19 a parent or parents or a legal custodian, or consisting of a childless couple, is \$350 per month
322.20 effective October 1, 2024, and must be adjusted by a percentage equal to the change in the
322.21 consumer price index as of January 1 every year, beginning October 1, 2025.

322.22 (c) For an assistance unit consisting of a single adult who lives with a parent or parents,
322.23 the general assistance standard of assistance is \$350 per month effective October 1, ~~2023~~
322.24 2024, and must be adjusted by a percentage equal to the change in the consumer price index
322.25 as of January 1 every year, beginning October 1, 2025. Benefits received by a responsible
322.26 relative of the assistance unit under the Supplemental Security Income program, a workers'
322.27 compensation program, the Minnesota supplemental aid program, or any other program
322.28 based on the responsible relative's disability, and any benefits received by a responsible
322.29 relative of the assistance unit under the Social Security retirement program, may not be
322.30 counted in the determination of eligibility or benefit level for the assistance unit. Except as
322.31 provided below, the assistance unit is ineligible for general assistance if the available
322.32 resources or the countable income of the assistance unit and the parent or parents with whom
322.33 the assistance unit lives are such that a family consisting of the assistance unit's parent or
322.34 parents, the parent or parents' other family members and the assistance unit as the only or

323.1 additional minor child would be financially ineligible for general assistance. For the purposes
323.2 of calculating the countable income of the assistance unit's parent or parents, the calculation
323.3 methods must follow the provisions under section 256P.06.

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

323.5 Sec. 5. Minnesota Statutes 2022, section 256I.04, subdivision 2f, is amended to read:

323.6 Subd. 2f. **Required services.** (a) In ~~licensed and registered~~ authorized settings under
323.7 subdivision 2a, providers shall ensure that participants have at a minimum:

323.8 (1) food preparation and service for three nutritional meals a day on site;

323.9 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

323.10 (3) housekeeping, including cleaning and lavatory supplies or service; and

323.11 (4) maintenance and operation of the building and grounds, including heat, water, garbage
323.12 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
323.13 and maintain equipment and facilities.

323.14 (b) In addition, when providers serve participants described in subdivision 1, paragraph
323.15 (c), the providers are required to assist the participants in applying for continuing housing
323.16 support payments before the end of the eligibility period.

323.17 Sec. 6. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 1a, is amended
323.18 to read:

323.19 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
323.20 subdivision 3, the agency may negotiate a payment not to exceed \$494.91 for other services
323.21 necessary to provide room and board if the residence is licensed by or registered by the
323.22 Department of Health, or licensed by the Department of Human Services to provide services
323.23 in addition to room and board, and if the provider of services is not also concurrently
323.24 receiving funding for services for a recipient in the residence under the following programs
323.25 or funding sources: (1) home and community-based waiver services under chapter 256S or
323.26 section 256B.0913, 256B.092, or 256B.49; (2) personal care assistance under section
323.27 256B.0659; (3) community first services and supports under section 256B.85; or (4) services
323.28 for adults with mental illness grants under section 245.73. If funding is available for other
323.29 necessary services through a home and community-based waiver under chapter 256S, or
323.30 section 256B.0913, 256B.092, or 256B.49; personal care assistance services under section
323.31 256B.0659; community first services and supports under section 256B.85; or services for
323.32 adults with mental illness grants under section 245.73, then the housing support rate is

324.1 limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may
324.2 the supplementary service rate exceed \$494.91. The registration and licensure requirement
324.3 does not apply to establishments which are exempt from state licensure because they are
324.4 located on Indian reservations and for which the tribe has prescribed health and safety
324.5 requirements. Service payments under this section may be prohibited under rules to prevent
324.6 the supplanting of federal funds with state funds.

324.7 ~~(b) The commissioner is authorized to make cost-neutral transfers from the housing~~
324.8 ~~support fund for beds under this section to other funding programs administered by the~~
324.9 ~~department after consultation with the agency in which the affected beds are located. The~~
324.10 ~~commissioner may also make cost-neutral transfers from the housing support fund to agencies~~
324.11 ~~for beds permanently removed from the housing support census under a plan submitted by~~
324.12 ~~the agency and approved by the commissioner. The commissioner shall report the amount~~
324.13 ~~of any transfers under this provision annually to the legislature.~~

324.14 ~~(e)~~ (b) Agencies must not negotiate supplementary service rates with providers of housing
324.15 support that are licensed as board and lodging with special services and that do not encourage
324.16 a policy of sobriety on their premises and make referrals to available community services
324.17 for volunteer and employment opportunities for residents.

324.18 Sec. 7. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 11, is amended
324.19 to read:

324.20 Subd. 11. ~~Transfer of emergency shelter funds~~ Cost-neutral transfers from the
324.21 housing support fund. (a) The commissioner is authorized to make cost-neutral transfers
324.22 from the housing support fund for beds under this section to other funding programs
324.23 administered by the department after consultation with the agency in which the affected
324.24 beds are located.

324.25 (b) The commissioner may also make cost-neutral transfers from the housing support
324.26 fund to agencies for beds removed from the housing support census under a plan submitted
324.27 by the agency and approved by the commissioner.

324.28 ~~(a)~~ (c) The commissioner shall make a cost-neutral transfer of funding from the housing
324.29 support fund to the agency for emergency shelter beds removed from the housing support
324.30 census under a ~~biennial~~ plan submitted by the agency and approved by the commissioner.
324.31 Plans submitted under this paragraph must include anticipated and actual outcomes for
324.32 persons experiencing homelessness in emergency shelters.

325.1 ~~The plan~~ (d) Plans submitted under paragraph (b) or (c) must describe: (1) ~~anticipated~~
325.2 ~~and actual outcomes for persons experiencing homelessness in emergency shelters;~~ (2)
325.3 improved efficiencies in administration; ~~(3)~~ (2) requirements for individual eligibility; and
325.4 ~~(4)~~ (3) plans for quality assurance monitoring and quality assurance outcomes. The
325.5 commissioner shall review ~~the agency plan~~ plans to monitor implementation and outcomes
325.6 at least biennially, and more frequently if the commissioner deems necessary.

325.7 ~~(b)~~ (e) Funding under paragraph ~~(a)~~ (b), (c), or (d) may be used for the provision
325.8 of room and board or supplemental services according to section 256I.03, subdivisions 14a
325.9 and 14b. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f.
325.10 Funding must be allocated annually, and the room and board portion of the allocation shall
325.11 be adjusted according to the percentage change in the housing support room and board rate.
325.12 ~~The room and board portion of the allocation shall be determined at the time of transfer.~~
325.13 The commissioner or agency may return beds to the housing support fund with 180 days'
325.14 notice, including financial reconciliation.

325.15 Sec. 8. Minnesota Statutes 2023 Supplement, section 342.06, is amended to read:

325.16 **342.06 APPROVAL OF CANNABIS FLOWER, PRODUCTS, AND**
325.17 **CANNABINOIDS.**

325.18 (a) For the purposes of this section, "product category" means a type of product that
325.19 may be sold in different sizes, distinct packaging, or at various prices but is still created
325.20 using the same manufacturing or agricultural processes. A new or additional stock keeping
325.21 unit (SKU) or Universal Product Code (UPC) shall not prevent a product from being
325.22 considered the same type as another unit. All other terms have the meanings provided in
325.23 section 342.01.

325.24 (b) The office shall approve product categories of cannabis flower, cannabis products,
325.25 lower-potency hemp edibles, and hemp-derived consumer products for retail sale.

325.26 (c) The office may establish limits on the total THC of cannabis flower, cannabis products,
325.27 and hemp-derived consumer products. As used in this paragraph, "total THC" means the
325.28 sum of the percentage by weight of tetrahydrocannabinolic acid multiplied by 0.877 plus
325.29 the percentage by weight of all tetrahydrocannabinols.

325.30 (d) The office shall not approve any cannabis product, lower-potency hemp edible, or
325.31 hemp-derived consumer product that:

325.32 (1) is or appears to be a lollipop or ice cream;

326.1 (2) bears the likeness or contains characteristics of a real or fictional person, animal, or
326.2 fruit;

326.3 (3) is modeled after a type or brand of products primarily consumed by or marketed to
326.4 children;

326.5 (4) is substantively similar to a meat food product; poultry food product as defined in
326.6 section 31A.02, subdivision 10; or a dairy product as defined in section 32D.01, subdivision
326.7 7;

326.8 (5) contains a synthetic cannabinoid;

326.9 (6) is made by applying a cannabinoid, including but not limited to an artificially derived
326.10 cannabinoid, to a finished food product that does not contain cannabinoids and is sold to
326.11 consumers, including but not limited to a candy or snack food; or

326.12 (7) if the product is an edible cannabis product or lower-potency hemp edible, contains
326.13 an ingredient, other than a cannabinoid, that is not approved by the United States Food and
326.14 Drug Administration for use in food.

326.15 (e) The office must not approve any cannabis flower, cannabis product, or hemp-derived
326.16 consumer product intended to be inhaled as smoke, aerosol, or vapor from the product that:

326.17 (1) contains any added artificial, synthetic, or natural flavoring, either in the product
326.18 itself or in its components or parts;

326.19 (2) presents any descriptor or depiction of flavor that would imply to an ordinary person
326.20 that the product contains flavors other than the natural taste or smell of cannabis;

326.21 (3) imparts a taste or smell, other than the taste or smell of cannabis, that is distinguishable
326.22 by an ordinary consumer prior to or during the consumption of the product; or

326.23 (4) imparts a cooling, a burning, a numbing, or another sensation distinguishable by an
326.24 ordinary consumer to impart a flavor other than cannabis either prior to or during the
326.25 consumption of the product.

326.26 (f) Notwithstanding paragraph (e), the office may approve cannabis flower, cannabis
326.27 products, or hemp-derived consumer products intended to be inhaled as smoke, aerosol, or
326.28 vapor that contain or impart a flavor or smell only if the additives are terpenes extracted
326.29 from cannabis plants or hemp plants and are present at no greater concentrations than those
326.30 found naturally occurring in the cannabis plants or hemp plants from which the
326.31 tetrahydrocannabinol was extracted.

327.1 Sec. 9. Minnesota Statutes 2023 Supplement, section 342.63, is amended by adding a
327.2 subdivision to read:

327.3 Subd. 7. **Content of label; products intended to be inhaled as smoke, aerosol, or**
327.4 **vapor. All cannabis flower, cannabis products, and hemp-derived consumer products**
327.5 **intended to be inhaled as smoke, aerosol, or vapor and sold to customers or patients must**
327.6 **not present, on the label or affixed on the packaging or container, any descriptor or depiction**
327.7 **of flavor that would imply to an ordinary person that the product contains flavors other than**
327.8 **the natural taste or smell of cannabis. A cannabis plant or hemp plant strain name that**
327.9 **includes a descriptor of a fruit, flavor, or food term may be listed on the label or affixed to**
327.10 **the packaging or container only in a font that does not exceed six points and in black or**
327.11 **white type.**

327.12 Sec. 10. **REVISOR INSTRUCTION.**

327.13 The revisor of statutes shall renumber Minnesota Statutes, section 256D.21, as Minnesota
327.14 Statutes, section 261.004.

327.15 Sec. 11. **REPEALER.**

327.16 Minnesota Statutes 2022, sections 256D.19, subdivisions 1 and 2; 256D.20, subdivisions
327.17 1, 2, 3, and 4; and 256D.23, subdivisions 1, 2, and 3, are repealed.

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

327.19 **ARTICLE 13**

327.20 **HUMAN SERVICES FORECAST ADJUSTMENTS**

327.21 Section 1. **HUMAN SERVICES FORECAST ADJUSTMENTS.**

327.22 The sums shown in the columns marked "Appropriations" are added to or, if shown in
327.23 parentheses, subtracted from the appropriations in Laws 2023, chapter 61, article 9, and
327.24 Laws 2023, chapter 70, article 20, to the commissioner of human services from the general
327.25 fund or other named fund for the purposes specified in section 2 and are available for the
327.26 fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article
327.27 mean that the addition to or subtraction from the appropriation listed under them is available
327.28 for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.

327.29 **APPROPRIATIONS**

327.30 **Available for the Year**

		<u>Ending June 30</u>	
		<u>2024</u>	<u>2025</u>
328.1			
328.2			
328.3	Sec. 2. <u>COMMISSIONER OF HUMAN</u>		
328.4	<u>SERVICES</u>		
328.5	<u>Subdivision 1. Total Appropriation</u>	\$ <u>137,604,000</u>	\$ <u>329,432,000</u>
328.6	<u>Appropriations by Fund</u>		
328.7	<u>General Fund</u>	<u>139,746,000</u>	<u>325,606,000</u>
328.8	<u>Health Care Access</u>		
328.9	<u>Fund</u>	<u>10,542,000</u>	<u>6,224,000</u>
328.10	<u>Federal TANF</u>	<u>(12,684,000)</u>	<u>(2,398,000)</u>
328.11	<u>Subd. 2. Forecasted Programs</u>		
328.12	<u>(a) MFIP/DWP</u>		
328.13	<u>Appropriations by Fund</u>		
328.14	<u>General Fund</u>	<u>(5,990,000)</u>	<u>(2,793,000)</u>
328.15	<u>Federal TANF</u>	<u>(12,684,000)</u>	<u>(2,398,000)</u>
328.16	<u>(b) MFIP Child Care Assistance</u>	<u>(36,726,000)</u>	<u>(26,004,000)</u>
328.17	<u>(c) General Assistance</u>	<u>(567,000)</u>	<u>292,000</u>
328.18	<u>(d) Minnesota Supplemental Aid</u>	<u>1,424,000</u>	<u>1,500,000</u>
328.19	<u>(e) Housing Support</u>	<u>11,200,000</u>	<u>14,667,000</u>
328.20	<u>(f) Northstar Care for Children</u>	<u>(3,697,000)</u>	<u>(11,309,000)</u>
328.21	<u>(g) MinnesotaCare</u>	<u>10,542,000</u>	<u>6,224,000</u>
328.22	<u>These appropriations are from the health care</u>		
328.23	<u>access fund.</u>		
328.24	<u>(h) Medical Assistance</u>	<u>180,321,000</u>	<u>352,357,000</u>
328.25	<u>(i) Behavioral Health Fund</u>	<u>(6,219,000)</u>	<u>(3,104,000)</u>

328.26 **Sec. 3. EFFECTIVE DATE.**

328.27 This article is effective the day following final enactment.

328.28 **ARTICLE 14**

328.29 **APPROPRIATIONS**

328.30 **Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

329.1 The sums shown in the columns marked "Appropriations" are added to or, if shown in
 329.2 parentheses, subtracted from the appropriations in Laws 2023, chapter 70, article 20, to the
 329.3 agencies and for the purposes specified in this article. The appropriations are from the
 329.4 general fund or other named fund and are available for the fiscal years indicated for each
 329.5 purpose. The figures "2024" and "2025" used in this article mean that the addition to or
 329.6 subtraction from the appropriation listed under them is available for the fiscal year ending
 329.7 June 30, 2024, or June 30, 2025, respectively. Base adjustments mean the addition to or
 329.8 subtraction from the base level adjustment set in Laws 2023, chapter 70, article 20.
 329.9 Supplemental appropriations and reductions to appropriations for the fiscal year ending
 329.10 June 30, 2024, are effective the day following final enactment unless a different effective
 329.11 date is explicit.

APPROPRIATIONS
Available for the Year
Ending June 30
2024 **2025**

329.16 **Sec. 2. COMMISSIONER OF HUMAN**
 329.17 **SERVICES**

329.18 **Subdivision 1. Total Appropriation** \$ **(3,352,000)** \$ **4,420,000**

<u>Appropriations by Fund</u>	<u>2024</u>	<u>2025</u>
329.20 <u>General</u>	<u>(136,000)</u>	<u>2,944,000</u>
329.21 <u>Health Care Access</u>	<u>(3,216,000)</u>	<u>1,476,000</u>

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

329.26 **Subd. 2. Central Office; Operations**

<u>Appropriations by Fund</u>	<u>2024</u>	<u>2025</u>
329.27 <u>General</u>	<u>-0-</u>	<u>(1,039,000)</u>
329.28 <u>Health Care Access</u>	<u>-0-</u>	<u>572,000</u>

329.30 **(a) Residential Mental Health Crisis**
 329.31 **Stabilization.** \$204,000 in fiscal year 2025 is
 329.32 from the general fund to develop a covered
 329.33 benefit under medical assistance to provide
 329.34 residential mental health crisis stabilization

330.1 for children and submit a report to the
 330.2 legislature. This is a onetime appropriation.

330.3 **(b) Base Level Adjustment.** The general fund
 330.4 base is increased by \$331,000 in fiscal year
 330.5 2026 and \$252,000 in fiscal year 2027. The
 330.6 health care access fund base is increased by
 330.7 \$114,000 in fiscal year 2026 and \$114,000 in
 330.8 fiscal year 2027.

330.9 **Subd. 4. Central Office; Health Care**

330.10	<u>Appropriations by Fund</u>		
330.11	<u>General</u>	<u>-0-</u>	<u>400,000</u>
330.12	<u>Health Care Access</u>	<u>(3,216,000)</u>	<u>3,216,000</u>

330.13 **Subd. 5. Forecasted Programs; MinnesotaCare** -0- (2,306,000)

330.14 This appropriation is from the health care
 330.15 access fund.

330.16 **Subd. 6. Forecasted Programs; Medical**
 330.17 **Assistance**

330.18	<u>Appropriations by Fund</u>		
330.19	<u>General</u>	<u>-0-</u>	<u>1,444,000</u>
330.20	<u>Health Care Access</u>	<u>-0-</u>	<u>(6,000)</u>

330.21 **Subd. 7. Grant Programs; Children's Mental**
 330.22 **Health Grants** -0- 8,112,000

330.23 **Respite Care Services.** \$8,112,000 in fiscal
 330.24 year 2025 is for respite care services under
 330.25 Minnesota Statutes, section 245.4889,
 330.26 subdivision 1, paragraph (b), clause (3). Of
 330.27 this appropriation, \$1,000,000 in fiscal year
 330.28 2025 only is for grants to private child-placing
 330.29 agencies, as defined in Minnesota Rules,
 330.30 chapter 9545, to conduct recruitment and
 330.31 support licensing activities that are specific to
 330.32 increasing the availability of licensed foster
 330.33 homes to provide respite care services. The
 330.34 base for this appropriation is \$8,945,000 in

332.1 (a) Natural Organic Reduction. \$140,000 in
 332.2 fiscal year 2025 is from the state government
 332.3 special revenue fund for the licensure of
 332.4 natural organic reduction facilities. The base
 332.5 for this appropriation is \$85,000 in fiscal year
 332.6 2026 and \$16,000 in fiscal year 2027.

332.7 (b) Groundwater Thermal Exchange Device
 332.8 Permitting. \$4,000 in fiscal year 2024 and
 332.9 \$4,000 in fiscal year 2025 are from the state
 332.10 government special revenue fund for costs
 332.11 related to issuing permits for groundwater
 332.12 thermal exchange devices.

332.13 (c) Base Level Adjustment. The general fund
 332.14 base is increased by \$448,000 in fiscal year
 332.15 2026 and \$185,000 in fiscal year 2027. The
 332.16 state government special revenue fund base is
 332.17 increased by \$89,000 in fiscal year 2026 and
 332.18 \$20,000 in fiscal year 2027.

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

332.20	Sec. 4. <u>BOARD OF PHARMACY</u>	<u>\$</u>	<u>1,500,000</u>	<u>\$</u>	<u>36,000</u>
332.21	<u>Appropriations by Fund</u>				
332.22	<u>General</u>	<u>1,500,000</u>	<u>-0-</u>		
332.23	<u>State Government</u>				
332.24	<u>Special Revenue</u>	<u>-0-</u>	<u>36,000</u>		

332.25 (a) Legal Costs. \$1,500,000 in fiscal year
 332.26 2024 is from the general fund for legal costs
 332.27 of the board. This is a onetime appropriation.

332.28 (b) Pharmacist Authority; Laboratory Tests
 332.29 and Vaccines. \$27,000 in fiscal year 2025 is
 332.30 from the state government special revenue
 332.31 fund for board costs related to pharmacist
 332.32 authority to order and perform laboratory tests
 332.33 and initiate, order, and administer vaccines.

333.1 (c) Statewide Protocol; Drugs to Prevent
 333.2 the Acquisition of HIV. \$9,000 in fiscal year
 333.3 2025 is from the state government special
 333.4 revenue fund for the board to develop a
 333.5 statewide protocol for administering drugs to
 333.6 prevent the acquisition of human
 333.7 immunodeficiency virus (HIV). This is a
 333.8 onetime appropriation.

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

333.10 Sec. 5. BOARD OF DIRECTORS OF MNSURE \$ -0- \$ 807,000

333.11 Cost-Sharing Reduction Program
 333.12 Administration. \$807,000 in fiscal year 2025
 333.13 is from the general fund for MNsure
 333.14 information technology and administrative
 333.15 costs for the cost-sharing reduction program.
 333.16 The base for this appropriation is \$506,000 in
 333.17 fiscal year 2026 and \$0 in fiscal year 2027.

333.18 Sec. 6. TRANSFERS.

333.19 (a) \$8,830,000 in fiscal year 2026 is transferred from the premium security plan account
 333.20 under Minnesota Statutes, section 62E.25, subdivision 1, to the general fund. This is a
 333.21 onetime transfer.

333.22 (b) \$50,000 in fiscal year 2025, \$50,000 in fiscal year 2026, and \$50,000 in fiscal year
 333.23 2027 are transferred from the health care access fund to the insulin repayment account under
 333.24 Minnesota Statutes, section 151.741, subdivision 5. These are onetime transfers.

333.25 Sec. 7. Laws 2023, chapter 22, section 4, subdivision 2, is amended to read:

333.26 Subd. 2. **Grants to navigators.**

333.27 (a) \$1,936,000 in fiscal year 2024 is
 333.28 appropriated from the health care access fund
 333.29 to the commissioner of human services for
 333.30 grants to organizations with a MNsure grant
 333.31 services navigator assister contract in good
 333.32 standing as of the date of enactment. The grant

334.1 payment to each organization must be in
 334.2 proportion to the number of medical assistance
 334.3 and MinnesotaCare enrollees each
 334.4 organization assisted that resulted in a
 334.5 successful enrollment in the second quarter of
 334.6 fiscal years 2020 and 2023, as determined by
 334.7 MNsure's navigator payment process. This is
 334.8 a onetime appropriation and is available until
 334.9 June 30, 2025.

334.10 (b) \$3,000,000 in fiscal year 2024 is
 334.11 appropriated from the health care access fund
 334.12 to the commissioner of human services for
 334.13 grants to organizations with a MNsure grant
 334.14 services navigator assister contract for
 334.15 successful enrollments in medical assistance
 334.16 and MinnesotaCare. This is a onetime
 334.17 appropriation and is available until June 30,
 334.18 2025.

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

334.20 Sec. 8. Laws 2023, chapter 70, article 20, section 2, subdivision 5, is amended to read:

334.21 **Subd. 5. Central Office; Health Care**

334.22	Appropriations by Fund		
334.23	General	35,807,000	31,349,000
334.24	Health Care Access	30,668,000	50,168,000

334.25 **(a) Medical assistance and MinnesotaCare**
 334.26 **accessibility improvements. \$4,000,000**
 334.27 **\$784,000 in fiscal year 2024 is and \$3,216,000**
 334.28 **in fiscal year 2025 are** from the general fund
 334.29 for interactive voice response upgrades and
 334.30 translation services for medical assistance and
 334.31 MinnesotaCare enrollees with limited English
 334.32 proficiency. This appropriation is available
 334.33 until June 30, ~~2025~~ 2027.

335.1 **(b) Transforming service delivery.** \$155,000
335.2 in fiscal year 2024 and \$180,000 in fiscal year
335.3 2025 are from the general fund for
335.4 transforming service delivery projects.

335.5 **(c) Improving the Minnesota eligibility**
335.6 **technology system functionality.** \$1,604,000
335.7 in fiscal year 2024 and \$711,000 in fiscal year
335.8 2025 are from the general fund for improving
335.9 the Minnesota eligibility technology system
335.10 functionality. The base for this appropriation
335.11 is \$1,421,000 in fiscal year 2026 and \$0 in
335.12 fiscal year 2027.

335.13 **(d) Actuarial and economic analyses.**
335.14 \$2,500,000 is from the health care access fund
335.15 for actuarial and economic analyses and to
335.16 prepare and submit a state innovation waiver
335.17 under section 1332 of the federal Affordable
335.18 Care Act for a Minnesota public option health
335.19 care plan. This is a onetime appropriation and
335.20 is available until June 30, 2025.

335.21 **(e) Contingent appropriation for Minnesota**
335.22 **public option health care plan.** \$22,000,000
335.23 in fiscal year 2025 is from the health care
335.24 access fund to implement a Minnesota public
335.25 option health care plan. This is a onetime
335.26 appropriation and is available upon approval
335.27 of a state innovation waiver under section
335.28 1332 of the federal Affordable Care Act. This
335.29 appropriation is available until June 30, 2027.

335.30 **(f) Carryforward authority.** Notwithstanding
335.31 Minnesota Statutes, section 16A.28,
335.32 subdivision 3, \$2,367,000 of the appropriation
335.33 in fiscal year 2024 is available until June 30,
335.34 2027.

336.1 (g) **Base level adjustment.** The general fund
 336.2 base is \$32,315,000 in fiscal year 2026 and
 336.3 \$27,536,000 in fiscal year 2027. The health
 336.4 care access fund base is \$28,168,000 in fiscal
 336.5 year 2026 and \$28,168,000 in fiscal year 2027.

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

336.7 Sec. 9. Laws 2023, chapter 70, article 20, section 2, subdivision 7, is amended to read:

336.8 **Subd. 7. Central Office; Behavioral Health, Deaf**
 336.9 **and Hard of Hearing, and Housing Services**

336.10	Appropriations by Fund		
336.11		27,870,000	27,592,000
336.12	General	<u>27,734,000</u>	<u>27,728,000</u>
336.13	Lottery Prize	163,000	163,000

336.14 (a) **Homeless management system.** \$250,000
 336.15 in fiscal year 2024 and \$1,000,000 in fiscal
 336.16 year 2025 are from the general fund for a
 336.17 homeless management information system.
 336.18 The base for this appropriation is \$1,140,000
 336.19 in fiscal year 2026 and \$1,140,000 in fiscal
 336.20 year 2027.

336.21 (b) **Online behavioral health program**
 336.22 **locator.** \$959,000 in fiscal year 2024 and
 336.23 \$959,000 in fiscal year 2025 are from the
 336.24 general fund for an online behavioral health
 336.25 program locator.

336.26 (c) **Integrated services for children and**
 336.27 **families.** \$286,000 in fiscal year 2024 and
 336.28 \$286,000 in fiscal year 2025 are from the
 336.29 general fund for integrated services for
 336.30 children and families projects.

336.31 Notwithstanding Minnesota Statutes, section
 336.32 16A.28, subdivision 3, \$1,797,000 of the
 336.33 appropriation in fiscal year 2024 is available
 336.34 until June 30, 2027.

337.1 **(d) Carryforward authority.**

337.2 Notwithstanding Minnesota Statutes, section
 337.3 16A.28, subdivision 3, \$842,000 of the
 337.4 appropriation in fiscal year 2024 is available
 337.5 until June 30, 2027, \$136,000 of the
 337.6 appropriation in fiscal year 2025 is available
 337.7 until June 30, 2027, and \$852,000 of the
 337.8 appropriation in fiscal year 2025 is available
 337.9 until June 30, 2028.

337.10 **(f) Base level adjustment.** The general fund
 337.11 base is \$25,243,000 in fiscal year 2026 and
 337.12 \$24,682,000 in fiscal year 2027.

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

337.14 Sec. 10. Laws 2023, chapter 70, article 20, section 2, subdivision 29, is amended to read:

337.15 Subd. 29. **Grant Programs; Adult Mental Health**
 337.16 **Grants**

	132,327,000	121,270,000
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337.17 **(a) Mobile crisis grants to Tribal Nations.**
 337.18 \$1,000,000 in fiscal year 2024 and \$1,000,000
 337.19 in fiscal year 2025 are for mobile crisis grants
 337.20 under Minnesota Statutes ~~section~~, sections
 337.21 245.4661, subdivision 9, paragraph (b), clause
 337.22 (15), and 245.4889, subdivision 1, paragraph
 337.23 (b), clause (4), to Tribal Nations.

337.24 **(b) Mental health provider supervision**
 337.25 **grant program.** \$1,500,000 in fiscal year
 337.26 2024 and \$1,500,000 in fiscal year 2025 are
 337.27 for the mental health provider supervision
 337.28 grant program under Minnesota Statutes,
 337.29 section 245.4663.

337.30 **(c) Minnesota State University, Mankato**
 337.31 **community behavioral health center.**
 337.32 \$750,000 in fiscal year 2024 and \$750,000 in
 337.33 fiscal year 2025 are for a grant to the Center
 337.34 for Rural Behavioral Health at Minnesota State

338.1 University, Mankato to establish a community
338.2 behavioral health center and training clinic.
338.3 The community behavioral health center must
338.4 provide comprehensive, culturally specific,
338.5 trauma-informed, practice- and
338.6 evidence-based, person- and family-centered
338.7 mental health and substance use disorder
338.8 treatment services in Blue Earth County and
338.9 the surrounding region to individuals of all
338.10 ages, regardless of an individual's ability to
338.11 pay or place of residence. The community
338.12 behavioral health center and training clinic
338.13 must also provide training and workforce
338.14 development opportunities to students enrolled
338.15 in the university's training programs in the
338.16 fields of social work, counseling and student
338.17 personnel, alcohol and drug studies,
338.18 psychology, and nursing. Upon request, the
338.19 commissioner must make information
338.20 regarding the use of this grant funding
338.21 available to the chairs and ranking minority
338.22 members of the legislative committees with
338.23 jurisdiction over behavioral health. This is a
338.24 onetime appropriation and is available until
338.25 June 30, 2027.

338.26 **(d) White Earth Nation; adult mental health**
338.27 **initiative.** \$300,000 in fiscal year 2024 and
338.28 \$300,000 in fiscal year 2025 are for adult
338.29 mental health initiative grants to the White
338.30 Earth Nation. This is a onetime appropriation.

338.31 **(e) Mobile crisis grants.** \$8,472,000 in fiscal
338.32 year 2024 and \$8,380,000 in fiscal year 2025
338.33 are for the mobile crisis grants under
338.34 Minnesota Statutes, ~~section~~ sections 245.4661,
338.35 subdivision 9, paragraph (b), clause (15), and

339.1 245.4889, subdivision 1, paragraph (b), clause
 339.2 (4). This is a onetime appropriation and is
 339.3 available until June 30, 2027.

339.4 **(f) Base level adjustment.** The general fund
 339.5 base is \$121,980,000 in fiscal year 2026 and
 339.6 \$121,980,000 in fiscal year 2027.

339.7 Sec. 11. Laws 2023, chapter 70, article 20, section 3, subdivision 2, is amended to read:

339.8 **Subd. 2. Health Improvement**

339.9	Appropriations by Fund		
339.10	General	229,600,000	210,030,000
339.11	State Government		
339.12	Special Revenue	12,392,000	12,682,000
339.13	Health Care Access	49,051,000	53,290,000
339.14	Federal TANF	11,713,000	11,713,000

339.15 **(a) Studies of telehealth expansion and**
 339.16 **payment parity.** \$1,200,000 in fiscal year
 339.17 2024 is from the general fund for studies of
 339.18 telehealth expansion and payment parity. This
 339.19 is a onetime appropriation and is available
 339.20 until June 30, 2025.

339.21 **(b) Advancing equity through capacity**
 339.22 **building and resource allocation grant**
 339.23 **program.** \$916,000 in fiscal year 2024 and
 339.24 \$916,000 in fiscal year 2025 are from the
 339.25 general fund for grants under Minnesota
 339.26 Statutes, section 144.9821. This is a onetime
 339.27 appropriation.

339.28 **(c) Grant to Minnesota Community Health**
 339.29 **Worker Alliance.** \$971,000 in fiscal year
 339.30 2024 and \$971,000 in fiscal year 2025 are
 339.31 from the general fund for Minnesota Statutes,
 339.32 section 144.1462.

339.33 **(d) Community solutions for healthy child**
 339.34 **development grants.** \$2,730,000 in fiscal year

340.1 2024 and \$2,730,000 in fiscal year 2025 are
340.2 from the general fund for grants under
340.3 Minnesota Statutes, section 145.9257. The
340.4 base for this appropriation is \$2,415,000 in
340.5 fiscal year 2026 and \$2,415,000 in fiscal year
340.6 2027.

340.7 **(e) Comprehensive Overdose and Morbidity**
340.8 **Prevention Act.** \$9,794,000 in fiscal year
340.9 2024 and \$10,458,000 in fiscal year 2025 are
340.10 from the general fund for comprehensive
340.11 overdose and morbidity prevention strategies
340.12 under Minnesota Statutes, section 144.0528.
340.13 The base for this appropriation is \$10,476,000
340.14 in fiscal year 2026 and \$10,476,000 in fiscal
340.15 year 2027.

340.16 **(f) Emergency preparedness and response.**
340.17 \$10,486,000 in fiscal year 2024 and
340.18 \$14,314,000 in fiscal year 2025 are from the
340.19 general fund for public health emergency
340.20 preparedness and response, the sustainability
340.21 of the strategic stockpile, and COVID-19
340.22 pandemic response transition. The base for
340.23 this appropriation is \$11,438,000 in fiscal year
340.24 2026 and \$11,362,000 in fiscal year 2027.

340.25 **(g) Healthy Beginnings, Healthy Families.**
340.26 (1) \$8,440,000 in fiscal year 2024 and
340.27 \$7,305,000 in fiscal year 2025 are from the
340.28 general fund for grants under Minnesota
340.29 Statutes, sections 145.9571 to 145.9576. The
340.30 base for this appropriation is \$1,500,000 in
340.31 fiscal year 2026 and \$1,500,000 in fiscal year
340.32 2027. (2) Of the amount in clause (1),
340.33 \$400,000 in fiscal year 2024 is to support the
340.34 transition from implementation of activities
340.35 under Minnesota Statutes, section 145.4235,

341.1 to implementation of activities under
341.2 Minnesota Statutes, sections 145.9571 to
341.3 145.9576. The commissioner shall award four
341.4 sole-source grants of \$100,000 each to Face
341.5 to Face, Cradle of Hope, Division of Indian
341.6 Work, and Minnesota Prison Doula Project.
341.7 The amount in this clause is a onetime
341.8 appropriation.

341.9 **(h) Help Me Connect.** \$463,000 in fiscal year
341.10 2024 and \$921,000 in fiscal year 2025 are
341.11 from the general fund for the Help Me
341.12 Connect program under Minnesota Statutes,
341.13 section 145.988.

341.14 **(i) Home visiting.** \$2,000,000 in fiscal year
341.15 2024 and \$2,000,000 in fiscal year 2025 are
341.16 from the general fund for home visiting under
341.17 Minnesota Statutes, section 145.87, to provide
341.18 home visiting to priority populations under
341.19 Minnesota Statutes, section 145.87,
341.20 subdivision 1, paragraph (e).

341.21 **(j) No Surprises Act enforcement.**
341.22 \$1,210,000 in fiscal year 2024 and \$1,090,000
341.23 in fiscal year 2025 are from the general fund
341.24 for implementation of the federal No Surprises
341.25 Act under Minnesota Statutes, section
341.26 62Q.021, and an assessment of the feasibility
341.27 of a statewide provider directory. The general
341.28 fund base for this appropriation is \$855,000
341.29 in fiscal year 2026 and \$855,000 in fiscal year
341.30 2027.

341.31 **(k) Office of African American Health.**
341.32 \$1,000,000 in fiscal year 2024 and \$1,000,000
341.33 in fiscal year 2025 are from the general fund
341.34 for grants under the authority of the Office of

- 342.1 African American Health under Minnesota
342.2 Statutes, section 144.0756.
- 342.3 **(l) Office of American Indian Health.**
342.4 \$1,000,000 in fiscal year 2024 and \$1,000,000
342.5 in fiscal year 2025 are from the general fund
342.6 for grants under the authority of the Office of
342.7 American Indian Health under Minnesota
342.8 Statutes, section 144.0757.
- 342.9 **(m) Public health system transformation**
342.10 **grants.** (1) \$9,844,000 in fiscal year 2024 and
342.11 \$9,844,000 in fiscal year 2025 are from the
342.12 general fund for grants under Minnesota
342.13 Statutes, section 145A.131, subdivision 1,
342.14 paragraph (f).
- 342.15 (2) \$535,000 in fiscal year 2024 and \$535,000
342.16 in fiscal year 2025 are from the general fund
342.17 for grants under Minnesota Statutes, section
342.18 145A.14, subdivision 2b.
- 342.19 (3) \$321,000 in fiscal year 2024 and \$321,000
342.20 in fiscal year 2025 are from the general fund
342.21 for grants under Minnesota Statutes, section
342.22 144.0759.
- 342.23 **(n) Health care workforce.** (1) \$1,010,000
342.24 in fiscal year 2024 and \$2,550,000 in fiscal
342.25 year 2025 are from the health care access fund
342.26 for rural training tracks and rural clinicals
342.27 grants under Minnesota Statutes, sections
342.28 144.1505 and 144.1507. The base for this
342.29 appropriation is \$4,060,000 in fiscal year 2026
342.30 and \$3,600,000 in fiscal year 2027.
- 342.31 (2) \$420,000 in fiscal year 2024 and \$420,000
342.32 in fiscal year 2025 are from the health care
342.33 access fund for immigrant international

343.1 medical graduate training grants under
343.2 Minnesota Statutes, section 144.1911.

343.3 (3) \$5,654,000 in fiscal year 2024 and
343.4 \$5,550,000 in fiscal year 2025 are from the
343.5 health care access fund for site-based clinical
343.6 training grants under Minnesota Statutes,
343.7 section 144.1508. The base for this
343.8 appropriation is \$4,657,000 in fiscal year 2026
343.9 and \$3,451,000 in fiscal year 2027.

343.10 (4) \$1,000,000 in fiscal year 2024 and
343.11 \$1,000,000 in fiscal year 2025 are from the
343.12 health care access fund for mental health for
343.13 health care professional grants. This is a
343.14 onetime appropriation and is available until
343.15 June 30, 2027.

343.16 (5) \$502,000 in fiscal year 2024 and \$502,000
343.17 in fiscal year 2025 are from the health care
343.18 access fund for workforce research and data
343.19 analysis of shortages, maldistribution of health
343.20 care providers in Minnesota, and the factors
343.21 that influence decisions of health care
343.22 providers to practice in rural areas of
343.23 Minnesota.

343.24 (o) **School health.** \$800,000 in fiscal year
343.25 2024 and \$1,300,000 in fiscal year 2025 are
343.26 from the general fund for grants under
343.27 Minnesota Statutes, section 145.903. The base
343.28 for this appropriation is \$2,300,000 in fiscal
343.29 year 2026 and \$2,300,000 in fiscal year 2027.

343.30 (p) **Long COVID.** \$3,146,000 in fiscal year
343.31 2024 and \$3,146,000 in fiscal year 2025 are
343.32 from the general fund for grants and to
343.33 implement Minnesota Statutes, section
343.34 145.361.

344.1 (q) **Workplace safety grants.** \$4,400,000 in
344.2 fiscal year 2024 is from the general fund for
344.3 grants to health care entities to improve
344.4 employee safety or security. This is a onetime
344.5 appropriation and is available until June 30,
344.6 2027. The commissioner may use up to ten
344.7 percent of this appropriation for
344.8 administration.

344.9 (r) **Clinical dental education innovation**
344.10 **grants.** \$1,122,000 in fiscal year 2024 and
344.11 \$1,122,000 in fiscal year 2025 are from the
344.12 general fund for clinical dental education
344.13 innovation grants under Minnesota Statutes,
344.14 section 144.1913.

344.15 (s) **Emmett Louis Till Victims Recovery**
344.16 **Program.** \$500,000 in fiscal year 2024 is from
344.17 the general fund for a grant to the Emmett
344.18 Louis Till Victims Recovery Program. The
344.19 commissioner must not use any of this
344.20 appropriation for administration. This is a
344.21 onetime appropriation and is available until
344.22 June 30, 2025.

344.23 (t) **Center for health care affordability.**
344.24 \$2,752,000 in fiscal year 2024 and \$3,989,000
344.25 in fiscal year 2025 are from the general fund
344.26 to establish a center for health care
344.27 affordability and to implement Minnesota
344.28 Statutes, section 62J.312. The general fund
344.29 base for this appropriation is \$3,988,000 in
344.30 fiscal year 2026 and \$3,988,000 in fiscal year
344.31 2027.

344.32 (u) **Federally qualified health centers**
344.33 **apprenticeship program.** \$690,000 in fiscal
344.34 year 2024 and \$690,000 in fiscal year 2025

345.1 are from the general fund for grants under
345.2 Minnesota Statutes, section 145.9272.

345.3 **(v) Alzheimer's public information**
345.4 **program.** \$80,000 in fiscal year 2024 and
345.5 \$80,000 in fiscal year 2025 are from the
345.6 general fund for grants to community-based
345.7 organizations to co-create culturally specific
345.8 messages to targeted communities and to
345.9 promote public awareness materials online
345.10 through diverse media channels.

345.11 ~~(w) **Keeping Nurses at the Bedside Act;**~~
345.12 ~~**contingent appropriation Nurse and Patient**~~
345.13 ~~**Safety Act. The appropriations in this**~~
345.14 ~~**paragraph are contingent upon legislative**~~
345.15 ~~**enactment of 2023 Senate File 1384 by the**~~
345.16 ~~**93rd Legislature.** The appropriations in this~~
345.17 ~~**paragraph are available until June 30, 2027.**~~

345.18 (1) \$5,317,000 in fiscal year 2024 and
345.19 \$5,317,000 in fiscal year 2025 are from the
345.20 general fund for loan forgiveness under
345.21 Minnesota Statutes, section 144.1501, for
345.22 eligible nurses who have agreed to work as
345.23 hospital nurses in accordance with Minnesota
345.24 Statutes, section 144.1501, subdivision 2,
345.25 paragraph (a), clause (7).

345.26 (2) \$66,000 in fiscal year 2024 and \$66,000
345.27 in fiscal year 2025 are from the general fund
345.28 for loan forgiveness under Minnesota Statutes,
345.29 section 144.1501, for eligible nurses who have
345.30 agreed to teach in accordance with Minnesota
345.31 Statutes, section 144.1501, subdivision 2,
345.32 paragraph (a), clause (3).

345.33 ~~(3) \$545,000 in fiscal year 2024 and \$879,000~~
345.34 ~~in fiscal year 2025 are from the general fund~~

346.1 ~~to administer Minnesota Statutes, section~~
346.2 ~~144.7057; to perform the evaluation duties~~
346.3 ~~described in Minnesota Statutes, section~~
346.4 ~~144.7058; to continue prevention of violence~~
346.5 ~~in health care program activities; to analyze~~
346.6 ~~potential links between adverse events and~~
346.7 ~~understaffing; to convene stakeholder groups~~
346.8 ~~and create a best practices toolkit; and for a~~
346.9 ~~report on the current status of the state's~~
346.10 ~~nursing workforce employed by hospitals. The~~
346.11 ~~base for this appropriation is \$624,000 in fiscal~~
346.12 ~~year 2026 and \$454,000 in fiscal year 2027.~~

346.13 **(x) Supporting healthy development of**
346.14 **babies.** \$260,000 in fiscal year 2024 and
346.15 \$260,000 in fiscal year 2025 are from the
346.16 general fund for a grant to the Amherst H.
346.17 Wilder Foundation for the African American
346.18 Babies Coalition initiative. The base for this
346.19 appropriation is \$520,000 in fiscal year 2026
346.20 and \$0 in fiscal year 2027. Any appropriation
346.21 in fiscal year 2026 is available until June 30,
346.22 2027. This paragraph expires on June 30,
346.23 2027.

346.24 **(y) Health professional education loan**
346.25 **forgiveness.** \$2,780,000 in fiscal year 2024
346.26 is from the general fund for eligible mental
346.27 health professional loan forgiveness under
346.28 Minnesota Statutes, section 144.1501. This is
346.29 a onetime appropriation. The commissioner
346.30 may use up to ten percent of this appropriation
346.31 for administration.

346.32 **(z) Primary care residency expansion grant**
346.33 **program.** \$400,000 in fiscal year 2024 and
346.34 \$400,000 in fiscal year 2025 are from the

347.1 general fund for a psychiatry resident under
347.2 Minnesota Statutes, section 144.1506.

347.3 **(aa) Pediatric primary care mental health**
347.4 **training grant program.** \$1,000,000 in fiscal
347.5 year 2024 and \$1,000,000 in fiscal year 2025
347.6 are from the general fund for grants under
347.7 Minnesota Statutes, section 144.1509. The
347.8 commissioner may use up to ten percent of
347.9 this appropriation for administration.

347.10 **(bb) Mental health cultural community**
347.11 **continuing education grant program.**
347.12 \$500,000 in fiscal year 2024 and \$500,000 in
347.13 fiscal year 2025 are from the general fund for
347.14 grants under Minnesota Statutes, section
347.15 144.1511. The commissioner may use up to
347.16 ten percent of this appropriation for
347.17 administration.

347.18 **(cc) Labor trafficking services grant**
347.19 **program.** \$500,000 in fiscal year 2024 and
347.20 \$500,000 in fiscal year 2025 are from the
347.21 general fund for grants under Minnesota
347.22 Statutes, section 144.3885.

347.23 **(dd) Palliative Care Advisory Council.**
347.24 ~~\$40,000~~ \$44,000 in fiscal year 2024 and
347.25 ~~\$40,000~~ \$44,000 in fiscal year 2025 are from
347.26 the general fund for ~~grants~~ administration
347.27 under Minnesota Statutes, section 144.059.

347.28 **(ee) Analysis of a universal health care**
347.29 **financing system.** \$1,815,000 in fiscal year
347.30 2024 and \$580,000 in fiscal year 2025 are
347.31 from the general fund to the commissioner to
347.32 contract for an analysis of the benefits and
347.33 costs of a legislative proposal for a universal
347.34 health care financing system and a similar

348.1 analysis of the current health care financing
348.2 system. The base for this appropriation is
348.3 \$580,000 in fiscal year 2026 and \$0 in fiscal
348.4 year 2027. This appropriation is available until
348.5 June 30, 2027.

348.6 **(ff) Charitable assets public interest review.**

348.7 (1) The appropriations under this paragraph
348.8 are contingent upon legislative enactment of
348.9 2023 House File 402 by the 93rd Legislature.

348.10 (2) \$1,584,000 in fiscal year 2024 and
348.11 \$769,000 in fiscal year 2025 are from the
348.12 general fund to review certain health care
348.13 entity transactions; to conduct analyses of the
348.14 impacts of health care transactions on health
348.15 care cost, quality, and competition; and to
348.16 issue public reports on health care transactions
348.17 in Minnesota and their impacts. The base for
348.18 this appropriation is \$710,000 in fiscal year
348.19 2026 and \$710,000 in fiscal year 2027.

348.20 **(gg) Study of the development of a statewide**
348.21 **registry for provider orders for**

348.22 **life-sustaining treatment.** \$365,000 in fiscal
348.23 year 2024 and \$365,000 in fiscal year 2025
348.24 are from the general fund for a study of the
348.25 development of a statewide registry for
348.26 provider orders for life-sustaining treatment.
348.27 This is a onetime appropriation.

348.28 **(hh) Task Force on Pregnancy Health and**

348.29 **Substance Use Disorders.** \$199,000 in fiscal
348.30 year 2024 and \$100,000 in fiscal year 2025
348.31 are from the general fund for the Task Force
348.32 on Pregnancy Health and Substance Use
348.33 Disorders. This is a onetime appropriation and
348.34 is available until June 30, 2025.

349.1 (ii) **988 Suicide and crisis lifeline.** \$4,000,000
349.2 in fiscal year 2024 is from the general fund
349.3 for 988 national suicide prevention lifeline
349.4 grants under Minnesota Statutes, section
349.5 145.561. This is a onetime appropriation.

349.6 (jj) **Equitable Health Care Task Force.**
349.7 \$779,000 in fiscal year 2024 and \$749,000 in
349.8 fiscal year 2025 are from the general fund for
349.9 the Equitable Health Care Task Force. This is
349.10 a onetime appropriation.

349.11 (kk) **Psychedelic Medicine Task Force.**
349.12 \$338,000 in fiscal year 2024 and \$171,000 in
349.13 fiscal year 2025 are from the general fund for
349.14 the Psychedelic Medicine Task Force. This is
349.15 a onetime appropriation.

349.16 (ll) **Medical education and research costs.**
349.17 \$300,000 in fiscal year 2024 and \$300,000 in
349.18 fiscal year 2025 are from the general fund for
349.19 the medical education and research costs
349.20 program under Minnesota Statutes, section
349.21 62J.692.

349.22 (mm) **Special Guerilla Unit Veterans grant**
349.23 **program.** \$250,000 in fiscal year 2024 and
349.24 \$250,000 in fiscal year 2025 are from the
349.25 general fund for a grant to the Special
349.26 Guerrilla Units Veterans and Families of the
349.27 United States of America to offer
349.28 programming and culturally specific and
349.29 specialized assistance to support the health
349.30 and well-being of Special Guerilla Unit
349.31 Veterans. The base for this appropriation is
349.32 \$500,000 in fiscal year 2026 and \$0 in fiscal
349.33 year 2027. Any amount appropriated in fiscal
349.34 year 2026 is available until June 30, 2027.
349.35 This paragraph expires June 30, 2027.

350.1 (nn) **Safe harbor regional navigator.**
350.2 \$300,000 in fiscal year 2024 and \$300,000 in
350.3 fiscal year 2025 are for a regional navigator
350.4 in northwestern Minnesota. The commissioner
350.5 may use up to ten percent of this appropriation
350.6 for administration.

350.7 (oo) **Network adequacy.** \$798,000 in fiscal
350.8 year 2024 and \$491,000 in fiscal year 2025
350.9 are from the general fund for reviews of
350.10 provider networks under Minnesota Statutes,
350.11 section 62K.10, to determine network
350.12 adequacy.

350.13 **(pp) Grants to Minnesota Alliance for**
350.14 **Volunteer Advancement.** \$278,000 in fiscal
350.15 year 2024 is from the general fund for a grant
350.16 to the Minnesota Alliance for Volunteer
350.17 Advancement to administer needs-based
350.18 volunteerism subgrants targeting
350.19 underresourced nonprofit organizations in
350.20 greater Minnesota. Subgrants must be used to
350.21 support the ongoing efforts of selected
350.22 organizations to address and minimize
350.23 disparities in access to human services through
350.24 increased volunteerism. Subgrant applicants
350.25 must demonstrate that the populations to be
350.26 served by the subgrantee are underserved or
350.27 suffer from or are at risk of homelessness,
350.28 hunger, poverty, lack of access to health care,
350.29 or deficits in education. The Minnesota
350.30 Alliance for Volunteer Advancement must
350.31 give priority to organizations that are serving
350.32 the needs of vulnerable populations. This is a
350.33 onetime appropriation and is available until
350.34 June 30, 2025.

351.1 ~~(pp)(1)~~(qq)(1) **TANF Appropriations.** TANF
351.2 funds must be used as follows:

351.3 (i) \$3,579,000 in fiscal year 2024 and
351.4 \$3,579,000 in fiscal year 2025 are from the
351.5 TANF fund for home visiting and nutritional
351.6 services listed under Minnesota Statutes,
351.7 section 145.882, subdivision 7, clauses (6) and
351.8 (7). Funds must be distributed to community
351.9 health boards according to Minnesota Statutes,
351.10 section 145A.131, subdivision 1;

351.11 (ii) \$2,000,000 in fiscal year 2024 and
351.12 \$2,000,000 in fiscal year 2025 are from the
351.13 TANF fund for decreasing racial and ethnic
351.14 disparities in infant mortality rates under
351.15 Minnesota Statutes, section 145.928,
351.16 subdivision 7;

351.17 (iii) \$4,978,000 in fiscal year 2024 and
351.18 \$4,978,000 in fiscal year 2025 are from the
351.19 TANF fund for the family home visiting grant
351.20 program under Minnesota Statutes, section
351.21 145A.17. \$4,000,000 of the funding in fiscal
351.22 year 2024 and \$4,000,000 in fiscal year 2025
351.23 must be distributed to community health
351.24 boards under Minnesota Statutes, section
351.25 145A.131, subdivision 1. \$978,000 of the
351.26 funding in fiscal year 2024 and \$978,000 in
351.27 fiscal year 2025 must be distributed to Tribal
351.28 governments under Minnesota Statutes, section
351.29 145A.14, subdivision 2a;

351.30 (iv) \$1,156,000 in fiscal year 2024 and
351.31 \$1,156,000 in fiscal year 2025 are from the
351.32 TANF fund for sexual and reproductive health
351.33 services grants under Minnesota Statutes,
351.34 section 145.925; and

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

352.9 **(2) TANF Carryforward.** Any unexpended
 352.10 balance of the TANF appropriation in the first
 352.11 year does not cancel but is available in the
 352.12 second year.

352.13 ~~(qq)~~ **(rr) Base level adjustments.** The general
 352.14 fund base is \$197,644,000 in fiscal year 2026
 352.15 and \$195,714,000 in fiscal year 2027. The
 352.16 health care access fund base is \$53,354,000
 352.17 in fiscal year 2026 and \$50,962,000 in fiscal
 352.18 year 2027.

352.19 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
 352.20 **paragraph (pp) is effective retroactively from July 1, 2023.**

352.21 Sec. 12. Laws 2023, chapter 70, article 20, section 12, as amended by Laws 2023, chapter
 352.22 75, section 13, is amended to read:

352.23 **Sec. 12. COMMISSIONER OF**
 352.24 **MANAGEMENT AND BUDGET** \$ 12,932,000 \$ 3,412,000

352.25 **(a) Outcomes and evaluation consultation.**
 352.26 \$450,000 in fiscal year 2024 and \$450,000 in
 352.27 fiscal year 2025 are for outcomes and
 352.28 evaluation consultation requirements.

352.29 **(b) Department of Children, Youth, and**
 352.30 **Families.** \$11,931,000 in fiscal year 2024 and
 352.31 \$2,066,000 in fiscal year 2025 are to establish
 352.32 the Department of Children, Youth, and
 352.33 Families. This is a onetime appropriation.

353.1 ~~(e) Keeping Nurses at the Bedside Act~~
353.2 ~~impact evaluation; contingent~~
353.3 ~~appropriation. \$232,000 in fiscal year 2025~~
353.4 ~~is for the Keeping Nurses at the Bedside Act~~
353.5 ~~impact evaluation. This appropriation is~~
353.6 ~~contingent upon legislative enactment by the~~
353.7 ~~93rd Legislature of a provision substantially~~
353.8 ~~similar to the impact evaluation provision in~~
353.9 ~~2023 S.F. No. 2995, the third engrossment,~~
353.10 ~~article 3, section 22. This is a onetime~~
353.11 ~~appropriation and is available until June 30,~~
353.12 ~~2029.~~

353.13 ~~(d)~~ (c) **Health care subcabinet.** \$551,000 in
353.14 fiscal year 2024 and \$664,000 in fiscal year
353.15 2025 are to hire an executive director for the
353.16 health care subcabinet and to provide staffing
353.17 and administrative support for the health care
353.18 subcabinet.

353.19 ~~(e)~~ (d) **Base level adjustment.** The general
353.20 fund base is \$1,114,000 in fiscal year 2026
353.21 and \$1,114,000 in fiscal year 2027.

353.22 Sec. 13. **APPROPRIATIONS GIVEN EFFECT ONCE.**

353.23 If an appropriation or transfer in this article is enacted more than once during the 2024
353.24 regular session, the appropriation or transfer must be given effect once.

353.25 Sec. 14. **EXPIRATION OF UNCODIFIED LANGUAGE.**

353.26 All uncodified language contained in this article expires on June 30, 2025, unless a
353.27 different expiration date is explicit.

353.28 Sec. 15. **REPEALER.**

353.29 (a) Laws 2023, chapter 70, article 20, section 2, subdivision 31, as amended by Laws
353.30 2023, chapter 75, section 12, is repealed.

353.31 (b) Laws 2023, chapter 75, section 10, is repealed.

354.1 **EFFECTIVE DATE.** Paragraph (b) is effective the day following final enactment.

62A.041 MATERNITY BENEFITS.

Subd. 3. **Abortion.** For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

62J.312 CENTER FOR HEALTH CARE AFFORDABILITY.

Subd. 6. **340B covered entity report.** (a) Beginning April 1, 2024, each 340B covered entity, as defined by section 340B(a)(4) of the Public Health Service Act, must report to the commissioner of health by April 1 of each year the following information related to its participation in the federal 340B program for the previous calendar year:

- (1) the National Provider Identification (NPI) number;
- (2) the name of the 340B covered entity;
- (3) the servicing address of the 340B covered entity;
- (4) the classification of the 340B covered entity;
- (5) the aggregated acquisition cost for prescription drugs obtained under the 340B program;
- (6) the aggregated payment amount received for drugs obtained under the 340B program and dispensed to patients;
- (7) the aggregated payment made to pharmacies under contract to dispense drugs obtained under the 340B program; and
- (8) the number of claims for prescription drugs described in clause (6).

(b) The information required under paragraph (a) must be reported by payer type, including commercial insurance, medical assistance and MinnesotaCare, and Medicare, in the form and manner defined by the commissioner. For covered entities that are hospitals, the information required under paragraph (a), clauses (5) to (8), must also be reported at the national drug code level for the 50 most frequently dispensed drugs by the facility under the 340B program.

(c) Data submitted under paragraph (a) must include prescription drugs dispensed by outpatient facilities that are identified as child facilities under the federal 340B program based on their inclusion on the hospital's Medicare cost report.

(d) Data submitted to the commissioner under paragraph (a) must be classified as nonpublic data as defined in section 13.02, subdivision 9.

(e) Beginning November 15, 2024, and by November 15 of each year thereafter, the commissioner shall prepare a report that aggregates the data submitted under paragraph (a). The commissioner shall submit this report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

62Q.522 COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES.

Subd. 3. **Exemption.** (a) An exempt organization is not required to cover contraceptives or contraceptive services if the exempt organization has religious objections to the coverage. An exempt organization that chooses to not provide coverage for some or all contraceptives and contraceptive services must notify employees as part of the hiring process and to all employees at least 30 days before:

- (1) an employee enrolls in the health plan; or
- (2) the effective date of the health plan, whichever occurs first.

(b) If the exempt organization provides coverage for some contraceptive methods or services, the notice required under paragraph (a) must provide a list of the contraceptive methods or services the organization refuses to cover.

Subd. 4. **Accommodation for eligible organizations.** (a) A health plan established or maintained by an eligible organization complies with the requirements of subdivision 2 to provide coverage of contraceptive methods and services, with respect to the contraceptive methods or services identified in the notice under this paragraph, if the eligible organization provides notice to any health plan

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company the eligible organization contracts with that it is an eligible organization and that the eligible organization has a religious objection to coverage for all or a subset of contraceptive methods or services.

(b) The notice from an eligible organization to a health plan company under paragraph (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to coverage for some or all of contraceptive methods or services, including a list of the contraceptive methods or services the eligible organization objects to, if applicable; and (3) the health plan name. The notice must be executed by a person authorized to provide notice on behalf of the eligible organization.

(c) An eligible organization must provide a copy of the notice under paragraph (a) to prospective employees as part of the hiring process and to all employees at least 30 days before:

- (1) an employee enrolls in the health plan; or
- (2) the effective date of the health plan, whichever occurs first.

(d) A health plan company that receives a copy of the notice under paragraph (a) with respect to a health plan established or maintained by an eligible organization must, for all future enrollments in the health plan:

(1) expressly exclude coverage for those contraceptive methods or services identified in the notice under paragraph (a) from the health plan; and

(2) provide separate payments for any contraceptive methods or services required to be covered under subdivision 2 for enrollees as long as the enrollee remains enrolled in the health plan.

(e) The health plan company must not impose any cost-sharing requirements, including co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or other charge for contraceptive services or methods on the eligible organization, health plan, or enrollee.

(f) On January 1, 2024, and every year thereafter a health plan company must notify the commissioner, in a manner determined by the commissioner, of the number of eligible organizations granted an accommodation under this subdivision.

144.0528 COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY PREVENTION ACT.

Subd. 5. **Promotion; administration.** In fiscal years 2026 and beyond, the commissioner may spend up to 25 percent of the total funding appropriated for the comprehensive drug overdose and morbidity program in each fiscal year to promote, administer, support, and evaluate the programs authorized under this section and to provide technical assistance to program grantees.

144.497 ST ELEVATION MYOCARDIAL INFARCTION.

The commissioner of health shall assess and report on the quality of care provided in the state for ST elevation myocardial infarction response and treatment. The commissioner shall:

(1) utilize and analyze data provided by ST elevation myocardial infarction receiving centers to the ACTION Registry-Get with the guidelines or an equivalent data platform that does not identify individuals or associate specific ST elevation myocardial infarction heart attack events with an identifiable individual;

(2) annually post a summary report of the data in aggregate form on the Department of Health website; and

(3) coordinate to the extent possible with national voluntary health organizations involved in ST elevation myocardial infarction heart attack quality improvement to encourage ST elevation myocardial infarction receiving centers to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed ST elevation myocardial infarction heart attacks within the state and encourage sharing of information among health care providers on ways to improve the quality of care of ST elevation myocardial infarction patients in Minnesota.

144E.001 DEFINITIONS.

Subd. 5. **Board.** "Board" means the Emergency Medical Services Regulatory Board.

144E.01 EMERGENCY MEDICAL SERVICES REGULATORY BOARD.

Subdivision 1. **Membership.** (a) The Emergency Medical Services Regulatory Board consists of the following members, all of whom must work in Minnesota, except for the person listed in clause (14):

- (1) an emergency physician certified by the American Board of Emergency Physicians;
- (2) a representative of Minnesota hospitals;
- (3) a representative of fire chiefs;
- (4) a full-time firefighter who serves as an emergency medical responder on or within a nontransporting or nonregistered agency and who is a member of a professional firefighter's union;
- (5) a volunteer firefighter who serves as an emergency medical responder on or within a nontransporting or nonregistered agency;
- (6) an attendant currently practicing on a licensed ambulance service who is a paramedic or an emergency medical technician;
- (7) an ambulance director for a licensed ambulance service;
- (8) a representative of sheriffs;
- (9) a member of a community health board to represent community health services;
- (10) two representatives of regional emergency medical services programs, one of whom must be from the metropolitan regional emergency medical services program;
- (11) a registered nurse currently practicing in a hospital emergency department;
- (12) a pediatrician, certified by the American Board of Pediatrics, with experience in emergency medical services;
- (13) a family practice physician who is currently involved in emergency medical services;
- (14) a public member who resides in Minnesota; and
- (15) the commissioners of health and public safety or their designees.

(b) The governor shall appoint members under paragraph (a). Appointments under paragraph (a), clauses (1) to (9) and (11) to (13), are subject to the advice and consent of the senate. In making appointments under paragraph (a), clauses (1) to (9) and (11) to (13), the governor shall consider recommendations of the American College of Emergency Physicians, the Minnesota Hospital Association, the Minnesota and State Fire Chief's Association, the Minnesota Ambulance Association, the Minnesota Emergency Medical Services Association, the Minnesota State Sheriff's Association, the Association of Minnesota Counties, the Minnesota Nurses Association, and the Minnesota chapter of the Academy of Pediatrics.

(c) At least seven members appointed under paragraph (a) must reside outside of the seven-county metropolitan area, as defined in section 473.121.

Subd. 2. **Ex officio members.** The speaker of the house and the Committee on Rules and Administration of the senate shall appoint one representative and one senator to serve as ex officio, nonvoting members.

Subd. 3. **Chair.** The governor shall designate one of the members appointed under subdivision 1 as chair of the board.

Subd. 4. **Compensation; terms.** Membership terms, compensation, and removal of members appointed under subdivision 1, are governed by section 15.0575.

Subd. 5. **Staff.** The board shall appoint an executive director who shall serve in the unclassified service and may appoint other staff. The service of the executive director shall be subject to the terms described in section 214.04, subdivision 2a.

Subd. 6. **Duties of board.** (a) The Emergency Medical Services Regulatory Board shall:

- (1) administer and enforce the provisions of this chapter and other duties as assigned to the board;

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(2) advise applicants for state or federal emergency medical services funds, review and comment on such applications, and approve the use of such funds unless otherwise required by federal law;

(3) make recommendations to the legislature on improving the access, delivery, and effectiveness of the state's emergency medical services delivery system; and

(4) establish procedures for investigating, hearing, and resolving complaints against emergency medical services providers.

(b) The Emergency Medical Services Board may prepare an initial work plan, which may be updated biennially. The work plan may include provisions to:

(1) prepare an emergency medical services assessment which addresses issues affecting the statewide delivery system;

(2) establish a statewide public information and education system regarding emergency medical services;

(3) create, in conjunction with the Department of Public Safety, a statewide injury and trauma prevention program; and

(4) designate an annual emergency medical services personnel recognition day.

Subd. 7. **Conflict of interest.** No member of the Emergency Medical Services Board may participate or vote in board proceedings in which the member has a direct conflict of interest, financial or otherwise.

144E.123 PREHOSPITAL CARE DATA.

Subd. 5. **Working group.** By October 1, 2011, the board must convene a working group composed of six members, three of which must be appointed by the board and three of which must be appointed by the Minnesota Ambulance Association, to redesign the board's policies related to collection of data from licenses. The issues to be considered include, but are not limited to, the following: user-friendly reporting requirements; data sets; improved accuracy of reported information; appropriate use of information gathered through the reporting system; and methods for minimizing the financial impact of data reporting on licenses, particularly for rural volunteer services. The working group must report its findings and recommendations to the board no later than July 1, 2012.

144E.27 EDUCATION PROGRAMS; BOARD APPROVAL.

Subdivision 1. **Education program instructor.** An education program instructor must be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.

Subd. 1a. **Approval required.** (a) All education programs for an emergency medical responder must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

(iii) admission criteria for students; and

(iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to Emergency Medical Responder registration education;

(3) have a program medical director and a program coordinator;

(4) have at least one instructor for every ten students at the practical skill stations;

(5) retain documentation of program approval by the board, course outline, and student information; and

(6) submit the appropriate fee as required under section 144E.29.

APPENDIX
Repealed Minnesota Statutes: H4571-1

(c) The National EMS Education Standards by the NHTSA, United States Department of Transportation contains the minimal entry level of knowledge and skills for emergency medical responders. Medical directors of emergency medical responder groups may expand the knowledge and skill set.

144E.50 EMERGENCY MEDICAL SERVICES FUND.

Subd. 3. **Definition.** For purposes of this section, "board" means the Emergency Medical Services Regulatory Board.

151.74 INSULIN SAFETY NET PROGRAM.

Subd. 16. **Legislative review; sunset.** (a) The legislature shall review the reports from the Board of Pharmacy under subdivision 13, paragraph (b); the program review by the legislative auditor under subdivision 14; and the report from the commissioner of health on the survey results under subdivision 15, paragraph (e); and any other relevant information related to the cost, access, and affordability of insulin, and make a determination on whether there is a need for the continued implementation of the long-term safety net program described in subdivisions 4 to 6 to ensure that Minnesota residents have access to affordable emergency and long-term insulin or whether the market has sufficiently changed to where the continuation of this program is no longer needed past December 31, 2024, or whether there are more appropriate options available to ensure access to affordable insulin for all Minnesota residents.

(b) Subdivisions 4 to 6, 8, and 9 expire December 31, 2024, unless the legislature affirmatively determines the need for the continuation of the long-term safety net program described in subdivisions 4 to 6.

245C.08 BACKGROUND STUDY; COMMISSIONER REVIEWS.

Subd. 2. **Background studies conducted by a county agency for family child care.** (a) Before the implementation of NETStudy 2.0, for a background study conducted by a county agency for family child care services, the commissioner shall review:

(1) information from the county agency's record of substantiated maltreatment of adults and the maltreatment of minors;

(2) information from juvenile courts as required in subdivision 4 for:

(i) individuals listed in section 245C.03, subdivision 1, paragraph (a), who are ages 13 through 23 living in the household where the licensed services will be provided; and

(ii) any other individual listed under section 245C.03, subdivision 1, when there is reasonable cause; and

(3) information from the Bureau of Criminal Apprehension.

(b) If the individual has resided in the county for less than five years, the study shall include the records specified under paragraph (a) for the previous county or counties of residence for the past five years.

(c) Notwithstanding expungement by a court, the county agency may consider information obtained under paragraph (a), clause (3), unless:

(1) the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner; or

(2) the commissioner received notice of the expungement order issued pursuant to section 609A.017, 609A.025, or 609A.035, and the order for expungement is directed specifically to the commissioner.

245C.125 BACKGROUND STUDY; HEAD START PROGRAMS.

(a) Head Start programs that receive funds under section 119A.52 may contract with the commissioner to:

(1) conduct background studies on individuals affiliated with a Head Start program; and

(2) obtain background study data on individuals affiliated with a Head Start program.

(b) The commissioner must include a national criminal history record check in a background study conducted under paragraph (a).

(c) A Head Start program site that does not contract with the commissioner, is not licensed, and is not registered to receive payments under chapter 119B is exempt from the relevant requirements in this chapter. Nothing in this section supersedes requirements for background studies in this chapter or chapter 119B or 245H that relate to licensed child care programs or programs registered to receive payments under chapter 119B. For a background study conducted under this section to be transferable to other child care entities, the study must include all components of studies for a certified license-exempt child care center under this chapter.

256D.19 ABOLITION OF TOWNSHIP SYSTEM OF POOR RELIEF.

Subdivision 1. **Town system abolished.** The town system for caring for the poor in each of the counties in which it is in effect is hereby abolished. The local social services agency of each county shall administer general assistance under the provisions of Laws 1973, chapter 650, article 21.

Subd. 2. **Local social services agencies duty.** All local social services agencies affected by Laws 1973, chapter 650, article 21 are hereby authorized to take over for the county as of January 1, 1974, the ownership of all case records relating to the administration of poor relief.

256D.20 TRANSFER OF TOWN EMPLOYEES.

Subdivision 1. **Rules for merit system.** The term "merit system" as used herein shall mean the rules for a merit system of personnel administration for employees of local social services agencies adopted by the commissioner of human services in accordance with the provisions of section 393.07, including the merit system established for Hennepin County pursuant to Laws 1965, chapter 855, as amended, the federal Social Security article as amended, and merit system standards and regulations issued by the federal Social Security Board and the United States Children's Bureau.

Subd. 2. **Designation of employees.** All employees of any municipality or town who are engaged full time in poor relief work therein on January 1, 1974 shall be retained as employees of the county and placed under the jurisdiction of its local social services agency.

All transferred employees shall be blanketed into the merit system with comparable status, classification, longevity, and seniority, and subject to the administrative requirements of the local social services agency. Employees with permanent status under any civil service provision on January 1, 1974, shall be granted permanent status under the merit system at comparable classifications and in accordance with work assignments made under the authority of the local social services agency as provided by the merit system rules.

The determination of proper job allocation shall be the responsibility of the personnel officer or director as provided under merit system rules applicable to the county involved with the right of appeal of allocation to the Merit System Council or personnel board by any employee affected by this transfer.

All transferred employees shall receive salaries for the classification to which they are allocated in accordance with the schedule in effect for local social services agency employees and at a salary step which they normally would have received had they been employed by the local social services agency for the same period of service they had previously served under the civil service provisions of any municipality or town; provided, however, that no salary shall be reduced as a result of the transfer.

All accumulated sick leave of transferred employees in the amount of 60 days or less shall be transferred to the records of the local social services agency and such accumulated sick leave shall be the legal liability of the local social services agency. All accumulated sick leave in excess of 60 days shall be paid in cash to transferred employees by the municipality or town by which they were employed prior to their transfer, at the time of transfer. In lieu of the cash payment, the municipality or town shall, at the option of the employee concerned, allow a leave of absence with pay, prior to transfer, for all or part of the accumulated sick leave.

Subd. 3. **Merit system transfer.** Employees of municipalities and towns engaged in the work of administering poor relief who are not covered by civil service provisions shall be blanketed into the merit system subject to a qualifying examination. Employees with one year or more service shall be subject to a qualifying examination and those with less than one year's service shall be subject to an open competitive examination.

Subd. 4. **Disbursement of vacation time.** All vacation leave of employees referred to in subdivision 2, accumulated prior to their transfer to county employment shall be paid in cash to them by the municipality or town by which they were employed prior to their transfer, and at the time of their transfer. In lieu of the cash payment, the municipality or town shall, at the option of

the employee concerned, allow a leave of absence with pay, prior to such transfer, for all or part of the accumulated vacation time.

256D.23 TEMPORARY COUNTY ASSISTANCE PROGRAM.

Subdivision 1. **Program established.** Minnesota residents who meet the income and resource standards of section 256D.01, subdivision 1a, but do not qualify for cash benefits under sections 256D.01 to 256D.21, may qualify for a county payment under this section.

Subd. 2. **Payment amount, duration, and method.** (a) A county may make a payment of up to \$203 for a single individual and up to \$260 for a married couple under the terms of this subdivision.

(b) Payments to an individual or married couple may only be made once in a calendar year. If the applicant qualifies for a payment as a result of an emergency, as defined by the county, the payment shall be made within ten working days of the date of application. If the applicant does not qualify under the county definition of emergency, the payment shall be made at the beginning of the second month following the month of application, and the applicant must receive the payment in person at the local agency office.

(c) Payments may be made in the form of cash or as vendor payments for rent and utilities. If vendor payments are made, they shall be equal to \$203 for a single individual or \$260 for a married couple, or the actual amount of rent and utilities, whichever is less.

(d) Each county must develop policies and procedures as necessary to implement this section.

(e) Payments under this section are not an entitlement. No county is required to make a payment in excess of the amount available to the county under subdivision 3.

Subd. 3. **State allocation to counties.** The commissioner shall allocate to each county on an annual basis the amount specifically appropriated for payments under this section. The allocation shall be based on each county's proportionate share of state fiscal year 1994 work readiness expenditures.

256R.02 DEFINITIONS.

Subd. 46. **Resource utilization group.** "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Laws 2023, chapter 70, article 20, section 2, subdivision 31, as amended by Laws 2023, chapter 75, section 12;

Sec. 2. COMMISSIONER OF HUMAN SERVICES

Subd. 31. **Direct Care and Treatment - Mental Health and Substance Abuse**

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6,109,000

(a) **Keeping Nurses at the Bedside Act; contingent appropriation.** The appropriation in this subdivision is contingent upon legislative enactment by the 93rd Legislature of 2023 Senate File 1384 by the 93rd Legislature provisions substantially similar to 2023 S.F. No. 1561, the second engrossment, article 2.

(b) **Base level adjustment.** The general fund base is increased by \$7,566,000 in fiscal year 2026 and increased by \$7,566,000 in fiscal year 2027.
Laws 2023, chapter 75, section 10

Sec. 10. USE OF APPROPRIATION; LOAN FORGIVENESS ADMINISTRATION.

The commissioner of health may also use the appropriation in S.F. No. 2995, article 20, section 3, subdivision 2, paragraph (w), clause (3), if enacted during 2023 regular legislative session, for administering sections 2 to 5.

Laws 2024, chapter 80, article 2, section 6, subdivision 4

Sec. 6. [142B.11] LICENSE APPLICATION AFTER CHANGE OF OWNERSHIP.

Subd. 4. **Temporary change in ownership license.** (a) After receiving the party's application pursuant to subdivision 3, upon the written request of the existing license holder and the party, the commissioner may issue a temporary change in ownership license to the party while the commissioner evaluates the party's application. Until a decision is made to grant or deny a license under this chapter, the existing license holder and the party shall both be responsible for operating the program or service according to applicable laws and rules, and the sale or transfer of the existing license holder's ownership interest in the licensed program or service does not terminate the existing license.

(b) The commissioner may issue a temporary change in ownership license when a license holder's death, divorce, or other event affects the ownership of the program and an applicant seeks to assume operation of the program or service to ensure continuity of the program or service while a license application is evaluated.

(c) This subdivision applies to any program or service licensed under this chapter.

2960.0620 USE OF PSYCHOTROPIC MEDICATIONS.

Subp. 3. **Monitoring for tardive dyskinesia.** The license holder, under the direction of a medically licensed person, must monitor for tardive dyskinesia at least every three months if a resident is prescribed antipsychotic medication or amoxapine and must document the monitoring. A resident prescribed antipsychotic medication or amoxapine for more than 90 days must be checked for tardive dyskinesia at least 30 and 60 days after discontinuation of the antipsychotic medication or amoxapine. Monitoring must include use of a standardized rating scale and examination procedure. The license holder must provide the assessments to the physician for review if the results meet criteria that require physician review.

9502.0425 PHYSICAL ENVIRONMENT.

Subp. 5. **Occupancy separations.** Day care residences with an attached garage must have a self-closing, tight fitting solid wood bonded core door at least 1-3/8 inch thick, or door with a fire protection rating of 20 minutes or greater and a separation wall consisting of 5/8 inch thick gypsum wallboard or its equivalent on the garage side between the residence and garage.