

150.20 **ARTICLE 3**

150.21 **HEALTH DEPARTMENT**

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

150.23 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the
 150.24 e-Health Advisory Committee, shall develop uniform standards to be used for the
 150.25 interoperable electronic health records system for sharing and synchronizing patient data
 150.26 across systems. The standards must be compatible with federal efforts. The uniform standards
 150.27 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~
 150.28 ~~shall include an update on standards development as part of an annual report to the legislature.~~
 150.29 Individual health care providers in private practice with no other providers and health care
 150.30 providers that do not accept reimbursement from a group purchaser, as defined in section
 150.31 62J.03, subdivision 6, are excluded from the requirements of this section.

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

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

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

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

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

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

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

63.19 **ARTICLE 2**

63.20 **HEALTH DEPARTMENT**

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

63.22 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the
 63.23 e-Health Advisory Committee, shall develop uniform standards to be used for the
 63.24 interoperable electronic health records system for sharing and synchronizing patient data
 63.25 across systems. The standards must be compatible with federal efforts. The uniform standards
 63.26 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~
 63.27 ~~shall include an update on standards development as part of an annual report to the legislature.~~
 63.28 Individual health care providers in private practice with no other providers and health care
 63.29 providers that do not accept reimbursement from a group purchaser, as defined in section
 63.30 62J.03, subdivision 6, are excluded from the requirements of this section.

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 64.4 the following matters:

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 64.6 the state, licensed health care providers and facilities, and local public health agencies;

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

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 64.12 information technology and systems to improve patient care and reduce the cost of care,
 64.13 including applications relating to disease management and personal health management
 64.14 that enable remote monitoring of patients' conditions, especially those with chronic
 64.15 conditions; and

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

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

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

151.30 ~~(d)~~ This subdivision expires June 30, ~~2021~~ 2031.

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

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

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

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

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

152.13 (d) The electronic health record must meet the standards established according to section
 152.14 3004 of the HITECH Act as applicable.

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

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

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

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

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

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

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

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

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 65.3 care providers must meet the following criteria when implementing an interoperable
 65.4 electronic health records system within their hospital system or clinical practice setting.

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

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

65.13 (d) The electronic health record must meet the standards established according to section
 65.14 3004 of the HITECH Act as applicable.

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

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

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

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 65.25 consultation with the e-Health Advisory Committee, shall update the statewide
 65.26 implementation plan required under subdivision 2 and released June 2008, to be consistent
 65.27 with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator~~
 65.28 ~~in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the~~
 65.29 ~~requirements for a plan required under section 3013 of the HITECH Act plans.~~

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

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

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

153.11 ~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to
 153.12 encourage implementation of admission, discharge and transfer alerts, and care summary
 153.13 document exchange transactions and to evaluate the impact of health information technology
 153.14 on cost and quality of care. Communications about available financial and technical support
 153.15 shall include clear information about the interoperable health record requirements in
 153.16 subdivision 1, including a separate statement in bold-face type clarifying the exceptions to
 153.17 those requirements;

153.18 ~~(4)~~ (2) providing educational resources and technical assistance to health care providers
 153.19 and patients related to state and national privacy, security, and consent laws governing
 153.20 clinical health information, including the requirements in sections 144.291 to 144.298. In
 153.21 carrying out these activities, the commissioner's technical assistance does not constitute
 153.22 legal advice;

153.23 ~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health
 153.24 information exchange, including the requirements in sections 144.291 to 144.298, and
 153.25 making recommendations for modifications that would strengthen the ability of Minnesota
 153.26 health care providers to securely exchange data in compliance with patient preferences and
 153.27 in a way that is efficient and financially sustainable; and

153.28 ~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements
 153.29 related to patient consent for release of health records for the purposes of treatment, payment,
 153.30 and health care operations, as required in section 144.293, subdivision 2. The commissioner
 153.31 shall provide a report to the legislature on the findings of this public input process no later
 153.32 than February 1, 2017.

153.33 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
 153.34 monitor national activity related to health information technology and shall coordinate
 154.1 statewide input on policy development. The commissioner shall coordinate statewide
 154.2 responses to proposed federal health information technology regulations in order to ensure

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

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

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

66.11 ~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to
 66.12 encourage implementation of admission, discharge and transfer alerts, and care summary
 66.13 document exchange transactions and to evaluate the impact of health information technology
 66.14 on cost and quality of care. Communications about available financial and technical support
 66.15 shall include clear information about the interoperable health record requirements in
 66.16 subdivision 1, including a separate statement in bold-face type clarifying the exceptions to
 66.17 those requirements;

66.18 ~~(4)~~ (2) providing educational resources and technical assistance to health care providers
 66.19 and patients related to state and national privacy, security, and consent laws governing
 66.20 clinical health information, including the requirements in sections 144.291 to 144.298. In
 66.21 carrying out these activities, the commissioner's technical assistance does not constitute
 66.22 legal advice;

66.23 ~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health
 66.24 information exchange, including the requirements in sections 144.291 to 144.298, and
 66.25 making recommendations for modifications that would strengthen the ability of Minnesota
 66.26 health care providers to securely exchange data in compliance with patient preferences and
 66.27 in a way that is efficient and financially sustainable; and

66.28 ~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements
 66.29 related to patient consent for release of health records for the purposes of treatment, payment,
 66.30 and health care operations, as required in section 144.293, subdivision 2. The commissioner
 66.31 shall provide a report to the legislature on the findings of this public input process no later
 66.32 than February 1, 2017.

66.33 (c) The commissioner, in consultation with the e-Health Advisory Committee, shall
 66.34 monitor national activity related to health information technology and shall coordinate
 67.1 statewide input on policy development. The commissioner shall coordinate statewide
 67.2 responses to proposed federal health information technology regulations in order to ensure

154.3 that the needs of the Minnesota health care community are adequately and efficiently
 154.4 addressed in the proposed regulations. The commissioner's responses may include, but are
 154.5 not limited to:

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

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

154.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~
 154.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~
 154.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~
 154.14 ~~62U; and~~

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

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

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

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

154.29 Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

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

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

67.3 that the needs of the Minnesota health care community are adequately and efficiently
 67.4 addressed in the proposed regulations. The commissioner's responses may include, but are
 67.5 not limited to:

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

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

67.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~
 67.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~
 67.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~
 67.14 ~~62U; and~~

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

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

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

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

- 155.8 ~~(c)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance,
 155.9 pursuant to a valid prescription.
- 155.10 ~~(d)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
 155.11 title 45, part 160.103.
- 155.12 ~~(e)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or
 155.13 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
 155.14 or group purchaser, either directly or through an intermediary, including an e-prescribing
 155.15 network. E-prescribing includes, but is not limited to, two-way transmissions between the
 155.16 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
 155.17 and medication history information.
- 155.18 ~~(f)~~ (f) "Electronic prescription drug program" means a program that provides for
 155.19 e-prescribing.
- 155.20 ~~(g)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.
- 155.21 ~~(h)~~ (h) "HL7 messages" means a standard approved by the standards development
 155.22 organization known as Health Level Seven.
- 155.23 ~~(i)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code
 155.24 of Federal Regulations, title 45, part 162.406.
- 155.25 ~~(j)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.
- 155.26 ~~(k)~~ (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the
 155.27 National Council for Prescription Drug Programs Formulary and Benefits Standard;
 155.28 ~~Implementation Guide, Version 1, Release 0, October 2005~~ or the most recent standard
 155.29 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare
 155.30 Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations
 155.31 adopted under it. The standards shall be implemented according to the Centers for Medicare
 155.32 and Medicaid Services schedule for compliance.
- 156.1 ~~(l)~~ (l) "NCPDP SCRIPT Standard" means the most recent version of the National
 156.2 Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard,
 156.3 ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005~~, or the most recent
 156.4 standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
 156.5 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and
 156.6 regulations adopted under it. The standards shall be implemented according to the Centers
 156.7 for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions~~
 156.8 ~~of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard~~
 156.9 ~~is backward compatible to the current version adopted by the Centers for Medicare and~~
 156.10 ~~Medicaid Services.~~
- 156.11 ~~(m)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

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

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

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

156.18 Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

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

- 156.23 ~~(1) get message transaction;~~
- 156.24 ~~(2) status response transaction;~~
- 156.25 ~~(3) error response transaction;~~
- 156.26 ~~(4) new prescription transaction;~~
- 156.27 ~~(5) prescription change request transaction;~~
- 156.28 ~~(6) prescription change response transaction;~~
- 156.29 ~~(7) refill prescription request transaction;~~
- 156.30 ~~(8) refill prescription response transaction;~~
- 156.31 ~~(9) verification transaction;~~
- 157.1 ~~(10) password change transaction;~~
- 157.2 ~~(11) cancel prescription request transaction; and~~
- 157.3 ~~(12) cancel prescription response transaction.~~

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

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

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

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

157.15 Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

157.16 **62J.498 HEALTH INFORMATION EXCHANGE.**

157.17 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to
 157.18 62J.4982:

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

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

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

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

158.1 (f) "Health data intermediary" means an entity that provides the technical capabilities
 158.2 or related products and services to enable health information exchange among health care
 158.3 providers that are not related health care entities as defined in section 144.291, subdivision
 158.4 2, paragraph (k). This includes but is not limited to health information service providers
 158.5 (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries
 158.6 as defined in section 62J.495.

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

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

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

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

158.17 ~~(k)~~ (i) "Major participating entity" means:

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

67.30 **62J.498 HEALTH INFORMATION EXCHANGE.**

67.31 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to
 67.32 62J.4982:

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

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

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

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

68.13 (f) "Health data intermediary" means an entity that provides the technical capabilities
 68.14 or related products and services to enable health information exchange among health care
 68.15 providers that are not related health care entities as defined in section 144.291, subdivision
 68.16 2, paragraph (k). This includes but is not limited to health information service providers
 68.17 (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries
 68.18 as defined in section 62J.495.

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

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

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

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

68.29 ~~(k)~~ (i) "Major participating entity" means:

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

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

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

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

159.1 ~~(m)~~ "Meaningful use" means use of certified electronic health record technology to
 159.2 improve quality, safety, and efficiency and reduce health disparities; engage patients and
 159.3 families; improve care coordination and population and public health; and maintain privacy
 159.4 and security of patient health information as established by the Centers for Medicare and
 159.5 Medicaid Services and the Minnesota Department of Human Services pursuant to sections
 159.6 4101, 4102, and 4201 of the HITECH Act.

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

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

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

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

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

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

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

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

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

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

69.13 ~~(m)~~ "Meaningful use" means use of certified electronic health record technology to
 69.14 improve quality, safety, and efficiency and reduce health disparities; engage patients and
 69.15 families; improve care coordination and population and public health; and maintain privacy
 69.16 and security of patient health information as established by the Centers for Medicare and
 69.17 Medicaid Services and the Minnesota Department of Human Services pursuant to sections
 69.18 4101, 4102, and 4201 of the HITECH Act.

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

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

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

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

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

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

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

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

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

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

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

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

160.6 (2) require information to be provided as needed from health information exchange
 160.7 service providers in order to meet requirements established under sections 62J.498 to
 160.8 62J.4982;

160.9 ~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under
 160.10 sections 62J.498 to 62J.4982;

160.11 ~~(3)~~ (4) respond to public complaints related to health information exchange services;

160.12 ~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines,
 160.13 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

160.14 ~~(5)~~ (6) provide a biennial report on the status of health information exchange services
 160.15 that includes but is not limited to:

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

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

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

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

160.25 ~~(6)~~ (7) other duties necessary to protect the public interest.

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

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

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

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

70.12 Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect
 70.13 the public interest on matters pertaining to health information exchange. The commissioner
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70.15 (1) review and act on applications from ~~health data intermediaries and~~ health information
 70.16 organizations for certificates of authority to operate in Minnesota;

70.17 (2) require information to be provided as needed from health information exchange
 70.18 service providers in order to meet requirements established under sections 62J.498 to
 70.19 62J.4982;

70.20 ~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under
 70.21 sections 62J.498 to 62J.4982;

70.22 ~~(3)~~ (4) respond to public complaints related to health information exchange services;

70.23 ~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines,
 70.24 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

70.25 ~~(5)~~ (6) provide a biennial report on the status of health information exchange services
 70.26 that includes but is not limited to:

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

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

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

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

71.5 ~~(6)~~ (7) other duties necessary to protect the public interest.

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

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

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

161.3 (c) When the commissioner is actively considering a suspension or revocation of a
161.4 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data
161.5 that are collected, created, or maintained related to the suspension or revocation are classified
161.6 as confidential data on individuals and as protected nonpublic data in the case of data not
161.7 on individuals.

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

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

161.14 Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

161.15 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
161.16 **INFORMATION EXCHANGE SERVICES.**

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

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

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

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

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

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

71.14 (c) When the commissioner is actively considering a suspension or revocation of a
71.15 certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data
71.16 that are collected, created, or maintained related to the suspension or revocation are classified
71.17 as confidential data on individuals and as protected nonpublic data in the case of data not
71.18 on individuals.

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

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

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

71.26 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
71.27 **INFORMATION EXCHANGE SERVICES.**

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

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

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

161.31 ~~contract unless the organization has a certificate of authority or has an application under~~
 161.32 ~~active consideration under this section.~~

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

162.4 ~~(1) hold reciprocal agreements with at least one state-certified health information~~
 162.5 ~~organization to access patient data, and for the transmission and receipt of clinical~~
 162.6 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~
 162.7 ~~5; and~~

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

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

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

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

162.23 (1) the entity is a legally established organization;

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

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

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

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

72.11 ~~contract unless the organization has a certificate of authority or has an application under~~
 72.12 ~~active consideration under this section.~~

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

72.16 ~~(1) hold reciprocal agreements with at least one state-certified health information~~
 72.17 ~~organization to access patient data, and for the transmission and receipt of clinical~~
 72.18 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~
 72.19 ~~5; and~~

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

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

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

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

73.4 (1) the entity is a legally established organization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 74.29 be in a form prescribed by the commissioner and verified by an officer or authorized
 74.30 representative of the applicant. Each application shall include the following in addition to
 74.31 information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

166.20 Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

166.21 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

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

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

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

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

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

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

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

167.5 (7) whether the violation was intentional;

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

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

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

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

167.15 (12) the financial condition of the health information ~~exchange service provider~~
 167.16 organization including, but not limited to, whether the health information ~~exchange service~~

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

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

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

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

77.5 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

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

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

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

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

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

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

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

77.20 (7) whether the violation was intentional;

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

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

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

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

77.30 (12) the financial condition of the health information ~~exchange service provider~~
 77.31 organization including, but not limited to, whether the health information ~~exchange service~~

167.17 ~~provider organization~~ had financial difficulties that affected its ability to comply or whether
 167.18 the imposition of an administrative monetary penalty would jeopardize the ability of the
 167.19 health information ~~exchange service provider organization~~ to continue to deliver health
 167.20 information exchange services.

167.21 The commissioner shall give reasonable notice in writing to the health information
 167.22 ~~exchange service provider organization~~ of the intent to levy the penalty and the reasons for
 167.23 it. A health information ~~exchange service provider organization~~ may have 15 days within
 167.24 which to contest whether the facts found constitute a violation of sections 62J.4981 and
 167.25 62J.4982, according to the contested case and judicial review provisions of sections 14.57
 167.26 to 14.69.

167.27 (b) If the commissioner has reason to believe that a violation of section 62J.4981 or
 167.28 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved
 167.29 before commencing action under subdivision 2. The commissioner may notify the health
 167.30 information ~~exchange service provider organization~~ and the representatives, or other persons
 167.31 who appear to be involved in the suspected violation, to arrange a voluntary conference
 167.32 with the alleged violators or their authorized representatives. The purpose of the conference
 167.33 is to attempt to learn the facts about the suspected violation and, if it appears that a violation
 168.1 has occurred or is threatened, to find a way to correct or prevent it. The conference is not
 168.2 governed by any formal procedural requirements, and may be conducted as the commissioner
 168.3 considers appropriate.

168.4 (c) The commissioner may issue an order directing a health information ~~exchange service~~
 168.5 ~~provider organization~~ or a representative of a health information ~~exchange service provider~~
 168.6 ~~organization~~ to cease and desist from engaging in any act or practice in violation of sections
 168.7 62J.4981 and 62J.4982.

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

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

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

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

78.1 ~~provider organization~~ had financial difficulties that affected its ability to comply or whether
 78.2 the imposition of an administrative monetary penalty would jeopardize the ability of the
 78.3 health information ~~exchange service provider organization~~ to continue to deliver health
 78.4 information exchange services.

78.5 The commissioner shall give reasonable notice in writing to the health information
 78.6 ~~exchange service provider organization~~ of the intent to levy the penalty and the reasons for
 78.7 it. A health information ~~exchange service provider organization~~ may have 15 days within
 78.8 which to contest whether the facts found constitute a violation of sections 62J.4981 and
 78.9 62J.4982, according to the contested case and judicial review provisions of sections 14.57
 78.10 to 14.69.

78.11 (b) If the commissioner has reason to believe that a violation of section 62J.4981 or
 78.12 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved
 78.13 before commencing action under subdivision 2. The commissioner may notify the health
 78.14 information ~~exchange service provider organization~~ and the representatives, or other persons
 78.15 who appear to be involved in the suspected violation, to arrange a voluntary conference
 78.16 with the alleged violators or their authorized representatives. The purpose of the conference
 78.17 is to attempt to learn the facts about the suspected violation and, if it appears that a violation
 78.18 has occurred or is threatened, to find a way to correct or prevent it. The conference is not
 78.19 governed by any formal procedural requirements, and may be conducted as the commissioner
 78.20 considers appropriate.

78.21 (c) The commissioner may issue an order directing a health information ~~exchange service~~
 78.22 ~~provider organization~~ or a representative of a health information ~~exchange service provider~~
 78.23 ~~organization~~ to cease and desist from engaging in any act or practice in violation of sections
 78.24 62J.4981 and 62J.4982.

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

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

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

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

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

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

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

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

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

169.4 (7) the health information ~~exchange service provider~~ organization has otherwise failed
 169.5 to substantially comply with section 62J.4981 or with any other statute or administrative
 169.6 rule applicable to health information exchange service providers, or has submitted false
 169.7 information in any report required under sections 62J.498 to 62J.4982.

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

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

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

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

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

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

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

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

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

79.19 (7) the health information ~~exchange service provider~~ organization has otherwise failed
 79.20 to substantially comply with section 62J.4981 or with any other statute or administrative
 79.21 rule applicable to health information exchange service providers, or has submitted false
 79.22 information in any report required under sections 62J.498 to 62J.4982.

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

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

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

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

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

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

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

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

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

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

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

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

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

170.21 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every
 170.22 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and
 170.23 62J.4982 as follows:

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

170.26 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~
 170.27 ~~\$7,000;~~

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

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

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

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

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

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

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

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

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

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

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

81.3 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every
 81.4 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and
 81.5 62J.4982 as follows:

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

81.8 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~
 81.9 ~~\$7,000;~~

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

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

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

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

171.4 Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

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

171.16 Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

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

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

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

171.25 (2) (1) require reports or surveys to evaluate the performance of current health care
171.26 purchasing or administrative simplification strategies;

171.27 (3) (2) calculate fiscal impacts, including net savings and return on investment, of health
171.28 care purchasing strategies and initiatives;

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

172.1 (5) (3) support the Administrative Uniformity Committee under section sections 62J.50
172.2 and 62J.536 and other relevant groups or activities to advance agreement on health care
172.3 administrative process streamlining;

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

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

- 172.4 ~~(6) consult with the Health Economics Unit of the Department of Health regarding~~
 172.5 ~~reports and assessments of the health care marketplace;~~
- 172.6 ~~(7) consult with the Department of Commerce regarding health care regulatory issues~~
 172.7 ~~and legislative initiatives;~~
- 172.8 ~~(8) work with appropriate Department of Human Services staff and the Centers for~~
 172.9 ~~Medicare and Medicaid Services to address federal requirements and conformity issues for~~
 172.10 ~~health care purchasing;~~
- 172.11 ~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing~~
 172.12 ~~strategies;~~
- 172.13 ~~(10) convene medical directors of agencies engaged in health care purchasing for advice,~~
 172.14 ~~collaboration, and exploring possible synergies;~~
- 172.15 ~~(11) (4) contact and participate with other relevant health care task forces, study activities,~~
 172.16 ~~and similar efforts with regard to health care performance measurement and~~
 172.17 ~~performance-based purchasing; and~~
- 172.18 ~~(12) (5) assist in seeking external funding through appropriate grants or other funding~~
 172.19 ~~opportunities and may administer grants and externally funded projects.~~
- 172.20 Sec. 12. **[62J.826] MEDICAL PRACTICES; CURRENT STANDARD CHARGES.**
- 172.21 Subdivision 1. **Definitions.** ~~(a) The definitions in this subdivision apply to this section.~~
- 172.22 ~~(b) "Chargemaster" means the list of all individual items and services maintained by a~~
 172.23 ~~medical practice for which the medical practice has established a charge.~~
- 172.24 ~~(c) "Diagnostic laboratory testing" means a service charged using a CPT code within~~
 172.25 ~~the CPT code range of 80047 to 89398.~~
- 172.26 ~~(d) "Diagnostic radiology service" means a service charged using a CPT code within~~
 172.27 ~~the CPT code range of 70010 to 7999 and includes the provision of x-rays, computed~~
 172.28 ~~tomography scans, positron emission tomography scans, magnetic resonance imaging scans,~~
 172.29 ~~and mammographies.~~
- 172.30 ~~(e) "Hospital" means an acute care institution licensed under sections 144.50 to 144.58,~~
 172.31 ~~but does not include a health care institution conducted for those who rely primarily upon~~
 173.1 ~~treatment by prayer or spiritual means in accordance with the creed or tenets of any church~~
 173.2 ~~or denomination.~~
- 173.3 ~~(f) "Medical practice" means a business that:~~
- 173.4 ~~(1) earns revenue by providing medical care to the public;~~
- 173.5 ~~(2) issues payment claims to health plan companies and other payers; and~~

- 173.6 (3) may be identified by its federal tax identification number.
- 173.7 (g) "Outpatient surgical center" means a health care facility other than a hospital offering
 173.8 elective outpatient surgery under a license issued under sections 144.50 to 144.58.
- 173.9 Subd. 2. **Requirement; current standard charges.** The following medical practices
 173.10 must make available to the public a list of the medical practice's current standard charges,
 173.11 as reflected in the medical practice's chargemaster, for all items and services provided by
 173.12 the medical practice:
- 173.13 (1) hospitals;
- 173.14 (2) outpatient surgical centers; and
- 173.15 (3) any other medical practice that has revenue of greater than \$50,000,000 per year and
 173.16 that derives the majority of the medical practice's revenue by providing one or more of the
 173.17 following services:
- 173.18 (i) diagnostic radiology services;
- 173.19 (ii) diagnostic laboratory testing;
- 173.20 (iii) orthopedic surgical procedures, including joint arthroplasty procedures within the
 173.21 CPT code range of 26990 to 27899;
- 173.22 (iv) ophthalmologic surgical procedures, including cataract surgery coded using CPT
 173.23 code 66982 or 66984, or refractive correction surgery to improve visual acuity;
- 173.24 (v) anesthesia services commonly provided as an ancillary to services provided at a
 173.25 hospital, outpatient surgical center, or medical practice that provides orthopedic surgical
 173.26 procedures or ophthalmologic surgical procedures; or
- 173.27 (vi) oncology services, including radiation oncology treatments within the CPT code
 173.28 range of 77261 to 77799 and drug infusions.
- 173.29 Subd. 3. **Required file format and data attributes.** (a) A medical practice required to
 173.30 post the medical practice's current standard charges must post the following data attributes
 173.31 in the listed order:
- 174.1 (1) federal tax identification number for the medical practice;
- 174.2 (2) name of the medical practice, defined as the provider name that the medical practice
 174.3 enters on the CMS claim form 1500 or a successor form when the medical practice submits
 174.4 health care claims to a payer organization;
- 174.5 (3) internal chargemaster record identification, defined as the internal record identifier
 174.6 for this chargemaster line item in the medical practice's billing system;

- 174.7 (4) service billing code system, defined as a code signifying the HIPAA-compliant
 174.8 billing code system from which the service billing code was drawn;
- 174.9 (5) service billing code, defined as a specific billing code drawn from the service billing
 174.10 code system denoted by the value in the service billing code type field;
- 174.11 (6) service description, defined as the shortest, nonabbreviated official description
 174.12 associated with the service billing code in the applicable service billing code system;
- 174.13 (7) revenue code, defined as the National Uniform Billing Committee revenue code
 174.14 denoting the patient's location within the medical practice where the patient will receive the
 174.15 item or service subject to this charge. This value is required only if the charge amount is
 174.16 dependent on the location within the medical practice where the item or service is provided;
- 174.17 (8) revenue code description, defined as the description provided by the National Uniform
 174.18 Billing Committee for the revenue code. This value is required only if the charge amount
 174.19 is dependent on the location within the medical practice where the item or service is provided;
- 174.20 (9) national drug code, defined as the national drug code for a drug that is administered
 174.21 as part of the service subject to this charge. This field is required only when the charge
 174.22 amount is dependent on which, if any, drug is being administered as part of this service;
- 174.23 (10) national drug code description, defined as the official description associated with
 174.24 the national drug code for a drug that is administered as part of the service subject to this
 174.25 charge. This field is required only when the charge amount is dependent on which, if any,
 174.26 drug is being administered as part of this service;
- 174.27 (11) inpatient gross charge, defined as the charge for an individual item or service that
 174.28 is reflected on a hospital's chargemaster, absent any discounts as defined in Code of Federal
 174.29 Regulations, title 45, section 180.20, for an item or service provided on an inpatient basis;
- 174.30 (12) outpatient gross charge, defined as the charge for an individual item or service that
 174.31 is reflected on a chargemaster, absent any discounts as defined in Code of Federal
 174.32 Regulations, title 45, section 180.20, for an item or service provided on an outpatient basis;
- 175.1 (13) inpatient discounted cash price, defined as the charge that applies to an individual
 175.2 who pays cash or a cash equivalent for an item or service being reported under this section
 175.3 and provided on an inpatient basis;
- 175.4 (14) outpatient discounted cash price, defined as the charge that applies to an individual
 175.5 who pays cash or a cash equivalent for an item or service being reported under this section
 175.6 and provided on an outpatient basis;
- 175.7 (15) charge unit, defined as the unit cost basis for the charge;
- 175.8 (16) effective date of the charge; and

175.9 (17) payer-specific negotiated charges, as defined in Code of Federal Regulations, title
175.10 45, section 180.20. There must be a separate field for each payer's rate and the payers must
175.11 be listed in alphabetical order.

175.12 (b) The data attributes specified in paragraph (a) must be posted in the form of a
175.13 comma-separated values file, with all text values quoted and all leading and trailing white
175.14 spaces trimmed before and after data attribute values.

175.15 (c) The data attributes specified in paragraph (a) must be posted on a web page labeled
175.16 "Cost of Care at [Name of Medical Practice]" which members of the public can access via
175.17 a direct, clearly labeled link on the medical practice's main billing web page, and which is
175.18 searchable by entering the words "cost of care at [name of medical practice]" into an Internet
175.19 search engine. The consumer-friendly list of standard charges for a limited set of shoppable
175.20 services required under Code of Federal Regulations, title 45, section 180.60, must be
175.21 presented on the same web page.

175.22 (d) The file must be named according to the following convention:
175.23 <ein> <hospital-name> standardcharges.csv as required by Code of Federal Regulations,
175.24 title 45, section 180.50.

175.25 **EFFECTIVE DATE.** This section is effective January 1, 2022.

81.17 Sec. 8. Minnesota Statutes 2020, section 62J.84, subdivision 6, is amended to read:

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

81.22 (1) a list of the prescription drugs reported under subdivisions 3, 4, and 5, and the
81.23 manufacturers of those prescription drugs; and

81.24 (2) information reported to the commissioner under subdivisions 3, 4, and 5.

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

81.28 (c) The commissioner shall not post to the department's website or a private entity
81.29 contracting with the commissioner shall not post any information described in this section
81.30 if the information is not public data under section 13.02, subdivision 8a; or is trade secret
81.31 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information
82.1 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section
82.2 1836, as amended. If a manufacturer believes information should be withheld from public
82.3 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify
82.4 that information and describe the legal basis in writing when the manufacturer submits the

175.26 Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

175.27 Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter,
 175.28 All health plan companies and third-party administrators shall submit encounter data on a
 175.29 monthly basis to a private entity designated by the commissioner of health. The data shall
 175.30 be submitted in a form and manner specified by the commissioner subject to the following
 175.31 requirements:

176.1 (1) the data must be de-identified data as described under the Code of Federal Regulations,
 176.2 title 45, section 164.514;

176.3 (2) the data for each encounter must include an identifier for the patient's health care
 176.4 home if the patient has selected a health care home and, for claims incurred on or after
 176.5 January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims
 176.6 in the individual health insurance market; and

176.7 (3) except for the identifier described in clause (2), the data must not include information
 176.8 that is not included in a health care claim or equivalent encounter information transaction
 176.9 that is required under section 62J.536.

176.10 (b) The commissioner or the commissioner's designee shall only use the data submitted
 176.11 under paragraph (a) to carry out the commissioner's responsibilities in this section, including
 176.12 supplying the data to providers so they can verify their results of the peer grouping process
 176.13 consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d),
 176.14 and adopted by the commissioner and, if necessary, submit comments to the commissioner
 176.15 or initiate an appeal.

176.16 (c) Data on providers collected under this subdivision are private data on individuals or
 176.17 nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this
 176.18 paragraph, data on providers collected under this subdivision may be released or published

82.5 information under this section. If the commissioner disagrees with the manufacturer's request
 82.6 to withhold information from public disclosure, the commissioner shall provide the
 82.7 manufacturer written notice that the information will be publicly posted 30 days after the
 82.8 date of the notice.

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

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

176.19 as authorized in subdivision 11. Notwithstanding the definition of summary data in section
 176.20 13.02, subdivision 19, summary data prepared under this subdivision may be derived from
 176.21 nonpublic data. The commissioner or the commissioner's designee shall establish procedures
 176.22 and safeguards to protect the integrity and confidentiality of any data that it maintains.

176.23 (d) The commissioner or the commissioner's designee shall not publish analyses or
 176.24 reports that identify, or could potentially identify, individual patients.

176.25 (e) The commissioner shall compile summary information on the data submitted under
 176.26 this subdivision. The commissioner shall work with its vendors to assess the data submitted
 176.27 in terms of compliance with the data submission requirements and the completeness of the
 176.28 data submitted by comparing the data with summary information compiled by the
 176.29 commissioner and with established and emerging data quality standards to ensure data
 176.30 quality.

176.31 Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

176.32 Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter,
 176.33 all health plan companies and third-party administrators shall submit data on their contracted
 177.1 prices with health care providers to a private entity designated by the commissioner of health
 177.2 for the purposes of performing the analyses required under this subdivision. The data shall
 177.3 be submitted in the form and manner specified by the commissioner of health.

177.4 (b) The commissioner or the commissioner's designee shall only use the data submitted
 177.5 under this subdivision to carry out the commissioner's responsibilities under this section,
 177.6 including supplying the data to providers so they can verify their results of the peer grouping
 177.7 process consistent with the recommendations developed pursuant to subdivision 3c, paragraph
 177.8 (d), and adopted by the commissioner and, if necessary, submit comments to the
 177.9 commissioner or initiate an appeal.

177.10 (c) Data collected under this subdivision are nonpublic data as defined in section 13.02.
 177.11 Notwithstanding the data classification in this paragraph, data collected under this subdivision
 177.12 may be released or published as authorized in subdivision 11. Notwithstanding the definition
 177.13 of summary data in section 13.02, subdivision 19, summary data prepared under this section
 177.14 may be derived from nonpublic data. The commissioner shall establish procedures and
 177.15 safeguards to protect the integrity and confidentiality of any data that it maintains.

177.16 Sec. 15. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

177.17 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
 177.18 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
 177.19 designee shall only use the data submitted under subdivisions 4 and 5 for the following
 177.20 purposes:

177.21 (1) to evaluate the performance of the health care home program as authorized under
 177.22 section 62U.03, subdivision 7;

- 177.23 (2) to study, in collaboration with the reducing avoidable readmissions effectively
 177.24 (RARE) campaign, hospital readmission trends and rates;
- 177.25 (3) to analyze variations in health care costs, quality, utilization, and illness burden based
 177.26 on geographical areas or populations;
- 177.27 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments
 177.28 of Health and Human Services, including the analysis of health care cost, quality, and
 177.29 utilization baseline and trend information for targeted populations and communities; and
- 177.30 (5) to compile one or more public use files of summary data or tables that must:
- 177.31 (i) be available to the public for no or minimal cost by March 1, 2016, and available by
 177.32 web-based electronic data download by June 30, 2019;
- 178.1 (ii) not identify individual patients; or payers; or providers but that may identify the
 178.2 rendering or billing hospital, clinic, or medical practice;
- 178.3 (iii) be updated by the commissioner, at least annually, with the most current data
 178.4 available;
- 178.5 (iv) contain clear and conspicuous explanations of the characteristics of the data, such
 178.6 as the dates of the data contained in the files, the absence of costs of care for uninsured
 178.7 patients or nonresidents, and other disclaimers that provide appropriate context; and
- 178.8 (v) not lead to the collection of additional data elements beyond what is authorized under
 178.9 this section as of June 30, 2015.
- 178.10 (b) The commissioner may publish the results of the authorized uses identified in
 178.11 paragraph (a) so long as the data released publicly do not contain information or descriptions
 178.12 in which the identity of individual hospitals, clinics, or other providers may be discerned.
 178.13 The data published under this paragraph may identify hospitals, clinics, and medical practices
 178.14 so long as no individual health professionals are identified and the commissioner finds the
 178.15 data to be accurate, valid, and suitable for publication for such use.
- 178.16 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from
 178.17 using the data collected under subdivision 4 to complete the state-based risk adjustment
 178.18 system assessment due to the legislature on October 1, 2015.
- 178.19 (d) The commissioner or the commissioner's designee may use the data submitted under
 178.20 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
 178.21 2023.
- 178.22 (e) The commissioner shall consult with the all-payer claims database work group
 178.23 established under subdivision 12 regarding the technical considerations necessary to create
 178.24 the public use files of summary data described in paragraph (a), clause (5).

178.25 Sec. 16. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

178.26 Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there

178.27 is a degradation of groundwater, the commissioner of health may promulgate health risk

178.28 limits under subdivision 2 for substances degrading the groundwater.

178.29 (b) Health risk limits shall be determined by two methods depending on their toxicological

178.30 end point.

179.1 (c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall

179.2 be derived using United States Environmental Protection Agency risk assessment methods

179.3 using a reference dose, a drinking water equivalent, and a relative source contribution factor.

179.4 (d) For toxicants that are known or probable carcinogens, the adopted health risk limits

179.5 shall be derived from a quantitative estimate of the chemical's carcinogenic potency published

179.6 by the United States Environmental Protection Agency ~~and~~ or determined by the

179.7 commissioner to have undergone thorough scientific review.

82.19 Sec. 9. Minnesota Statutes 2020, section 144.05, is amended by adding a subdivision to

82.20 read:

82.21 Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the

82.22 commissioner of health to the legislature is mandated by statute and the enabling legislation

82.23 does not include a date for the submission of a final report, the mandate to submit the report

82.24 shall expire in accordance with this section.

82.25 (b) If the mandate requires the submission of an annual report and the mandate was

82.26 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate

82.27 requires the submission of a biennial or less frequent report and the mandate was enacted

82.28 before January 1, 2021, the mandate shall expire on January 1, 2024.

82.29 (c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years

82.30 after the date of enactment if the mandate requires the submission of an annual report and

82.31 shall expire five years after the date of enactment if the mandate requires the submission

82.32 of a biennial or less frequent report, unless the enacting legislation provides for a difference

82.33 expiration date.

83.1 (d) The commissioner shall submit a list to the chairs and ranking minority members of

83.2 the legislative committee with jurisdiction over health by February 15 of each year, beginning

83.3 February 15, 2022, of all reports set to expire during the following calendar year in

83.4 accordance with this section.

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

- 83.6 Sec. 10. **[144.064] THE VIVIAN ACT.**
- 83.7 Subdivision 1. **Short title.** This section shall be known and may be cited as the "Vivian
- 83.8 **Act."**
- 83.9 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
- 83.10 **given them:**
- 83.11 (1) "commissioner" means the commissioner of health;
- 83.12 (2) "health care practitioner" means a medical professional that provides prenatal or
- 83.13 **postnatal care;**
- 83.14 (3) "CMV" means the human herpesvirus cytomegalovirus, also called HCMV, human
- 83.15 **herpesvirus 5, and HHV-5; and**
- 83.16 (4) "congenital CMV" means the transmission of a CMV infection from a pregnant
- 83.17 **mother to her fetus.**
- 83.18 Subd. 3. **Commissioner duties.** (a) The commissioner shall make available to health
- 83.19 **care practitioners, women who may become pregnant, expectant parents, and parents of**
- 83.20 **infants up-to-date and evidence-based information about congenital CMV that has been**
- 83.21 **reviewed by experts with knowledge of the disease. The information shall include the**
- 83.22 **following:**
- 83.23 (1) **the recommendation to consider testing for congenital CMV if the parent or legal**
- 83.24 **guardian of the infant elected not to have newborn screening performed under section**
- 83.25 **144.125, and the infant failed a newborn hearing screening or pregnancy history suggests**
- 83.26 **increased risk for congenital CMV infection;**
- 83.27 (2) **the incidence of CMV;**
- 83.28 (3) **the transmission of CMV to pregnant women and women who may become pregnant;**
- 83.29 (4) **birth defects caused by congenital CMV;**
- 83.30 (5) **available preventative measures to avoid the infection of women who are pregnant**
- 83.31 **or may become pregnant; and**
- 84.1 (6) **resources available for families of children born with congenital CMV.**
- 84.2 (b) The commissioner shall follow existing department practice, inclusive of community
- 84.3 **engagement, to ensure that the information in paragraph (a) is culturally and linguistically**
- 84.4 **appropriate for all recipients.**
- 84.5 (c) The department shall establish an outreach program to:
- 84.6 (1) **educate women who may become pregnant, expectant parents, and parents of infants**
- 84.7 **about CMV; and**

84.8 (2) raise awareness for CMV among health care providers who provide care to expectant
 84.9 mothers or infants.

179.8 Sec. 17. **144.066** **DISTRIBUTION OF COVID-19 VACCINES.**

179.9 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
 179.10 and sections 144.0661 to 144.0663.

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

179.12 (c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome
 179.13 coronavirus 2 (SARS-CoV-2).

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

179.15 (e) "Disproportionately impacted community" means a community or population that
 179.16 has been disproportionately and negatively impacted by the COVID-19 pandemic.

179.17 (f) "Local health department" has the meaning given in section 145A.02, subdivision
 179.18 8b.

179.19 (g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized
 179.20 or trailered, that is readily movable without disassembling, and at which vaccines are
 179.21 provided in more than one geographic location.

179.22 Subd. 2. **Distribution.** The commissioner shall establish and maintain partnerships or
 179.23 agreements with local health departments; local health care providers, including community
 179.24 health centers and primary care providers; and local pharmacies to administer COVID-19
 179.25 vaccines throughout the state. COVID-19 vaccines may also be administered via mobile
 179.26 vaccination vehicles authorized under section 144.0662.

179.27 Subd. 3. **Second dose or booster.** For all COVID-19 vaccines for which a second dose
 179.28 or booster is required, during the first vaccine appointment the registered vaccine provider
 179.29 should be directed by the department during the vaccine provider registration process to
 179.30 assist vaccine recipients with scheduling an appointment for the second dose or booster.
 179.31 This assistance may be provided during the observation period following vaccine
 179.32 administration.

180.1 Subd. 4. **Nondiscrimination.** Nothing in sections 144.066 to 144.0663 shall be construed
 180.2 to allow or require the denial of any benefit or opportunity on the basis of race, color, creed,
 180.3 marital status, status with regard to public assistance, disability, genetic information, sexual
 180.4 orientation, age, religion, national origin, sex, or membership in a local human rights
 180.5 commission.

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

180.7 Sec. 18. **[144.0661] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

180.8 Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall
 180.9 establish positions to continue the department's COVID-19 vaccination equity and outreach
 180.10 activities and to plan and implement actions and programs to overcome disparities in
 180.11 COVID-19 vaccination rates that are rooted in historic and current racism; biases based on
 180.12 ethnicity, income, primary language, immigration status, or disability; geography; or
 180.13 transportation access, language access, or Internet access. This work shall be managed by
 180.14 a director who shall serve in a leadership role in the department's COVID-19 response.

180.15 Subd. 2. **Vaccine education and outreach campaign; direct delivery of**
 180.16 **information.** (a) The commissioner shall administer a COVID-19 vaccine education and
 180.17 outreach campaign that engages in direct delivery of information to members of
 180.18 disproportionately impacted communities. In this campaign, the commissioner shall contract
 180.19 with community-based organizations including community faith-based organizations, tribal
 180.20 governments, local health departments, and local health care providers, including community
 180.21 health centers and primary care providers, to deliver the following information in a culturally
 180.22 relevant and linguistically appropriate manner:

180.23 (1) medically and scientifically accurate information on the safety, efficacy, science,
 180.24 and benefits of vaccines generally and COVID-19 vaccines in particular;

180.25 (2) information on how members of disproportionately impacted communities may
 180.26 obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile
 180.27 vaccination vehicle; and

180.28 (3) measures to prevent transmission of COVID-19, including adequate indoor ventilation,
 180.29 wearing face coverings, and physical distancing from individuals outside the household.

180.30 (b) This information must be delivered directly by methods that include phone calls,
 180.31 text messages, physically distanced door-to-door and street canvassing, and digital
 180.32 event-based communication involving live and interactive messengers. For purposes of this
 181.1 subdivision, direct delivery shall not include delivery by television, radio, newspaper, or
 181.2 other forms of mass media.

181.3 Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner
 181.4 shall administer a mass media campaign to provide COVID-19 vaccine education and
 181.5 outreach to members of disproportionately impacted communities. In this campaign, the
 181.6 commissioner shall contract with media vendors to provide the following information to
 181.7 members of disproportionately impacted communities in a manner that is culturally relevant
 181.8 and linguistically appropriate:

181.9 (1) medically and scientifically accurate information on the safety, efficacy, science,
 181.10 and benefits of COVID-19 vaccines; and

181.11 (2) information on how members of disproportionately impacted communities may
 181.12 obtain a COVID-19 vaccine.

181.13 Subd. 4. **Community assistance.** The commissioner shall administer a program to help
 181.14 members of disproportionately impacted communities arrange for and prepare to obtain a
 181.15 COVID-19 vaccine and to support transportation-limited members of these communities
 181.16 with transportation to vaccination appointments or otherwise arrange for vaccine providers
 181.17 to reach members of these communities.

181.18 Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall
 181.19 establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in
 181.20 the state, and shall set and periodically update goals for COVID-19 vaccine distribution in
 181.21 the state that are focused on equity.

181.22 Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in
 181.23 subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate
 181.24 until a sufficient percentage of individuals in each county or census tract have received the
 181.25 full series of COVID-19 vaccines to protect individuals in each county or census tract from
 181.26 COVID-19.

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

181.28 Sec. 19. **[144.0662] MOBILE VACCINATION PROGRAM.**

181.29 Subdivision 1. **Administration.** The commissioner, in partnership with local health
 181.30 departments and the regional health care coalitions, shall administer a mobile vaccination
 181.31 program in which mobile vaccination vehicles are deployed to communities around the state
 181.32 to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile
 181.33 vaccination vehicles to communities to improve access to vaccines based on factors that
 182.1 include but are not limited to vulnerability, likelihood of exposure, limits to transportation
 182.2 access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

182.3 Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19
 182.4 allocation and prioritization plan or guidance, all individuals in a community to which a
 182.5 mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from
 182.6 the vehicle.

182.7 Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with
 182.8 Centers for Disease Control and Prevention guidelines and may be staffed with additional
 182.9 support staff based on needs determined by local request. Additional support staff may
 182.10 include but are not limited to community partners and translators.

182.11 Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19
 182.12 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling
 182.13 an appointment with a mobile vaccination vehicle or with another vaccine provider for any
 182.14 needed second dose or booster. The commissioner shall, to the extent possible, deploy

182.15 mobile vaccination vehicles in a manner that allows vaccine recipients to receive second
 182.16 doses or boosters from a mobile vaccination vehicle.

182.17 Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle
 182.18 program until a sufficient percentage of individuals in each county or census tract have
 182.19 received the full series of COVID-19 vaccines to protect individuals in each county or
 182.20 census tract from the spread of COVID-19.

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

182.22 Sec. 20. **[144.0663] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

182.23 Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The
 182.24 commissioner shall:

182.25 (1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution
 182.26 established by the commissioner under section 144.0661, subdivision 5; and

182.27 (2) publish implementation protocols to address the disparities in COVID-19 vaccination
 182.28 rates in certain communities and ensure that members of disproportionately impacted
 182.29 communities are given adequate access to COVID-19 vaccines.

182.30 Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner
 182.31 shall publish on the department website:

183.1 (1) data measuring compliance with the set of metrics and goals for equitable COVID-19
 183.2 vaccine distribution established by the commissioner under section 144.0661, subdivision
 183.3 5; and

183.4 (2) summary data on individuals who have received one or two doses of a COVID-19
 183.5 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

183.6 Subd. 3. **Quarterly reports.** On a quarterly basis while funds are available, the
 183.7 commissioner shall report to the chairs and ranking minority members of the legislative
 183.8 committees with jurisdiction over finance, ways and means, and health care:

183.9 (1) funds distributed to local health departments for COVID-19 activities and the sources
 183.10 of the funds; and

183.11 (2) funds expended to implement sections 144.066 to 144.0663.

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

183.13 Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

183.14 Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner
 183.15 of health shall establish resident reimbursement case mix classifications based upon the
 183.16 assessments of residents of nursing homes and boarding care homes conducted under this
 183.17 section and according to section 256R.17.

183.18 Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

183.19 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
183.20 given.

183.21 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
183.22 periods in the MDS assessment process. This look-back period is also called the observation
183.23 or assessment period.

183.24 (b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

183.25 (c) "Index maximization" means classifying a resident who could be assigned to more
183.26 than one category, to the category with the highest case mix index.

183.27 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,
183.28 and functional status elements, that include common definitions and coding categories
183.29 specified by the Centers for Medicare and Medicaid Services and designated by the
183.30 Minnesota Department of Health.

184.1 (e) "Representative" means a person who is the resident's guardian or conservator, the
184.2 person authorized to pay the nursing home expenses of the resident, a representative of the
184.3 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
184.4 other individual designated by the resident.

184.5 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
184.6 facility's residents according to their clinical and functional status identified in data supplied
184.7 by the facility's Minimum Data Set.

184.8 (g) "Activities of daily living" ~~means grooming;~~ includes personal hygiene, dressing,
184.9 bathing, transferring, ~~bed~~ mobility, ~~positioning,~~ locomotion, eating, and toileting.

184.10 (h) "Nursing facility level of care determination" means the assessment process that
184.11 results in a determination of a resident's or prospective resident's need for nursing facility
184.12 level of care as established in subdivision 11 for purposes of medical assistance payment
184.13 of long-term care services for:

184.14 (1) nursing facility services under section 256B.434 or chapter 256R;

184.15 (2) elderly waiver services under chapter 256S;

184.16 (3) CADI and BI waiver services under section 256B.49; and

184.17 (4) state payment of alternative care services under section 256B.0913.

184.18 Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

184.19 Subd. 3a. **Resident reimbursement case mix classifications beginning January 1,**
184.20 **2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall
184.21 be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor
184.22 version mandated by the Centers for Medicare and Medicaid Services that nursing facilities

184.23 are required to complete for all residents. The commissioner of health shall establish resident
 184.24 classifications according to the RUG-IV, 48 group, resource utilization groups. Resident
 184.25 classification must be established based on the individual items on the Minimum Data Set,
 184.26 which must be completed according to the Long Term Care Facility Resident Assessment
 184.27 Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare
 184.28 and Medicaid Services.

184.29 (b) Each resident must be classified based on the information from the Minimum Data
 184.30 Set according to general categories ~~as defined in the Case Mix Classification Manual for~~
 184.31 ~~Nursing Facilities~~ issued by the Minnesota Department of Health.

185.1 Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

185.2 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
 185.3 admission assessment for all residents who stay in the facility 14 days or less; unless the
 185.4 resident is admitted and discharged from the facility on the same day, in which case the
 185.5 admission assessment is not required. When an admission assessment is not submitted, the
 185.6 case mix classification shall be the rate with a case mix index of 1.0.

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

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

185.14 Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

185.15 Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The
 185.16 commissioner of health shall provide to a nursing facility a notice for each resident of the
 185.17 ~~reimbursement~~ classification established under subdivision 1. The notice must inform the
 185.18 resident of the case mix classification ~~that was~~ assigned, the opportunity to review the
 185.19 documentation supporting the classification, the opportunity to obtain clarification from the
 185.20 commissioner, and the opportunity to request a reconsideration of the classification and the
 185.21 address and telephone number of the Office of Ombudsman for Long-Term Care. The
 185.22 commissioner must transmit the notice of resident classification by electronic means to the
 185.23 nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to
 185.24 each resident, ~~to the person responsible for the payment of the resident's nursing home~~
 185.25 ~~expenses, or to another person designated by the resident or the resident's representative.~~
 185.26 This notice must be distributed within three ~~working~~ business days after the facility's receipt
 185.27 ~~of the electronic file of notice of case mix classifications from the commissioner of health.~~

185.28 (b) If a facility submits a ~~modification to the most recent assessment used to establish~~
 185.29 ~~a case mix classification conducted under subdivision 3 that results modifying assessment~~
 185.30 resulting in a change in the case mix classification, the facility shall give must provide a

185.31 written notice to the resident or the resident's representative ~~about~~ regarding the item or
 185.32 items that ~~was~~ were modified and the reason for the ~~modification~~ modifications. The notice
 185.33 of modified assessment ~~may~~ must be provided at the same time that the resident or resident's
 186.1 representative is provided the resident's modified notice of classification within three business
 186.2 days after distribution of the resident case mix classification notice.

186.3 Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

186.4 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or
 186.5 resident's representative, or the nursing facility or boarding care home may request that the
 186.6 commissioner of health reconsider the assigned reimbursement case mix classification and
 186.7 any item or items changed during the audit process. The request for reconsideration must
 186.8 be submitted in writing to the commissioner within 30 days of the day the resident or the
 186.9 resident's representative receives the resident classification notice of health.

186.10 (b) For reconsideration requests initiated by the resident or the resident's representative:

186.11 (1) The resident or the resident's representative must submit in writing a reconsideration
 186.12 request to the facility administrator within 30 days of receipt of the resident classification
 186.13 notice. The written request for reconsideration must include the name of the resident, the
 186.14 name and address of the facility in which the resident resides, the reasons for the
 186.15 reconsideration, and documentation supporting the request. The documentation accompanying
 186.16 the reconsideration request is limited to a copy of the MDS that determined the classification
 186.17 and other documents that would support or change the MDS findings.

186.18 (2) Within three business days of receiving the reconsideration request, the nursing
 186.19 facility must submit to the commissioner of health a completed reconsideration request
 186.20 form, a copy of the resident's or resident's representative's written request, and all supporting
 186.21 documentation used to complete the assessment being considered. If the facility fails to
 186.22 provide the required information, the reconsideration will be completed with the information
 186.23 submitted and the facility cannot make further reconsideration requests on this classification.

186.24 ~~(b)~~ (3) Upon written request and within three business days, the nursing facility must
 186.25 give the resident or the resident's representative a copy of the assessment ~~form~~ being
 186.26 reconsidered and the other all supporting documentation that was given to the commissioner
 186.27 of health used to support complete the assessment findings. The nursing facility shall also
 186.28 provide access to and a copy of other information from the resident's record that has been
 186.29 requested by or on behalf of the resident to support a resident's reconsideration request. A
 186.30 copy of any requested material must be provided within three working days of receipt of a
 186.31 written request for the information. Notwithstanding any law to the contrary, the facility
 186.32 may not charge a fee for providing copies of the requested documentation. If a facility fails
 186.33 to provide the material required documents within this time, it is subject to the issuance of
 186.34 a correction order and penalty assessment under sections 144.653 and 144A.10.
 187.1 Notwithstanding those sections, any correction order issued under this subdivision must
 187.2 require that the nursing facility immediately comply with the request for information, and
 187.3 ~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state

187.4 a \$100 fine for the first day of noncompliance, and an increase in the \$100 fine by \$50
 187.5 increments for each day the noncompliance continues.

187.6 (c) in addition to the information required under paragraphs (a) and (b), a reconsideration
 187.7 request from a nursing facility must contain the following information: (i) the date the
 187.8 reimbursement classification notices were received by the facility; (ii) the date the
 187.9 classification notices were distributed to the resident or the resident's representative; and
 187.10 (iii) For reconsideration requests initiated by the facility:

187.11 (1) The facility is required to inform the resident or the resident's representative in writing
 187.12 that a reconsideration of the resident's case mix classification is being requested. The notice
 187.13 must inform the resident or the resident's representative:

187.14 (i) of the date and reason for the reconsideration request;

187.15 (ii) of the potential for a classification and subsequent rate change;

187.16 (iii) of the extent of the potential rate change;

187.17 (iv) that copies of the request and supporting documentation are available for review;

187.18 and

187.19 (v) that the resident or the resident's representative has the right to request a
 187.20 reconsideration.

187.21 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the
 187.22 facility must submit to the commissioner of health a completed reconsideration request
 187.23 form, all supporting documentation used to complete the assessment being reconsidered,
 187.24 and a copy of a the notice sent to informing the resident or to the resident's representative;
 187.25 This notice must inform the resident or the resident's representative that a reconsideration
 187.26 of the resident's classification is being requested, the reason for the request, that the resident's
 187.27 rate will change if the request is approved by the commissioner, the extent of the change,
 187.28 that copies of the facility's request and supporting documentation are available for review,
 187.29 and that the resident also has the right to request a reconsideration.

187.30 (3) If the facility fails to provide the required information listed in item (iii) with the
 187.31 reconsideration request, the commissioner may request that the facility provide the
 187.32 information within 14 calendar days; the reconsideration request must may be denied if the
 188.1 information is then not provided; and the facility may not make further reconsideration
 188.2 requests on that specific reimbursement this classification.

188.3 (d) Reconsideration by the commissioner must be made by individuals not involved in
 188.4 reviewing the assessment, audit, or reconsideration that established the disputed classification.
 188.5 The reconsideration must be based upon the assessment that determined the classification
 188.6 and upon the information provided to the commissioner of health under paragraphs (a) and
 188.7 (b) to (c). If necessary for evaluating the reconsideration request, the commissioner may
 188.8 conduct on-site reviews. Within 15 working business days of receiving the request for
 188.9 reconsideration, the commissioner shall affirm or modify the original resident classification.

188.10 The original classification must be modified if the commissioner determines that the
 188.11 assessment resulting in the classification did not accurately reflect characteristics of the
 188.12 resident at the time of the assessment. ~~The resident and the nursing facility or boarding care~~
 188.13 ~~home shall be notified within five working days after the decision is made.~~ The commissioner
 188.14 must transmit the reconsideration classification notice by electronic means to the nursing
 188.15 facility. The nursing facility is responsible for the distribution of the notice to the resident
 188.16 or the resident's representative. The notice must be distributed by the nursing facility within
 188.17 three business days after receipt. A decision by the commissioner under this subdivision is
 188.18 the final administrative decision of the agency for the party requesting reconsideration.

188.19 (e) The ~~resident~~ case mix classification established by the commissioner shall be the
 188.20 classification ~~that~~ which applies to the resident while the request for reconsideration is
 188.21 pending. If a request for reconsideration applies to an assessment used to determine nursing
 188.22 facility level of care under subdivision 4, paragraph (c), the resident shall continue to be
 188.23 eligible for nursing facility level of care while the request for reconsideration is pending.

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

188.26 Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

188.27 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
 188.28 assessments performed under section 256R.17 through any of the following: desk audits;
 188.29 on-site review of residents and their records; and interviews with staff, residents, or residents'
 188.30 families. The commissioner shall reclassify a resident if the commissioner determines that
 188.31 the resident was incorrectly classified.

188.32 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

189.1 (c) A facility must grant the commissioner access to examine the medical records relating
 189.2 to the resident assessments selected for audit under this subdivision. The commissioner may
 189.3 also observe and speak to facility staff and residents.

189.4 (d) The commissioner shall consider documentation under the time frames for coding
 189.5 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
 189.6 Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

189.7 (e) The commissioner shall develop an audit selection procedure that includes the
 189.8 following factors:

189.9 (1) Each facility shall be audited annually. If a facility has two successive audits in which
 189.10 the percentage of change is five percent or less and the facility has not been the subject of
 189.11 a special audit in the past 36 months, the facility may be audited biannually. A stratified
 189.12 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
 189.13 shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed
 189.14 as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a
 189.15 minimum of ten assessments. If the total change between the first and second samples is

189.16 35 percent or greater, the commissioner may expand the audit to all of the remaining
189.17 assessments.

189.18 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
189.19 again within six months. If a facility has two expanded audits within a 24-month period,
189.20 that facility will be audited at least every six months for the next 18 months.

189.21 (3) The commissioner may conduct special audits if the commissioner determines that
189.22 circumstances exist that could alter or affect the validity of case mix classifications of
189.23 residents. These circumstances include, but are not limited to, the following:

189.24 (i) frequent changes in the administration or management of the facility;

189.25 (ii) an unusually high percentage of residents in a specific case mix classification;

189.26 (iii) a high frequency in the number of reconsideration requests received from a facility;

189.27 (iv) frequent adjustments of case mix classifications as the result of reconsiderations or
189.28 audits;

189.29 (v) a criminal indictment alleging provider fraud;

189.30 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

189.31 (vii) an atypical pattern of scoring minimum data set items;

189.32 (viii) nonsubmission of assessments;

190.1 (ix) late submission of assessments; or

190.2 (x) a previous history of audit changes of 35 percent or greater.

190.3 (f) Within 15 working days of completing the audit process, the commissioner shall
190.4 make available electronically the results of the audit to the facility. If the results of the audit
190.5 reflect a change in the resident's case mix classification, a case mix classification notice
190.6 will be made available electronically to the facility, using the procedure in subdivision 7,
190.7 paragraph (a). The notice must contain the resident's classification and a statement informing
190.8 the resident, the resident's authorized representative, and the facility of their right to review
190.9 the commissioner's documents supporting the classification and to request a reconsideration
190.10 of the classification. This notice must also include the address and telephone number of the
190.11 Office of Ombudsman for Long-Term Care. If the audit results in a case mix classification
190.12 change, the commissioner must transmit the audit classification notice by electronic means
190.13 to the nursing facility within 15 business days of completing an audit. The nursing facility
190.14 is responsible for distribution of the notice to each resident or the resident's representative.
190.15 This notice must be distributed by the nursing facility within three business days after
190.16 receipt. The notice must inform the resident of the case mix classification assigned, the
190.17 opportunity to review the documentation supporting the classification, the opportunity to
190.18 obtain clarification from the commissioner, the opportunity to request a reconsideration of

190.19 the classification, and the address and telephone number of the Office of Ombudsman for
190.20 Long-Term Care.

190.21 Sec. 28. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

190.22 Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or
190.23 prospective resident whose level of care determination results in a denial of long-term care
190.24 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
190.25 paragraph (h), clause (9).

190.26 (b) The commissioner of human services shall ensure that notice of changes in eligibility
190.27 due to a nursing facility level of care determination is provided to each affected recipient
190.28 or the recipient's guardian at least 30 days before the effective date of the change. The notice
190.29 shall include the following information:

190.30 (1) how to obtain further information on the changes;

190.31 (2) how to receive assistance in obtaining other services;

190.32 (3) a list of community resources; and

190.33 (4) appeal rights.

191.1 ~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses~~
191.2 ~~(1) and (2), may request continued services pending appeal within the time period allowed~~
191.3 ~~to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is~~
191.4 ~~in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

191.5 Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

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

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

191.10		ANNUAL
191.11	TYPE	<u>LICENSE FEE</u>
191.12		\$19,920
191.13	Academic broad scope - type A, B, or C	<u>\$25,896</u>
191.14	Academic broad scope - type B	49,920
191.15	Academic broad scope - type C	49,920
191.16	<u>Academic broad scope - type A, B, or C (4-8 locations)</u>	<u>\$31,075</u>

84.10 Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

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

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

84.15		ANNUAL
84.16	TYPE	<u>LICENSE FEE</u>
84.17		\$19,920
84.18	Academic broad scope - type A, B, or C	<u>\$25,896</u>
84.19	Academic broad scope - type B	49,920
84.20	Academic broad scope - type C	49,920
84.21	<u>Academic broad scope - type A, B, or C (4-8 locations)</u>	<u>\$31,075</u>

191.17	<u>Academic broad scope - type A, B, or C (9 or more locations)</u>	<u>\$36,254</u>
191.18		<u>49,920</u>
191.19	Medical broad scope - type A	<u>\$25,896</u>
191.20	<u>Medical broad scope- type A (4-8 locations)</u>	<u>\$31,075</u>
191.21	<u>Medical broad scope- type A (9 or more locations)</u>	<u>\$36,254</u>
191.22	Medical institution - diagnostic and therapeutic	3,680
191.23	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
191.24	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
191.25	<u>medical therapy emerging technologies</u>	<u>\$4,784</u>
191.26	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
191.27	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
191.28	<u>medical therapy emerging technologies (4-8 locations)</u>	<u>\$5,740</u>
191.29	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
191.30	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
191.31	<u>medical therapy emerging technologies (9 or more locations)</u>	<u>\$6,697</u>
191.32	Medical institution - diagnostic (no written directives)	3,680
191.33	Medical private practice - diagnostic and therapeutic	3,680
191.34	Medical private practice - diagnostic (no written directives)	3,680
191.35	Eye applicators	3,680
191.36	Nuclear medical vans	3,680
191.37	High dose rate afterloader	3,680
191.38	Mobile high dose rate afterloader	3,680
191.39	Medical therapy - other emerging technology	3,680
192.1		<u>8,960</u>
192.2	Teletherapy	<u>\$11,648</u>
192.3		<u>8,960</u>
192.4	Gamma knife	<u>\$11,648</u>
192.5	Veterinary medicine	2,000 <u>\$2,600</u>

84.22	<u>Academic broad scope - type A, B, or C (9 or more locations)</u>	<u>\$36,254</u>
84.23		<u>49,920</u>
84.24	Medical broad scope - type A	<u>\$25,896</u>
84.25	<u>Medical broad scope- type A (4-8 locations)</u>	<u>\$31,075</u>
84.26	<u>Medical broad scope- type A (9 or more locations)</u>	<u>\$36,254</u>
84.27	Medical institution - diagnostic and therapeutic	3,680
84.28	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
84.29	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
84.30	<u>medical therapy emerging technologies</u>	<u>\$4,784</u>
84.31	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
84.32	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
84.33	<u>medical therapy emerging technologies (4-8 locations)</u>	<u>\$5,740</u>
84.34	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
84.35	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
84.36	<u>medical therapy emerging technologies (9 or more locations)</u>	<u>\$6,697</u>
84.37	Medical institution - diagnostic (no written directives)	3,680
85.1	Medical private practice - diagnostic and therapeutic	3,680
85.2	Medical private practice - diagnostic (no written directives)	3,680
85.3	Eye applicators	3,680
85.4	Nuclear medical vans	3,680
85.5	High dose rate afterloader	3,680
85.6	Mobile high dose rate afterloader	3,680
85.7	Medical therapy - other emerging technology	3,680
85.8		<u>8,960</u>
85.9	Teletherapy	<u>\$11,648</u>
85.10		<u>8,960</u>
85.11	Gamma knife	<u>\$11,648</u>
85.12	Veterinary medicine	2,000 <u>\$2,600</u>

192.6	In vitro testing lab	2,000 <u>\$2,600</u>
192.7		8,800
192.8	Nuclear pharmacy	<u>\$11,440</u>
192.9	<u>Nuclear pharmacy (5 or more locations)</u>	<u>\$13,728</u>
192.10	Radiopharmaceutical distribution (10 CFR 32.72)	3,840 <u>\$4,992</u>
192.11	Radiopharmaceutical processing and distribution (10 CFR	8,800
192.12	32.72)	<u>\$11,440</u>
192.13	<u>Radiopharmaceutical processing and distribution (10 CFR</u>	<u>\$13,728</u>
192.14	<u>32.72) (5 or more locations)</u>	
192.15	Medical sealed sources - distribution (10 CFR 32.74)	3,840 <u>\$4,992</u>
192.16	Medical sealed sources - processing and distribution (10 CFR	8,800
192.17	32.74)	<u>\$11,440</u>
192.18	<u>Medical sealed sources - processing and distribution (10 CFR</u>	<u>\$13,728</u>
192.19	<u>32.74) (5 or more locations)</u>	
192.20	Well logging - sealed sources	3,760 <u>\$4,888</u>
192.21	Measuring systems - (fixed gauge, portable gauge, gas	
192.22	chromatograph, other)	2,000 <u>\$2,600</u>
192.23	Measuring systems - portable gauge	2,000
192.24	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
192.25	<u>chromatograph, other) (4-8 locations)</u>	<u>\$3,120</u>
192.26	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
192.27	<u>chromatograph, other) (9 or more locations)</u>	<u>\$3,640</u>
192.28	X-ray fluorescent analyzer	1,520 <u>\$1,976</u>
192.29	Measuring systems - gas chromatograph	2,000
192.30	Measuring systems - other	2,000
192.31	Broad scope Manufacturing and distribution - type A <u>broad</u>	19,920
192.32	<u>scope</u>	<u>\$25,896</u>

85.13	In vitro testing lab	2,000 <u>\$2,600</u>
85.14		8,800
85.15	Nuclear pharmacy	<u>\$11,440</u>
85.16	<u>Nuclear pharmacy (5 or more locations)</u>	<u>\$13,728</u>
85.17	Radiopharmaceutical distribution (10 CFR 32.72)	3,840 <u>\$4,992</u>
85.18	Radiopharmaceutical processing and distribution (10 CFR	8,800
85.19	32.72)	<u>\$11,440</u>
85.20	<u>Radiopharmaceutical processing and distribution (10 CFR</u>	<u>\$13,728</u>
85.21	<u>32.72) (5 or more locations)</u>	
85.22	Medical sealed sources - distribution (10 CFR 32.74)	3,840 <u>\$4,992</u>
85.23	Medical sealed sources - processing and distribution (10 CFR	8,800
85.24	32.74)	<u>\$11,440</u>
85.25	<u>Medical sealed sources - processing and distribution (10 CFR</u>	<u>\$13,728</u>
85.26	<u>32.74) (5 or more locations)</u>	
85.27	Well logging - sealed sources	3,760 <u>\$4,888</u>
85.28	Measuring systems - (fixed gauge, portable gauge, gas	
85.29	chromatograph, other)	2,000 <u>\$2,600</u>
85.30	Measuring systems - portable gauge	2,000
85.31	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
85.32	<u>chromatograph, other) (4-8 locations)</u>	<u>\$3,120</u>
85.33	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
85.34	<u>chromatograph, other) (9 or more locations)</u>	<u>\$3,640</u>
85.35	X-ray fluorescent analyzer	1,520 <u>\$1,976</u>
85.36	Measuring systems - gas chromatograph	2,000
85.37	Measuring systems - other	2,000
85.38	Broad scope Manufacturing and distribution - type A <u>broad</u>	19,920
85.39	<u>scope</u>	<u>\$25,896</u>

192.33	<u>Manufacturing and distribution - type A broad scope (4-8 locations)</u>	<u>\$31,075</u>
192.34		
192.35	<u>Manufacturing and distribution - type A broad scope (9 or more locations)</u>	<u>\$36,254</u>
192.36		
192.37	Broad scope <u>Manufacturing and distribution - type B or C broad scope</u>	17,600 <u>\$22,880</u>
192.38		
192.39	Broad scope <u>Manufacturing and distribution - type C</u>	17,600
192.40	<u>Manufacturing and distribution - type B or C broad scope (4-8 locations)</u>	<u>\$27,456</u>
192.41		
192.42	<u>Manufacturing and distribution - type B or C broad scope (9 or more locations)</u>	<u>\$32,032</u>
192.43		
193.1	Manufacturing and distribution - other	5,280 <u>\$6,864</u>
193.2	<u>Manufacturing and distribution - other (4-8 locations)</u>	<u>\$8,236</u>
193.3	<u>Manufacturing and distribution - other (9 or more locations)</u>	<u>\$9,609</u>
193.4		18,640
193.5	Nuclear laundry	<u>\$24,232</u>
193.6	Decontamination services	4,960 <u>\$6,448</u>
193.7	Leak test services only	2,000 <u>\$2,600</u>
193.8	Instrument calibration service only, less than 100 curies	2,000 <u>\$2,600</u>
193.9	Instrument calibration service only, 100 curies or more	2,000
193.10	Service, maintenance, installation, source changes, etc.	4,960 <u>\$6,448</u>
193.11	Waste disposal service, prepackaged only	6,000 <u>\$7,800</u>
193.12		8,320
193.13	Waste disposal	<u>\$10,816</u>
193.14	Distribution - general licensed devices (sealed sources)	1,760 <u>\$2,288</u>
193.15	Distribution - general licensed material (unsealed sources)	1,120 <u>\$1,456</u>

85.40	<u>Manufacturing and distribution - type A broad scope (4-8 locations)</u>	<u>\$31,075</u>
85.41		
86.1	<u>Manufacturing and distribution - type A broad scope (9 or more locations)</u>	<u>\$36,254</u>
86.2		
86.3	Broad scope <u>Manufacturing and distribution - type B or C broad scope</u>	17,600 <u>\$22,880</u>
86.4		
86.5	Broad scope <u>Manufacturing and distribution - type C</u>	17,600
86.6	<u>Manufacturing and distribution - type B or C broad scope (4-8 locations)</u>	<u>\$27,456</u>
86.7		
86.8	<u>Manufacturing and distribution - type B or C broad scope (9 or more locations)</u>	<u>\$32,032</u>
86.9		
86.10	Manufacturing and distribution - other	5,280 <u>\$6,864</u>
86.11	<u>Manufacturing and distribution - other (4-8 locations)</u>	<u>\$8,236</u>
86.12	<u>Manufacturing and distribution - other (9 or more locations)</u>	<u>\$9,609</u>
86.13		18,640
86.14	Nuclear laundry	<u>\$24,232</u>
86.15	Decontamination services	4,960 <u>\$6,448</u>
86.16	Leak test services only	2,000 <u>\$2,600</u>
86.17	Instrument calibration service only, less than 100 curies	2,000 <u>\$2,600</u>
86.18	Instrument calibration service only, 100 curies or more	2,000
86.19	Service, maintenance, installation, source changes, etc.	4,960 <u>\$6,448</u>
86.20	Waste disposal service, prepackaged only	6,000 <u>\$7,800</u>
86.21		8,320
86.22	Waste disposal	<u>\$10,816</u>
86.23	Distribution - general licensed devices (sealed sources)	1,760 <u>\$2,288</u>
86.24	Distribution - general licensed material (unsealed sources)	1,120 <u>\$1,456</u>

193.16		9,840
193.17	Industrial radiography - fixed or temporary location	<u>\$12,792</u>
193.18	Industrial radiography - temporary job sites	9,840
193.19	<u>Industrial radiography - fixed or temporary location (5 or more locations)</u>	<u>\$16,629</u>
193.20		
193.21	Irradiators, self-shielding, less than 10,000 curies	2,880 <u>\$3,744</u>
193.22	Irradiators, other, less than 10,000 curies	5,360 <u>\$6,968</u>
193.23	Irradiators, self-shielding, 10,000 curies or more	2,880
193.24		9,520
193.25	Research and development - type A, B, or C broad scope	<u>\$12,376</u>
193.26	Research and development - type B broad scope	9,520
193.27	Research and development - type C broad scope	9,520
193.28	<u>Research and development - type A, B, or C broad scope (4-8 locations)</u>	<u>\$14,851</u>
193.29		
193.30	<u>Research and development - type A, B, or C broad scope (9 or more locations)</u>	<u>\$17,326</u>
193.31		
193.32	Research and development - other	4,480 <u>\$5,824</u>
193.33	Storage - no operations	2,000 <u>\$2,600</u>
193.34	Source material - shielding	584 <u>\$759</u>
193.35	Special nuclear material plutonium - neutron source in device	3,680 <u>\$4,784</u>
193.36	Pacemaker by-product and/or special nuclear material - medical	3,680 <u>\$4,784</u>
193.37	(institution)	
193.38	Pacemaker by-product and/or special nuclear material -	5,280 <u>\$6,864</u>
193.39	manufacturing and distribution	
193.40	Accelerator-produced radioactive material	3,840 <u>\$4,992</u>
194.1	Nonprofit educational institutions	300 <u>\$500</u>
194.2	General license registration	150

86.25		9,840
86.26	Industrial radiography - fixed or temporary location	<u>\$12,792</u>
86.27	Industrial radiography - temporary job sites	9,840
86.28	<u>Industrial radiography - fixed or temporary location (5 or more locations)</u>	<u>\$16,629</u>
86.29		
86.30	Irradiators, self-shielding, less than 10,000 curies	2,880 <u>\$3,744</u>
86.31	Irradiators, other, less than 10,000 curies	5,360 <u>\$6,968</u>
86.32	Irradiators, self-shielding, 10,000 curies or more	2,880
86.33		9,520
86.34	Research and development - type A, B, or C broad scope	<u>\$12,376</u>
86.35	Research and development - type B broad scope	9,520
86.36	Research and development - type C broad scope	9,520
86.37	<u>Research and development - type A, B, or C broad scope (4-8 locations)</u>	<u>\$14,851</u>
86.38		
86.39	<u>Research and development - type A, B, or C broad scope (9 or more locations)</u>	<u>\$17,326</u>
86.40		
86.41	Research and development - other	4,480 <u>\$5,824</u>
86.42	Storage - no operations	2,000 <u>\$2,600</u>
87.1	Source material - shielding	584 <u>\$759</u>
87.2	Special nuclear material plutonium - neutron source in device	3,680 <u>\$4,784</u>
87.3	Pacemaker by-product and/or special nuclear material - medical	3,680 <u>\$4,784</u>
87.4	(institution)	
87.5	Pacemaker by-product and/or special nuclear material -	5,280 <u>\$6,864</u>
87.6	manufacturing and distribution	
87.7	Accelerator-produced radioactive material	3,840 <u>\$4,992</u>
87.8	Nonprofit educational institutions	300 <u>\$500</u>
87.9	General license registration	150

194.3	Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:	
194.4	Subd. 4. Initial and renewal application fee. A licensee must pay an <u>initial and a</u>	
194.5	<u>renewal application fee as follows:</u> according to this subdivision.	
194.6	TYPE	APPLICATION FEE
194.7		\$5,920
194.8	Academic broad scope - type A, B, or C	\$6,808
194.9	Academic broad scope - type B	5,920
194.10	Academic broad scope - type C	5,920
194.11	Medical broad scope - type A	3,920 <u>\$4,508</u>
194.12	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
194.13	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
194.14	<u>medical therapy emerging technologies</u>	<u>\$1,748</u>
194.15	Medical institution - diagnostic and therapeutic	1,520
194.16	Medical institution - diagnostic (no written directives)	1,520
194.17	Medical private practice - diagnostic and therapeutic	1,520
194.18	Medical private practice - diagnostic (no written directives)	1,520
194.19	Eye applicators	1,520
194.20	Nuclear medical vans	1,520
194.21	High dose rate afterloader	1,520
194.22	Mobile high dose rate afterloader	1,520
194.23	Medical therapy - other emerging technology	1,520
194.24	Teletherapy	5,520 <u>\$6,348</u>
194.25	Gamma knife	5,520 <u>\$6,348</u>
194.26	Veterinary medicine	960 <u>\$1,104</u>
194.27	In vitro testing lab	960 <u>\$1,104</u>
194.28	Nuclear pharmacy	4,880 <u>\$5,612</u>

87.10	Sec. 12. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:	
87.11	Subd. 4. Initial and renewal application fee. A licensee must pay an <u>initial and a</u>	
87.12	<u>renewal application fee as follows:</u> according to this subdivision.	
87.13	TYPE	APPLICATION FEE
87.14		\$5,920
87.15	Academic broad scope - type A, B, or C	\$6,808
87.16	Academic broad scope - type B	5,920
87.17	Academic broad scope - type C	5,920
87.18	Medical broad scope - type A	3,920 <u>\$4,508</u>
87.19	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
87.20	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
87.21	<u>medical therapy emerging technologies</u>	<u>\$1,748</u>
87.22	Medical institution - diagnostic and therapeutic	1,520
87.23	Medical institution - diagnostic (no written directives)	1,520
87.24	Medical private practice - diagnostic and therapeutic	1,520
87.25	Medical private practice - diagnostic (no written directives)	1,520
87.26	Eye applicators	1,520
87.27	Nuclear medical vans	1,520
87.28	High dose rate afterloader	1,520
87.29	Mobile high dose rate afterloader	1,520
87.30	Medical therapy - other emerging technology	1,520
87.31	Teletherapy	5,520 <u>\$6,348</u>
87.32	Gamma knife	5,520 <u>\$6,348</u>
87.33	Veterinary medicine	960 <u>\$1,104</u>
87.34	In vitro testing lab	960 <u>\$1,104</u>
87.35	Nuclear pharmacy	4,880 <u>\$5,612</u>

194.29	Radiopharmaceutical distribution (10 CFR 32.72)	2,160 <u>\$2,484</u>
194.30	Radiopharmaceutical processing and distribution (10 CFR 32.72)	4,880 <u>\$5,612</u>
194.31		
194.32	Medical sealed sources - distribution (10 CFR 32.74)	2,160 <u>\$2,484</u>
194.33	Medical sealed sources - processing and distribution (10 CFR 32.74)	4,880 <u>\$5,612</u>
194.34		
194.35	Well logging - sealed sources	1,600 <u>\$1,840</u>
194.36	Measuring systems - (fixed gauge, <u>portable gauge, gas chromatograph, other</u>)	960 <u>\$1,104</u>
194.37		
194.38	Measuring systems - portable gauge	960
195.1	X-ray fluorescent analyzer	584 <u>\$671</u>
195.2	Measuring systems - gas chromatograph	960
195.3	Measuring systems - other	960
195.4	Broad scope Manufacturing and distribution - type A, B, and C broad scope	5,920 <u>\$6,854</u>
195.5		
195.6	Broad scope manufacturing and distribution - type B	5,920
195.7	Broad scope manufacturing and distribution - type C	5,920
195.8	Manufacturing and distribution - other	2,320 <u>\$2,668</u>
195.9		10,080
195.10	Nuclear laundry	<u>\$11,592</u>
195.11	Decontamination services	2,640 <u>\$3,036</u>
195.12	Leak test services only	960 <u>\$1,104</u>
195.13	Instrument calibration service only, less than 100 curies	960 <u>\$1,104</u>
195.14	Instrument calibration service only, 100 curies or more	960
195.15	Service, maintenance, installation, source changes, etc.	2,640 <u>\$3,036</u>
195.16	Waste disposal service, prepackaged only	2,240 <u>\$2,576</u>

87.36	Radiopharmaceutical distribution (10 CFR 32.72)	2,160 <u>\$2,484</u>
87.37	Radiopharmaceutical processing and distribution (10 CFR 32.72)	4,880 <u>\$5,612</u>
87.38		
88.1	Medical sealed sources - distribution (10 CFR 32.74)	2,160 <u>\$2,484</u>
88.2	Medical sealed sources - processing and distribution (10 CFR 32.74)	4,880 <u>\$5,612</u>
88.3		
88.4	Well logging - sealed sources	1,600 <u>\$1,840</u>
88.5	Measuring systems - (fixed gauge, <u>portable gauge, gas chromatograph, other</u>)	960 <u>\$1,104</u>
88.6		
88.7	Measuring systems - portable gauge	960
88.8	X-ray fluorescent analyzer	584 <u>\$671</u>
88.9	Measuring systems - gas chromatograph	960
88.10	Measuring systems - other	960
88.11	Broad scope Manufacturing and distribution - type A, B, and C broad scope	5,920 <u>\$6,854</u>
88.12		
88.13	Broad scope manufacturing and distribution - type B	5,920
88.14	Broad scope manufacturing and distribution - type C	5,920
88.15	Manufacturing and distribution - other	2,320 <u>\$2,668</u>
88.16		10,080
88.17	Nuclear laundry	<u>\$11,592</u>
88.18	Decontamination services	2,640 <u>\$3,036</u>
88.19	Leak test services only	960 <u>\$1,104</u>
88.20	Instrument calibration service only, less than 100 curies	960 <u>\$1,104</u>
88.21	Instrument calibration service only, 100 curies or more	960
88.22	Service, maintenance, installation, source changes, etc.	2,640 <u>\$3,036</u>
88.23	Waste disposal service, prepackaged only	2,240 <u>\$2,576</u>

195.17	Waste disposal	1,520 <u>\$1,748</u>
195.18	Distribution - general licensed devices (sealed sources)	880 <u>\$1,012</u>
195.19	Distribution - general licensed material (unsealed sources)	520 <u>\$598</u>
195.20	Industrial radiography - fixed or <u>temporary</u> location	2,640 <u>\$3,036</u>
195.21	Industrial radiography - temporary job sites	2,640
195.22	Irradiators, self-shielding, less than 10,000 curies	1,440 <u>\$1,656</u>
195.23	Irradiators, other, less than 10,000 curies	2,960 <u>\$3,404</u>
195.24	Irradiators, self-shielding, 10,000 curies or more	1,440
195.25	Research and development - type A, <u>B, or C</u> broad scope	4,960 <u>\$5,704</u>
195.26	Research and development - type B broad scope	4,960
195.27	Research and development - type C broad scope	4,960
195.28	Research and development - other	2,400 <u>\$2,760</u>
195.29	Storage - no operations	960 <u>\$1,104</u>
195.30	Source material - shielding	136 <u>\$156</u>
195.31	Special nuclear material plutonium - neutron source in device	1,200 <u>\$1,380</u>
195.32	Pacemaker by-product and/or special nuclear material - medical	1,200 <u>\$1,380</u>
195.33	(institution)	
195.34	Pacemaker by-product and/or special nuclear material -	2,320 <u>\$2,668</u>
195.35	manufacturing and distribution	
195.36	Accelerator-produced radioactive material	4,100 <u>\$4,715</u>
195.37	Nonprofit educational institutions	300 <u>\$345</u>
195.38	General license registration	0
195.39	Industrial radiographer certification	150
196.1	Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:	
196.2	Subd. 8. Reciprocity fee. A licensee submitting an application for reciprocal recognition	
196.3	of a materials license issued by another agreement state or the United States Nuclear	

88.24	Waste disposal	1,520 <u>\$1,748</u>
88.25	Distribution - general licensed devices (sealed sources)	880 <u>\$1,012</u>
88.26	Distribution - general licensed material (unsealed sources)	520 <u>\$598</u>
88.27	Industrial radiography - fixed or <u>temporary</u> location	2,640 <u>\$3,036</u>
88.28	Industrial radiography - temporary job sites	2,640
88.29	Irradiators, self-shielding, less than 10,000 curies	1,440 <u>\$1,656</u>
88.30	Irradiators, other, less than 10,000 curies	2,960 <u>\$3,404</u>
88.31	Irradiators, self-shielding, 10,000 curies or more	1,440
88.32	Research and development - type A, <u>B, or C</u> broad scope	4,960 <u>\$5,704</u>
88.33	Research and development - type B broad scope	4,960
88.34	Research and development - type C broad scope	4,960
88.35	Research and development - other	2,400 <u>\$2,760</u>
88.36	Storage - no operations	960 <u>\$1,104</u>
88.37	Source material - shielding	136 <u>\$156</u>
88.38	Special nuclear material plutonium - neutron source in device	1,200 <u>\$1,380</u>
88.39	Pacemaker by-product and/or special nuclear material - medical	1,200 <u>\$1,380</u>
88.40	(institution)	
89.1	Pacemaker by-product and/or special nuclear material -	2,320 <u>\$2,668</u>
89.2	manufacturing and distribution	
89.3	Accelerator-produced radioactive material	4,100 <u>\$4,715</u>
89.4	Nonprofit educational institutions	300 <u>\$345</u>
89.5	General license registration	0
89.6	Industrial radiographer certification	150
89.7	Sec. 13. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:	
89.8	Subd. 8. Reciprocity fee. A licensee submitting an application for reciprocal recognition	
89.9	of a materials license issued by another agreement state or the United States Nuclear	

196.4 Regulatory Commission for a period of 180 days or less during a calendar year must pay
 196.5 ~~\$1,200~~ \$2,400. For a period of 181 days or more, the licensee must obtain a license under
 196.6 subdivision 4.

196.7 Sec. 32. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

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

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

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

196.14 Sec. 33. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision
 196.15 to read:

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

196.19 Sec. 34. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

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

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

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

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

89.10 Regulatory Commission for a period of 180 days or less during a calendar year must pay
 89.11 ~~\$1,200~~ \$2,400. For a period of 181 days or more, the licensee must obtain a license under
 89.12 subdivision 4.

89.13 Sec. 14. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

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

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

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

89.20 Sec. 15. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision
 89.21 to read:

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

89.25 Sec. 16. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

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

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

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

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

90.12 Sec. 17. Minnesota Statutes 2020, section 144.125, subdivision 2, is amended to read:

90.13 Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall
 90.14 periodically revise the list of tests to be administered for determining the presence of a

197.6 Sec. 35. [144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.

197.7 Subdivision 1. Citation. This section may be cited as the "Dignity in Pregnancy and
197.8 Childbirth Act."

197.9 Subd. 2. Continuing education requirement. (a) Hospitals with obstetric care and birth
197.10 centers must provide continuing education on anti-racism training and implicit bias. The
197.11 continuing education must be evidence-based and must include at a minimum the following
197.12 criteria:

197.13 (1) education aimed at identifying personal, interpersonal, institutional, structural, and
197.14 cultural barriers to inclusion;

197.15 (2) identifying and implementing corrective measures to promote anti-racism practices
197.16 and decrease implicit bias at the interpersonal and institutional levels, including the
197.17 institution's ongoing policies and practices;

197.18 (3) providing information on the ongoing effects of historical and contemporary exclusion
197.19 and oppression of Black and Indigenous communities with the greatest health disparities
197.20 related to maternal and infant mortality and morbidity;

197.21 (4) providing information and discussion of health disparities in the perinatal health care
197.22 field including how systemic racism and implicit bias have different impacts on health
197.23 outcomes for different racial and ethnic communities; and

197.24 (5) soliciting perspectives of diverse, local constituency groups and experts on racial,
197.25 identity, cultural, and provider-community relationship issues.

197.26 (b) In addition to the initial continuing educational requirement in paragraph (a), hospitals
197.27 with obstetric care and birth centers must provide an annual refresher course that reflects
197.28 current trends on race, culture, identity, and anti-racism principles and institutional implicit
197.29 bias.

90.15 heritable or congenital disorder. Revisions to the list shall reflect advances in medical
90.16 science, new and improved testing methods, or other factors that will improve the public
90.17 health. In determining whether a test must be administered, the commissioner shall take
90.18 into consideration the adequacy of analytical methods to detect the heritable or congenital
90.19 disorder, the ability to treat or prevent medical conditions caused by the heritable or
90.20 congenital disorder, and the severity of the medical conditions caused by the heritable or
90.21 congenital disorder. The list of tests to be performed may be revised if the changes are
90.22 recommended by the advisory committee established under section 144.1255, approved by
90.23 the commissioner, and published in the State Register. The revision is exempt from the
90.24 rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

90.25 (b) Notwithstanding paragraph (a), a test to detect congenital human herpesvirus
90.26 cytomegalovirus shall be added to the list of tests to be administered under this section.

90.27 Sec. 18. [144.1461] PREGNANCY AND CHILDBIRTH; MIDWIFE AND DOULA
90.28 CARE.

197.30 (c) Hospitals with obstetric care and birth centers must develop continuing education
 197.31 materials on anti-racism and implicit bias that must be provided and updated annually for
 198.1 direct care employees and contractors who routinely care for patients who are pregnant or
 198.2 postpartum.

198.3 (d) Hospitals with obstetric care and birth centers shall coordinate with health-related
 198.4 licensing boards to obtain continuing education credits for the trainings and materials
 198.5 required in this section. The commissioner of health shall monitor compliance with this
 198.6 section. Initial training for the continuing education requirements in this subdivision must
 198.7 be completed by December 31, 2022. The commissioner may inspect the training records
 198.8 or require reports on the continuing education materials in this section from hospitals with
 198.9 obstetric care and birth centers.

198.10 (e) A facility described in paragraph (d) must provide a certificate of training completion
 198.11 to another facility or a training attendee upon request. A facility may accept the training
 198.12 certificate from another facility for a health care provider that works in more than one
 198.13 facility.

198.14 Subd. 3. **Midwife and doula care.** In order to improve maternal and infant health and
 198.15 to improve birth outcomes in groups with the most significant disparities, including Black
 198.16 communities, Indigenous communities, and other communities of color; rural communities;
 198.17 and people with low incomes, the commissioner of health, in partnership with patient groups
 198.18 and culturally based community organizations, shall:

198.19 (1) develop procedures and services to increase the availability of midwife and doula
 198.20 services to groups with the most significant disparities in maternal and infant morbidity and
 198.21 mortality;

198.22 (2) propose changes to midwife licensure to allow midwives with nationally recognized
 198.23 credentials to practice to the full scope of their competencies and education;

198.24 (3) promote racial, ethnic, and language diversity in the midwife and doula workforce
 198.25 that better aligns with the childbearing populations in groups with the most significant
 198.26 disparities in maternal and infant morbidity and mortality; and

198.27 (4) ensure that midwife and doula training and licensure are culturally responsive to the
 198.28 specific needs of groups with the most significant disparities in maternal and infant morbidity
 198.29 and mortality, including training on providing trauma-informed care and training on maternal
 198.30 mood disorders, intimate partner violence, and implicit bias and anti-racism.

198.31 Sec. 36. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

198.32 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
 198.33 a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist
 199.1 of the following members, all of whom must reside outside the seven-county metropolitan
 199.2 area, as defined in section 473.121, subdivision 2:

90.29 In order to improve maternal and infant health as well as improving birth outcomes in
 90.30 groups with the most significant disparities that include Black, Indigenous, and other
 90.31 communities of color; rural communities; and people with low incomes, the commissioner
 90.32 of health in partnership with patient groups and culturally based community organizations
 90.33 shall, within existing appropriations:

91.1 (1) develop procedures and services designed for making midwife and doula services
 91.2 available to groups with the most maternal and infant mortality and morbidity disparities;

91.3 (2) promote racial, ethnic, and language diversity in the midwife and doula workforce
 91.4 that better aligns with the childbearing population in groups with the most significant
 91.5 maternal and infant mortality and morbidity disparities; and

91.6 (3) ensure that midwife and doula training and education is tailored to the specific needs
 91.7 of groups with the most significant maternal and infant mortality and morbidity disparities,
 91.8 including trauma-informed care, maternal mood disorders, intimate partner violence, and
 91.9 systemic racism.

91.10 Sec. 19. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

91.11 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
 91.12 a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist
 91.13 of the following members, all of whom must reside outside the seven-county metropolitan
 91.14 area, as defined in section 473.121, subdivision 2:

199.3 (1) two members from the house of representatives of the state of Minnesota, one from
199.4 the majority party and one from the minority party;

199.5 (2) two members from the senate of the state of Minnesota, one from the majority party
199.6 and one from the minority party;

199.7 (3) a volunteer member of an ambulance service based outside the seven-county
199.8 metropolitan area;

199.9 (4) a representative of a hospital located outside the seven-county metropolitan area;

199.10 (5) a representative of a nursing home located outside the seven-county metropolitan
199.11 area;

199.12 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

199.13 (7) a dentist licensed under chapter 150A;

199.14 (8) a midlevel practitioner;

199.15 ~~(8)~~ (9) a registered nurse or licensed practical nurse;

199.16 ~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented
199.17 on the committee;

199.18 ~~(10)~~ (11) a representative of an institution of higher education located outside the
199.19 seven-county metropolitan area that provides training for rural health care providers; and

199.20 ~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who
199.21 are mentally ill or developmentally disabled.

199.22 The commissioner will make recommendations for committee membership. Committee
199.23 members will be appointed by the governor. In making appointments, the governor shall
199.24 ensure that appointments provide geographic balance among those areas of the state outside
199.25 the seven-county metropolitan area. The chair of the committee shall be elected by the
199.26 members. The advisory committee is governed by section 15.059, except that the members
199.27 do not receive per diem compensation.

199.28 Sec. 37. Minnesota Statutes 2020, section 144.1501, subdivision 1, is amended to read:

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

200.1 (b) "Advanced dental therapist" means an individual who is licensed as a dental therapist
200.2 under section 150A.06, and who is certified as an advanced dental therapist under section
200.3 150A.106.

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

91.15 (1) two members from the house of representatives of the state of Minnesota, one from
91.16 the majority party and one from the minority party;

91.17 (2) two members from the senate of the state of Minnesota, one from the majority party
91.18 and one from the minority party;

91.19 (3) a volunteer member of an ambulance service based outside the seven-county
91.20 metropolitan area;

91.21 (4) a representative of a hospital located outside the seven-county metropolitan area;

91.22 (5) a representative of a nursing home located outside the seven-county metropolitan
91.23 area;

91.24 (6) a medical doctor or doctor of osteopathic medicine licensed under chapter 147;

91.25 (7) a dentist licensed under chapter 150A;

91.26 (8) a midlevel practitioner;

91.27 ~~(8)~~ (9) a registered nurse or licensed practical nurse;

91.28 ~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented
91.29 on the committee;

91.30 ~~(10)~~ (11) a representative of an institution of higher education located outside the
91.31 seven-county metropolitan area that provides training for rural health care providers; and

92.1 ~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who
92.2 are mentally ill or developmentally disabled.

92.3 The commissioner will make recommendations for committee membership. Committee
92.4 members will be appointed by the governor. In making appointments, the governor shall
92.5 ensure that appointments provide geographic balance among those areas of the state outside
92.6 the seven-county metropolitan area. The chair of the committee shall be elected by the
92.7 members. The advisory committee is governed by section 15.059, except that the members
92.8 do not receive per diem compensation.

- 200.6 ~~(e)~~ (d) "Dental therapist" means an individual who is licensed as a dental therapist under
 200.7 section 150A.06.
- 200.8 ~~(d)~~ (e) "Dentist" means an individual who is licensed to practice dentistry.
- 200.9 ~~(e)~~ (f) "Designated rural area" means a statutory and home rule charter city or township
 200.10 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision
 200.11 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.
- 200.12 ~~(f)~~ (g) "Emergency circumstances" means those conditions that make it impossible for
 200.13 the participant to fulfill the service commitment, including death, total and permanent
 200.14 disability, or temporary disability lasting more than two years.
- 200.15 ~~(g)~~ (h) "Mental health professional" means an individual providing clinical services in
 200.16 the treatment of mental illness who is qualified in at least one of the ways specified in section
 200.17 245.462, subdivision 18.
- 200.18 ~~(h)~~ (i) "Medical resident" means an individual participating in a medical residency in
 200.19 family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.
- 200.20 ~~(i)~~ (j) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist,
 200.21 advanced clinical nurse specialist, or physician assistant.
- 200.22 ~~(j)~~ (k) "Nurse" means an individual who has completed training and received all licensing
 200.23 or certification necessary to perform duties as a licensed practical nurse or registered nurse.
- 200.24 ~~(k)~~ (l) "Nurse-midwife" means a registered nurse who has graduated from a program of
 200.25 study designed to prepare registered nurses for advanced practice as nurse-midwives.
- 200.26 ~~(l)~~ (m) "Nurse practitioner" means a registered nurse who has graduated from a program
 200.27 of study designed to prepare registered nurses for advanced practice as nurse practitioners.
- 200.28 ~~(m)~~ (n) "Pharmacist" means an individual with a valid license issued under chapter 151.
- 200.29 ~~(n)~~ (o) "Physician" means an individual who is licensed to practice medicine in the areas
 200.30 of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.
- 200.31 ~~(o)~~ (p) "Physician assistant" means a person licensed under chapter 147A.
- 201.1 ~~(p)~~ (q) "Public health nurse" means a registered nurse licensed in Minnesota who has
 201.2 obtained a registration certificate as a public health nurse from the Board of Nursing in
 201.3 accordance with Minnesota Rules, chapter 6316.
- 201.4 ~~(q)~~ (r) "Qualified educational loan" means a government, commercial, or foundation
 201.5 loan for actual costs paid for tuition, reasonable education expenses, and reasonable living
 201.6 expenses related to the graduate or undergraduate education of a health care professional.
- 201.7 ~~(r)~~ (s) "Underserved urban community" means a Minnesota urban area or population
 201.8 included in the list of designated primary medical care health professional shortage areas
 201.9 (HPSAs), medically underserved areas (MUAs), or medically underserved populations

201.10 (MUPs) maintained and updated by the United States Department of Health and Human
 201.11 Services.

201.12 Sec. 38. Minnesota Statutes 2020, section 144.1501, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

202.14 Sec. 39. Minnesota Statutes 2020, section 144.1501, subdivision 3, is amended to read:

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

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

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

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

202.30 Sec. 40. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

202.31 Subd. 6. **International medical graduate primary care residency grant program**
202.32 **and revolving account.** (a) The commissioner shall award grants to support primary care
203.1 residency positions designated for Minnesota immigrant physicians who are willing to serve
203.2 in rural or underserved areas of the state. No grant shall exceed \$150,000 per residency
203.3 position per year. Eligible primary care residency grant recipients include accredited family
203.4 medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and
203.5 pediatric residency programs. Eligible primary care residency programs shall apply to the
203.6 commissioner. Applications must include the number of anticipated residents to be funded
203.7 using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to
203.8 grantees in a grant agreement do not lapse until the grant agreement expires. Before any
203.9 funds are distributed, a grant recipient shall provide the commissioner with the following:

203.10 (1) a copy of the signed contract between the primary care residency program and the
203.11 participating international medical graduate;

203.12 (2) certification that the participating international medical graduate has lived in
203.13 Minnesota for at least two years and is certified by the Educational Commission on Foreign
203.14 Medical Graduates. Residency programs may also require that participating international
203.15 medical graduates hold a Minnesota certificate of clinical readiness for residency, once the
203.16 certificates become available; and

203.17 (3) verification that the participating international medical graduate has executed a
203.18 participant agreement pursuant to paragraph (b).

203.19 (b) Upon acceptance by a participating residency program, international medical graduates
 203.20 shall enter into an agreement with the commissioner to provide primary care for at least
 203.21 five years in a rural or underserved area of Minnesota after graduating from the residency
 203.22 program and make payments to the revolving international medical graduate residency
 203.23 account for five years beginning in their second year of postresidency employment.
 203.24 Participants shall pay \$15,000 or ten percent of their annual compensation each year,
 203.25 whichever is less.

203.26 (c) A revolving international medical graduate residency account is established as an
 203.27 account in the special revenue fund in the state treasury. The commissioner of management
 203.28 and budget shall credit to the account appropriations, payments, and transfers to the account.
 203.29 Earnings, such as interest, dividends, and any other earnings arising from fund assets, must
 203.30 be credited to the account. Funds in the account are appropriated annually to the
 203.31 commissioner to award grants and administer the grant program established in paragraph
 203.32 (a). Notwithstanding any law to the contrary, any funds deposited in the account do not
 203.33 expire. The commissioner may accept contributions to the account from private sector
 203.34 entities subject to the following provisions:

204.1 (1) the contributing entity may not specify the recipient or recipients of any grant issued
 204.2 under this subdivision;

204.3 (2) the commissioner shall make public the identity of any private contributor to the
 204.4 account, as well as the amount of the contribution provided; and

204.5 (3) a contributing entity may not specify that the recipient or recipients of any funds use
 204.6 specific products or services, nor may the contributing entity imply that a contribution is
 204.7 an endorsement of any specific product or service.

204.8 Sec. 41. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision
 204.9 to read:

204.10 Subd. 12. **Homeless youth.** "Homeless youth" has the meaning given in section 256K.45,
 204.11 subdivision 1a.

92.9 Sec. 20. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision
 92.10 to read:

92.11 Subd. 3. **Reporting safe place newborn births.** A hospital that receives a safe place
 92.12 newborn under section 145.902 shall report the birth of the newborn to the Office of Vital
 92.13 Records within five days after receiving the newborn. The state registrar must register
 92.14 information about the safe place newborn according to Minnesota Rules, part 4601.0600,
 92.15 subpart 4, item C.

92.16 **EFFECTIVE DATE.** This section is effective August 1, 2021.

92.17 Sec. 21. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision
92.18 to read:

92.19 Subd. 4. **Status of safe place birth registrations.** (a) Information about the safe place
92.20 newborn registered under subdivision 3 shall constitute the record of birth for the child. The
92.21 birth record for the child is confidential data on individuals as defined in section 13.02,
92.22 subdivision 3. Information about the child's birth record or a child's birth certificate issued
92.23 from the child's birth record shall be disclosed only to the responsible social services agency
92.24 as defined in section 260C.007, subdivision 27a, or pursuant to court order.

92.25 (b) Pursuant to section 144.218, subdivision 6, if the safe place newborn was born in a
92.26 hospital and it is known that the child's record of birth was registered, the Office of Vital
92.27 Records shall replace the original birth record registered under section 144.215.

92.28 **EFFECTIVE DATE.** This section is effective August 1, 2021.

93.1 Sec. 22. Minnesota Statutes 2020, section 144.218, is amended by adding a subdivision
93.2 to read:

93.3 Subd. 6. **Safe place newborns.** If a hospital receives a safe place newborn under section
93.4 145.902 and it is known that the child's record of birth was registered, the hospital shall
93.5 report the newborn to the Office of Vital Records and identify the child's birth record. The
93.6 state registrar shall issue a replacement birth record for the child that is free of information
93.7 that identifies a parent. The prior vital record is confidential data on individuals as defined
93.8 in section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

93.9 **EFFECTIVE DATE.** This section is effective August 1, 2021.

93.10 Sec. 23. Minnesota Statutes 2020, section 144.223, is amended to read:

93.11 **144.223 REPORT OF MARRIAGE.**

93.12 Data relating to certificates of marriage registered shall be reported to the state registrar
93.13 by the local registrar or designee of the county board in each of the 87 registration districts
93.14 pursuant to the rules of the commissioner. The information in clause (1) necessary to compile
93.15 the report shall be furnished by the applicant prior to the issuance of the marriage license.
93.16 The report shall contain the following:

93.17 (1) personal information on bride and groom:

93.18 (i) name;

93.19 (ii) residence;

93.20 (iii) date and place of birth;

93.21 ~~(iv) race;~~

93.22 ~~(iv)~~ (iv) if previously married, how terminated; and

204.12 Sec. 42. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

204.13 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data

204.14 pertaining to the birth of a child to a woman who was not married to the child's father when

204.15 the child was conceived nor when the child was born, including the original record of birth

204.16 and the certified vital record, are confidential data. At the time of the birth of a child to a

204.17 woman who was not married to the child's father when the child was conceived nor when

204.18 the child was born, the mother may designate demographic data pertaining to the birth as

204.19 public. Notwithstanding the designation of the data as confidential, it may be disclosed:

204.20 (1) to a parent or guardian of the child;

204.21 (2) to the child when the child is 16 years of age or older, except as provided in clause

204.22 (3);

204.23 (3) to the child if the child is a homeless youth;

204.24 ~~(3)~~ (4) under paragraph (b), (c), ~~(f)~~, or (g); or

204.25 ~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not

204.26 constitute a court order.

204.27 (b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible

204.28 to the public become public data if 100 years have elapsed since the birth of the child who

204.29 is the subject of the data, or as provided under section 13.10, whichever occurs first.

205.1 (c) If a child is adopted, data pertaining to the child's birth are governed by the provisions

205.2 relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision

205.3 1; 144.2252; and 259.89.

205.4 (d) The name and address of a mother under paragraph (a) and the child's date of birth

205.5 may be disclosed to the county social services, tribal health department, or public health

205.6 member of a family services collaborative for purposes of providing services under section

205.7 124D.23.

205.8 (e) The commissioner of human services shall have access to birth records for:

205.9 (1) the purposes of administering medical assistance and the MinnesotaCare program;

205.10 (2) child support enforcement purposes; and

93.23 ~~(v)~~ (v) signature of applicant, date signed, and Social Security number; and

93.24 (2) information concerning the marriage:

93.25 (i) date of marriage;

93.26 (ii) place of marriage; and

93.27 (iii) civil or religious ceremony.

205.11 (3) other public health purposes as determined by the commissioner of health.

205.12 (f) Tribal child support programs shall have access to birth records for child support

205.13 enforcement purposes.

205.14 (g) An entity administering a children's savings program that starts at birth shall have

205.15 access to birth records for the purpose of opening an account in the program for the child

205.16 as a beneficiary. For purposes of this paragraph, "children's savings program" means a

205.17 long-term savings or investment program that helps children and their families build savings

205.18 for the future.

205.19 Sec. 43. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

205.20 Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office

205.21 shall issue a certified birth or death record or a statement of no vital record found to an

205.22 individual upon the individual's proper completion of an attestation provided by the

205.23 commissioner and, except as provided in section 144.2255, payment of the required fee:

205.24 (1) to a person who ~~has a tangible interest in the requested vital record. A person who~~

205.25 ~~has a tangible interest~~ is:

205.26 (i) the subject of the vital record;

205.27 (ii) a child of the subject;

205.28 (iii) the spouse of the subject;

205.29 (iv) a parent of the subject;

205.30 (v) the grandparent or grandchild of the subject;

206.1 (vi) if the requested record is a death record, a sibling of the subject;

206.2 ~~(vii) the party responsible for filing the vital record;~~

206.3 ~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

206.4 ~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy

206.5 is required for administration of the estate;

206.6 ~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is

206.7 deceased, by sworn affidavit of the fact that the certified copy is required for administration

206.8 of the estate;

206.9 ~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit

206.10 of the fact that the certified copy is needed for the proper administration of the trust;

206.11 ~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary

206.12 for the determination or protection of a personal or property right, pursuant to rules adopted

206.13 by the commissioner; or

94.1 Sec. 24. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

94.2 Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office

94.3 shall issue a certified birth or death record or a statement of no vital record found to an

94.4 individual upon the individual's proper completion of an attestation provided by the

94.5 commissioner and payment of the required fee:

94.6 (1) to a person who ~~has a tangible interest in the requested vital record. A person who~~

94.7 ~~has a tangible interest~~ is:

94.8 (i) the subject of the vital record;

94.9 (ii) a child of the subject;

94.10 (iii) the spouse of the subject;

94.11 (iv) a parent of the subject;

94.12 (v) the grandparent or grandchild of the subject;

94.13 (vi) if the requested record is a death record, a sibling of the subject;

94.14 ~~(vii) the party responsible for filing the vital record;~~

94.15 ~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

94.16 ~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy

94.17 is required for administration of the estate;

94.18 ~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is

94.19 deceased, by sworn affidavit of the fact that the certified copy is required for administration

94.20 of the estate;

94.21 ~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit

94.22 of the fact that the certified copy is needed for the proper administration of the trust;

94.23 ~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary

94.24 for the determination or protection of a personal or property right, pursuant to rules adopted

94.25 by the commissioner; or

206.14 ~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches
 206.15 as required by section 259.83;

206.16 (2) to any local, state, tribal, or federal governmental agency upon request if the certified
 206.17 vital record is necessary for the governmental agency to perform its authorized duties;

206.18 (3) to an attorney representing the subject of the vital record or another person listed in
 206.19 clause (1), upon evidence of the attorney's license;

206.20 (4) pursuant to a court order issued by a court of competent jurisdiction. For purposes
 206.21 of this section, a subpoena does not constitute a court order; or

206.22 (5) to a representative authorized by a person under clauses (1) to (4).

206.23 (b) The state registrar or local issuance office shall also issue a certified death record to
 206.24 an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of
 206.25 the individual, a licensed mortician furnishes the registrar with a properly completed
 206.26 attestation in the form provided by the commissioner within 180 days of the time of death
 206.27 of the subject of the death record. This paragraph is not subject to the requirements specified
 206.28 in Minnesota Rules, part 4601.2600, subpart 5, item B.

206.29 Sec. 44. **[144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.**

206.30 Subdivision 1. **Application; certified birth record.** A subject of a birth record who is
 206.31 a homeless youth in Minnesota or another state may apply to the state registrar or a local
 207.1 issuance office for a certified birth record according to this section. The state registrar or
 207.2 local issuance office shall issue a certified birth record or statement of no vital record found
 207.3 to a subject of a birth record who submits:

207.4 (1) a completed application signed by the subject of the birth record;

207.5 (2) a statement that the subject of the birth record is a homeless youth, signed by the
 207.6 subject of the birth record; and

207.7 (3) one of the following:

207.8 (i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at
 207.9 the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600,
 207.10 subpart 9;

207.11 (ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7;
 207.12 or

207.13 (iii) a statement verifying that the subject of the birth record is a homeless youth that
 207.14 complies with the requirements in subdivision 2 and is from an employee of a human services
 207.15 agency that receives public funding to provide services to homeless youth, runaway youth,
 207.16 youth with mental illness, or youth with substance use disorders; a school staff person who
 207.17 provides services to homeless youth; or a school social worker.

94.26 ~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches
 94.27 as required by section 259.83;

94.28 (2) to any local, state, tribal, or federal governmental agency upon request if the certified
 94.29 vital record is necessary for the governmental agency to perform its authorized duties;

95.1 (3) to an attorney representing the subject of the vital record or another person listed in
 95.2 clause (1), upon evidence of the attorney's license;

95.3 (4) pursuant to a court order issued by a court of competent jurisdiction. For purposes
 95.4 of this section, a subpoena does not constitute a court order; or

95.5 (5) to a representative authorized by a person under clauses (1) to (4).

95.6 (b) The state registrar or local issuance office shall also issue a certified death record to
 95.7 an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of
 95.8 the individual, a licensed mortician furnishes the registrar with a properly completed
 95.9 attestation in the form provided by the commissioner within 180 days of the time of death
 95.10 of the subject of the death record. This paragraph is not subject to the requirements specified
 95.11 in Minnesota Rules, part 4601.2600, subpart 5, item B.

207.18 Subd. 2. **Statement verifying subject is a homeless youth.** A statement verifying that
 207.19 a subject of a birth record is a homeless youth must include:

207.20 (1) the following information regarding the individual providing the statement: first
 207.21 name, middle name, if any, and last name; home or business address; telephone number, if
 207.22 any; and e-mail address, if any;

207.23 (2) the first name, middle name, if any, and last name of the subject of the birth record;
 207.24 and

207.25 (3) a statement specifying the relationship of the individual providing the statement to
 207.26 the subject of the birth record and verifying that the subject of the birth record is a homeless
 207.27 youth.

207.28 The individual providing the statement must also provide a copy of the individual's
 207.29 employment identification.

207.30 Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth
 207.31 record under this section using the statement specified in subdivision 1, clause (3), item
 207.32 (iii), the certified birth record issued shall expire six months after the date of issuance. Upon
 208.1 expiration of the certified birth record, the subject of the birth record may surrender the
 208.2 expired birth record to the state registrar or a local issuance office and obtain another birth
 208.3 record. Each certified birth record obtained under this subdivision shall expire six months
 208.4 after the date of issuance. If the subject of the birth record does not surrender the expired
 208.5 birth record, the subject may apply for a certified birth record using the process in subdivision
 208.6 1.

208.7 Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any
 208.8 fee for issuance of a certified birth record or statement of no vital record found under this
 208.9 section.

208.10 Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii),
 208.11 are private data on individuals.

208.12 **EFFECTIVE DATE.** This section is effective the day following final enactment for
 208.13 applications for and the issuance of certified birth records on or after January 1, 2022.

95.12 Sec. 25. Minnesota Statutes 2020, section 144.226, subdivision 1, is amended to read:

95.13 Subdivision 1. **Which services are for fee.** (a) The fees for the following services shall
 95.14 be the following or an amount prescribed by rule of the commissioner:

95.15 (b) The fee for the administrative review and processing of a request for a certified vital
 95.16 record or a certification that the vital record cannot be found is \$9. The fee is payable at the
 95.17 time of application and is nonrefundable.

208.14 Sec. 45. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
208.15 to read:

208.16 Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge
208.17 a convenience fee and a transaction fee for electronic transactions and transactions by
208.18 telephone or Internet, as well as the fees established under subdivisions 1 to 4. The
208.19 convenience fee may not exceed three percent of the cost of the charges for payment. The
208.20 state registrar may permit agents to charge and retain a transaction fee as payment agreed
208.21 upon under contract. When an electronic convenience fee or transaction fee is charged, the
208.22 agent charging the fee is required to post information on their web page informing individuals
208.23 of the fee. The information must be near the point of payment, clearly visible, include the
208.24 amount of the fee, and state: "This contracted agent is allowed by state law to charge a
208.25 convenience fee and transaction fee for this electronic transaction."

208.26 Sec. 46. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
208.27 to read:

208.28 Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who
208.29 is a homeless youth shall not be charged any of the fees specified in this section for a certified
208.30 birth record or statement of no vital record found under section 144.2255.

95.18 (c) The fee for processing a request for the replacement of a birth record for all events,
95.19 except for safe place newborns pursuant to section 144.218, subdivision 6, and when filing
95.20 a recognition of parentage pursuant to section 257.73, subdivision 1, is \$40. The fee is
95.21 payable at the time of application and is nonrefundable.

95.22 (d) The fee for administrative review and processing of a request for the filing of a
95.23 delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of
95.24 application and is nonrefundable.

95.25 (e) The fee for administrative review and processing of a request for the amendment of
95.26 any vital record is \$40. The fee is payable at the time of application and is nonrefundable.

95.27 (f) The fee for administrative review and processing of a request for the verification of
95.28 information from vital records is \$9 when the applicant furnishes the specific information
95.29 to locate the vital record. When the applicant does not furnish specific information, the fee
95.30 is \$20 per hour for staff time expended. Specific information includes the correct date of
95.31 the event and the correct name of the subject of the record. Fees charged shall approximate
96.1 the costs incurred in searching and copying the vital records. The fee is payable at the time
96.2 of application and is nonrefundable.

96.3 (g) The fee for administrative review and processing of a request for the issuance of a
96.4 copy of any document on file pertaining to a vital record or statement that a related document
96.5 cannot be found is \$9. The fee is payable at the time of application and is nonrefundable.

96.6 **EFFECTIVE DATE.** This section is effective August 1, 2021.

208.31 **EFFECTIVE DATE.** This section is effective the day following final enactment for
 208.32 applications for and the issuance of certified birth records on or after January 1, 2022.

209.1 Sec. 47. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

209.2 Subd. 4. **Routine inspections; presumption.** Any hospital surveyed and accredited
 209.3 under the standards of the hospital accreditation program of an approved accrediting
 209.4 organization that submits to the commissioner within a reasonable time copies of (a) its
 209.5 currently valid accreditation certificate and accreditation letter, together with accompanying
 209.6 recommendations and comments and (b) any further recommendations, progress reports
 209.7 and correspondence directly related to the accreditation is presumed to comply with
 209.8 application requirements of subdivision 1 and the standards requirements of subdivision 3
 209.9 and no further routine inspections or accreditation information shall be required by the
 209.10 commissioner to determine compliance. Notwithstanding the provisions of sections 144.54
 209.11 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this
 209.12 section. The provisions of section 144.653 relating to the assessment and collection of fines
 209.13 shall not apply to any hospital. The commissioner of health shall annually conduct, with
 209.14 notice, validation inspections of a selected sample of the number of hospitals accredited by
 209.15 an approved accrediting organization, not to exceed ten percent of accredited hospitals, for
 209.16 the purpose of determining compliance with the provisions of subdivision 3. If a validation
 209.17 survey discloses a failure to comply with subdivision 3, the provisions of section 144.653
 209.18 relating to correction orders, reinspections, and notices of noncompliance shall apply. The
 209.19 commissioner shall also conduct any inspection necessary to determine whether hospital
 209.20 construction, addition, or remodeling projects comply with standards for construction
 209.21 promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any
 209.22 inspections necessary to determine whether a hospital or hospital corporate system continues
 209.23 to satisfy the conditions on which a hospital construction moratorium exception was granted
 209.24 under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any
 209.25 hospital that does not have a currently valid hospital accreditation certificate from an
 209.26 approved accrediting organization. Nothing in this subdivision shall be construed to limit
 209.27 the investigative powers of the Office of Health Facility Complaints as established in sections
 209.28 144A.51 to 144A.54.

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

209.30 Sec. 48. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

209.31 Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may
 209.32 refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

209.33 (1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards
 209.34 issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

210.1 (2) permitting, aiding, or abetting the commission of any illegal act in the institution;

210.2 (3) conduct or practices detrimental to the welfare of the patient; or

210.3 (4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

210.4 (5) with respect to hospitals and outpatient surgical centers, if the commissioner

210.5 determines that there is a pattern of conduct that one or more physicians or advanced practice

210.6 registered nurses who have a "financial or economic interest," as defined in section 144.6521,

210.7 subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and

210.8 disclosure of the financial or economic interest required by section 144.6521.

210.9 (b) The commissioner shall not renew a license for a boarding care bed in a resident

210.10 room with more than four beds.

210.11 (c) The commissioner shall not renew licenses for hospital beds issued to a hospital or

210.12 hospital corporate system pursuant to a hospital construction moratorium exception under

210.13 section 144.551 if the commissioner determines the hospital or hospital corporate system

210.14 is not satisfying the conditions on which the exception was granted.

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

210.16 license renewals occurring on or after that date.

210.17 Sec. 49. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

210.18 Subdivision 1. **Restricted construction or modification.** (a) The following construction

210.19 or modification may not be commenced:

210.20 (1) any erection, building, alteration, reconstruction, modernization, improvement,

210.21 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed

210.22 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site

210.23 to another, or otherwise results in an increase or redistribution of hospital beds within the

210.24 state; and

210.25 (2) the establishment of a new hospital.

210.26 (b) This section does not apply to:

210.27 (1) construction or relocation within a county by a hospital, clinic, or other health care

210.28 facility that is a national referral center engaged in substantial programs of patient care,

210.29 medical research, and medical education meeting state and national needs that receives more

210.30 than 40 percent of its patients from outside the state of Minnesota;

211.1 (2) a project for construction or modification for which a health care facility held an

211.2 approved certificate of need on May 1, 1984, regardless of the date of expiration of the

211.3 certificate;

211.4 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely

211.5 appeal results in an order reversing the denial;

211.6 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,

211.7 section 2;

96.7 Sec. 26. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

96.8 Subdivision 1. **Restricted construction or modification.** (a) The following construction

96.9 or modification may not be commenced:

96.10 (1) any erection, building, alteration, reconstruction, modernization, improvement,

96.11 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed

96.12 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site

96.13 to another, or otherwise results in an increase or redistribution of hospital beds within the

96.14 state; and

96.15 (2) the establishment of a new hospital.

96.16 (b) This section does not apply to:

96.17 (1) construction or relocation within a county by a hospital, clinic, or other health care

96.18 facility that is a national referral center engaged in substantial programs of patient care,

96.19 medical research, and medical education meeting state and national needs that receives more

96.20 than 40 percent of its patients from outside the state of Minnesota;

96.21 (2) a project for construction or modification for which a health care facility held an

96.22 approved certificate of need on May 1, 1984, regardless of the date of expiration of the

96.23 certificate;

96.24 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely

96.25 appeal results in an order reversing the denial;

96.26 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,

96.27 section 2;

211.8 (5) a project involving consolidation of pediatric specialty hospital services within the
 211.9 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
 211.10 of pediatric specialty hospital beds among the hospitals being consolidated;

211.11 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
 211.12 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
 211.13 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
 211.14 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
 211.15 hospitals must be reinstated at the capacity that existed on each site before the relocation;

211.16 (7) the relocation or redistribution of hospital beds within a hospital building or
 211.17 identifiable complex of buildings provided the relocation or redistribution does not result
 211.18 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
 211.19 one physical site or complex to another; or (iii) redistribution of hospital beds within the
 211.20 state or a region of the state;

211.21 (8) relocation or redistribution of hospital beds within a hospital corporate system that
 211.22 involves the transfer of beds from a closed facility site or complex to an existing site or
 211.23 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
 211.24 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
 211.25 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
 211.26 health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or
 211.27 redistribution does not involve the construction of a new hospital building; and (v) the
 211.28 transferred beds are used first to replace within the hospital corporate system the total number
 211.29 of beds previously used in the closed facility site or complex for mental health services and
 211.30 substance use disorder services. Only after the hospital corporate system has fulfilled the
 211.31 requirements of this item may the remainder of the available capacity of the closed facility
 211.32 site or complex be transferred for any other purpose;

212.1 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
 212.2 County that primarily serves adolescents and that receives more than 70 percent of its
 212.3 patients from outside the state of Minnesota;

212.4 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
 212.5 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
 212.6 and (ii) the total licensed capacity of the replacement hospital, either at the time of
 212.7 construction of the initial building or as the result of future expansion, will not exceed 70
 212.8 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

212.9 (11) the relocation of licensed hospital beds from an existing state facility operated by
 212.10 the commissioner of human services to a new or existing facility, building, or complex
 212.11 operated by the commissioner of human services; from one regional treatment center site
 212.12 to another; or from one building or site to a new or existing building or site on the same
 212.13 campus;

96.28 (5) a project involving consolidation of pediatric specialty hospital services within the
 96.29 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
 96.30 of pediatric specialty hospital beds among the hospitals being consolidated;

97.1 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
 97.2 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
 97.3 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
 97.4 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
 97.5 hospitals must be reinstated at the capacity that existed on each site before the relocation;

97.6 (7) the relocation or redistribution of hospital beds within a hospital building or
 97.7 identifiable complex of buildings provided the relocation or redistribution does not result
 97.8 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
 97.9 one physical site or complex to another; or (iii) redistribution of hospital beds within the
 97.10 state or a region of the state;

97.11 (8) relocation or redistribution of hospital beds within a hospital corporate system that
 97.12 involves the transfer of beds from a closed facility site or complex to an existing site or
 97.13 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
 97.14 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
 97.15 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
 97.16 health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
 97.17 redistribution does not involve the construction of a new hospital building;

97.18 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
 97.19 County that primarily serves adolescents and that receives more than 70 percent of its
 97.20 patients from outside the state of Minnesota;

97.21 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
 97.22 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
 97.23 and (ii) the total licensed capacity of the replacement hospital, either at the time of
 97.24 construction of the initial building or as the result of future expansion, will not exceed 70
 97.25 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

97.26 (11) the relocation of licensed hospital beds from an existing state facility operated by
 97.27 the commissioner of human services to a new or existing facility, building, or complex
 97.28 operated by the commissioner of human services; from one regional treatment center site
 97.29 to another; or from one building or site to a new or existing building or site on the same
 97.30 campus;

212.14 (12) the construction or relocation of hospital beds operated by a hospital having a
 212.15 statutory obligation to provide hospital and medical services for the indigent that does not
 212.16 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
 212.17 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
 212.18 Medical Center to Regions Hospital under this clause;

212.19 (13) a construction project involving the addition of up to 31 new beds in an existing
 212.20 nonfederal hospital in Beltrami County;

212.21 (14) a construction project involving the addition of up to eight new beds in an existing
 212.22 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

212.23 (15) a construction project involving the addition of 20 new hospital beds in an existing
 212.24 hospital in Carver County serving the southwest suburban metropolitan area;

212.25 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
 212.26 of up to two psychiatric facilities or units for children provided that the operation of the
 212.27 facilities or units have received the approval of the commissioner of human services;

212.28 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
 212.29 services in an existing hospital in Itasca County;

212.30 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
 212.31 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
 212.32 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
 212.33 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

213.1 (19) a critical access hospital established under section 144.1483, clause (9), and section
 213.2 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
 213.3 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
 213.4 to the extent that the critical access hospital does not seek to exceed the maximum number
 213.5 of beds permitted such hospital under federal law;

213.6 (20) notwithstanding section 144.552, a project for the construction of a new hospital
 213.7 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

213.8 (i) the project, including each hospital or health system that will own or control the entity
 213.9 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
 213.10 Council as of March 1, 2006;

213.11 (ii) the entity that will hold the new hospital license will be owned or controlled by one
 213.12 or more not-for-profit hospitals or health systems that have previously submitted a plan or
 213.13 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
 213.14 have been found to be in the public interest by the commissioner of health as of April 1,
 213.15 2005;

213.16 (iii) the new hospital's initial inpatient services must include, but are not limited to,
 213.17 medical and surgical services, obstetrical and gynecological services, intensive care services,

97.31 (12) the construction or relocation of hospital beds operated by a hospital having a
 97.32 statutory obligation to provide hospital and medical services for the indigent that does not
 97.33 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
 98.1 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
 98.2 Medical Center to Regions Hospital under this clause;

98.3 (13) a construction project involving the addition of up to 31 new beds in an existing
 98.4 nonfederal hospital in Beltrami County;

98.5 (14) a construction project involving the addition of up to eight new beds in an existing
 98.6 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

98.7 (15) a construction project involving the addition of 20 new hospital beds in an existing
 98.8 hospital in Carver County serving the southwest suburban metropolitan area;

98.9 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
 98.10 of up to two psychiatric facilities or units for children provided that the operation of the
 98.11 facilities or units have received the approval of the commissioner of human services;

98.12 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
 98.13 services in an existing hospital in Itasca County;

98.14 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
 98.15 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
 98.16 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
 98.17 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

98.18 (19) a critical access hospital established under section 144.1483, clause (9), and section
 98.19 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
 98.20 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
 98.21 to the extent that the critical access hospital does not seek to exceed the maximum number
 98.22 of beds permitted such hospital under federal law;

98.23 (20) notwithstanding section 144.552, a project for the construction of a new hospital
 98.24 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

98.25 (i) the project, including each hospital or health system that will own or control the entity
 98.26 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
 98.27 Council as of March 1, 2006;

98.28 (ii) the entity that will hold the new hospital license will be owned or controlled by one
 98.29 or more not-for-profit hospitals or health systems that have previously submitted a plan or
 98.30 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
 98.31 have been found to be in the public interest by the commissioner of health as of April 1,
 98.32 2005;

99.1 (iii) the new hospital's initial inpatient services must include, but are not limited to,
 99.2 medical and surgical services, obstetrical and gynecological services, intensive care services,

213.18 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
 213.19 services, and emergency room services;

213.20 (iv) the new hospital:

213.21 (A) will have the ability to provide and staff sufficient new beds to meet the growing
 213.22 needs of the Maple Grove service area and the surrounding communities currently being
 213.23 served by the hospital or health system that will own or control the entity that will hold the
 213.24 new hospital license;

213.25 (B) will provide uncompensated care;

213.26 (C) will provide mental health services, including inpatient beds;

213.27 (D) will be a site for workforce development for a broad spectrum of health-care-related
 213.28 occupations and have a commitment to providing clinical training programs for physicians
 213.29 and other health care providers;

213.30 (E) will demonstrate a commitment to quality care and patient safety;

213.31 (F) will have an electronic medical records system, including physician order entry;

213.32 (G) will provide a broad range of senior services;

214.1 (H) will provide emergency medical services that will coordinate care with regional
 214.2 providers of trauma services and licensed emergency ambulance services in order to enhance
 214.3 the continuity of care for emergency medical patients; and

214.4 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
 214.5 the control of the entity holding the new hospital license; and

214.6 (v) as of 30 days following submission of a written plan, the commissioner of health
 214.7 has not determined that the hospitals or health systems that will own or control the entity
 214.8 that will hold the new hospital license are unable to meet the criteria of this clause;

214.9 (21) a project approved under section 144.553;

214.10 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
 214.11 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
 214.12 is approved by the Cass County Board;

214.13 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
 214.14 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
 214.15 a separately licensed 13-bed skilled nursing facility;

214.16 (24) notwithstanding section 144.552, a project for the construction and expansion of a
 214.17 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
 214.18 who are under 21 years of age on the date of admission. The commissioner conducted a
 214.19 public interest review of the mental health needs of Minnesota and the Twin Cities

99.3 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
 99.4 services, and emergency room services;

99.5 (iv) the new hospital:

99.6 (A) will have the ability to provide and staff sufficient new beds to meet the growing
 99.7 needs of the Maple Grove service area and the surrounding communities currently being
 99.8 served by the hospital or health system that will own or control the entity that will hold the
 99.9 new hospital license;

99.10 (B) will provide uncompensated care;

99.11 (C) will provide mental health services, including inpatient beds;

99.12 (D) will be a site for workforce development for a broad spectrum of health-care-related
 99.13 occupations and have a commitment to providing clinical training programs for physicians
 99.14 and other health care providers;

99.15 (E) will demonstrate a commitment to quality care and patient safety;

99.16 (F) will have an electronic medical records system, including physician order entry;

99.17 (G) will provide a broad range of senior services;

99.18 (H) will provide emergency medical services that will coordinate care with regional
 99.19 providers of trauma services and licensed emergency ambulance services in order to enhance
 99.20 the continuity of care for emergency medical patients; and

99.21 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
 99.22 the control of the entity holding the new hospital license; and

99.23 (v) as of 30 days following submission of a written plan, the commissioner of health
 99.24 has not determined that the hospitals or health systems that will own or control the entity
 99.25 that will hold the new hospital license are unable to meet the criteria of this clause;

99.26 (21) a project approved under section 144.553;

99.27 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
 99.28 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
 99.29 is approved by the Cass County Board;

100.1 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
 100.2 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
 100.3 a separately licensed 13-bed skilled nursing facility;

100.4 (24) notwithstanding section 144.552, a project for the construction and expansion of a
 100.5 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
 100.6 who are under 21 years of age on the date of admission. The commissioner conducted a
 100.7 public interest review of the mental health needs of Minnesota and the Twin Cities

214.20 metropolitan area in 2008. No further public interest review shall be conducted for the
 214.21 construction or expansion project under this clause;

214.22 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
 214.23 commissioner finds the project is in the public interest after the public interest review
 214.24 conducted under section 144.552 is complete;

214.25 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
 214.26 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
 214.27 admission, if the commissioner finds the project is in the public interest after the public
 214.28 interest review conducted under section 144.552 is complete;

214.29 (ii) this project shall serve patients in the continuing care benefit program under section
 214.30 256.9693. The project may also serve patients not in the continuing care benefit program;
 214.31 and

214.32 (iii) if the project ceases to participate in the continuing care benefit program, the
 214.33 commissioner must complete a subsequent public interest review under section 144.552. If
 215.1 the project is found not to be in the public interest, the license must be terminated six months
 215.2 from the date of that finding. If the commissioner of human services terminates the contract
 215.3 without cause or reduces per diem payment rates for patients under the continuing care
 215.4 benefit program below the rates in effect for services provided on December 31, 2015, the
 215.5 project may cease to participate in the continuing care benefit program and continue to
 215.6 operate without a subsequent public interest review;

215.7 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
 215.8 in Hennepin County that is exclusively for patients who are under 21 years of age on the
 215.9 date of admission; ~~or~~

215.10 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
 215.11 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
 215.12 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
 215.13 In addition, five unlicensed observation mental health beds shall be added;_

215.14 (29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing
 215.15 safety net, level I trauma center hospital in Ramsey County as designated under section
 215.16 383A.91, subdivision 5. The commissioner conducted a public interest review of the
 215.17 construction and expansion of this hospital in 2018. No further public interest review shall
 215.18 be conducted for the project under this clause; or

215.19 (30) the addition of licensed beds in a hospital or hospital corporate system to primarily
 215.20 provide mental health services or substance use disorder services. In order to add beds under
 215.21 this clause, a hospital must have an emergency department and must not be a hospital that
 215.22 solely provides treatment to adults for mental illnesses or substance use disorders. Beds
 215.23 added under this clause must be available to serve medical assistance and MinnesotaCare

100.8 metropolitan area in 2008. No further public interest review shall be conducted for the
 100.9 construction or expansion project under this clause;

100.10 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
 100.11 commissioner finds the project is in the public interest after the public interest review
 100.12 conducted under section 144.552 is complete;

100.13 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
 100.14 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
 100.15 admission, if the commissioner finds the project is in the public interest after the public
 100.16 interest review conducted under section 144.552 is complete;

100.17 (ii) this project shall serve patients in the continuing care benefit program under section
 100.18 256.9693. The project may also serve patients not in the continuing care benefit program;
 100.19 and

100.20 (iii) if the project ceases to participate in the continuing care benefit program, the
 100.21 commissioner must complete a subsequent public interest review under section 144.552. If
 100.22 the project is found not to be in the public interest, the license must be terminated six months
 100.23 from the date of that finding. If the commissioner of human services terminates the contract
 100.24 without cause or reduces per diem payment rates for patients under the continuing care
 100.25 benefit program below the rates in effect for services provided on December 31, 2015, the
 100.26 project may cease to participate in the continuing care benefit program and continue to
 100.27 operate without a subsequent public interest review;

100.28 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
 100.29 in Hennepin County that is exclusively for patients who are under 21 years of age on the
 100.30 date of admission; ~~or~~

100.31 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
 100.32 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
 100.33 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
 100.34 In addition, five unlicensed observation mental health beds shall be added;_

101.1 (29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing
 101.2 safety net, level I trauma center hospital in Ramsey County as designated under section
 101.3 383A.91, subdivision 5. The commissioner conducted a public interest review of the
 101.4 construction and expansion of this hospital in 2018. No further public interest review shall
 101.5 be conducted for the project under this clause; or

101.6 (30) the addition of licensed beds in a hospital or hospital corporate system to provide
 101.7 primarily mental health services or substance use disorder services. Beds added under this
 101.8 clause must be available to serve medical assistance and MinnesotaCare enrollees.
 101.9 Notwithstanding section 144.552, a public interest review shall not be required for the
 101.10 addition of beds under this clause.

215.24 enrollees. Notwithstanding section 144.552, public interest review shall not be required for
 215.25 an addition of beds under this clause.

215.26 **EFFECTIVE DATE.** (a) Paragraph (b), clause (29), is effective the day following final
 215.27 enactment, contingent upon:

215.28 (1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause
 215.29 (28), to the Ramsey County level I trauma center's bed capacity;

215.30 (2) five of the 45 additional beds authorized in paragraph (b), clause (29), being
 215.31 designated for use for inpatient mental health and added to the hospital's bed capacity before
 215.32 the remaining 40 beds authorized under that clause are added; and

216.1 (3) the Ramsey County level I trauma center's agreement to not participate in the Revenue
 216.2 Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section
 216.3 270C.41.

216.4 (b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are
 216.5 effective the day following final enactment.

216.6 Sec. 50. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision
 216.7 to read:

216.8 Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions
 216.9 under this section. Each hospital or hospital corporate system granted an exception under
 216.10 this section shall submit to the commissioner each year a report on how the hospital or
 216.11 hospital corporate system continues to satisfy the conditions on which the exception was
 216.12 granted.

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

216.14 Sec. 51. Minnesota Statutes 2020, section 144.555, is amended to read:

216.15 **144.555 HOSPITAL FACILITY OR CAMPUS CLOSINGS, RELOCATING**
 216.16 **SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT**
 216.17 **RELOCATIONS.**

216.18 Subdivision 1. **Notice of closing or curtailing service operations; facilities other than**
 216.19 **hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital,
 216.20 voluntarily plans to cease operations or to curtail operations to the extent that patients or
 216.21 residents must be relocated, the controlling persons of the facility must notify the
 216.22 commissioner of health at least 90 days before the scheduled cessation or curtailment. The
 216.23 commissioner shall cooperate with the controlling persons and advise them about relocating
 216.24 the patients or residents.

216.25 Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to**
 216.26 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under
 216.27 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at

- 216.28 least nine months before a scheduled action if the hospital or hospital campus voluntarily
 216.29 plans to:
- 216.30 (1) cease operations;
- 216.31 (2) curtail operations to the extent that patients must be relocated;
- 217.1 (3) relocate the provision of health services to another hospital or another hospital
 217.2 campus; or
- 217.3 (4) cease offering maternity care and newborn care services, intensive care unit services,
 217.4 inpatient mental health services, or inpatient substance use disorder treatment services.
- 217.5 (b) The commissioner shall cooperate with the controlling persons and advise them
 217.6 about relocating the patients. The controlling persons of the hospital or hospital campus
 217.7 must comply with section 144.556.
- 217.8 Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner
 217.9 shall conduct a public hearing on the scheduled cessation of operations, curtailment of
 217.10 operations, relocation of health services, or cessation in offering health services. The
 217.11 commissioner must provide adequate public notice of the hearing in a time and manner
 217.12 determined by the commissioner. The public hearing must be held in the community where
 217.13 the hospital or hospital campus is located at least six months before the scheduled cessation
 217.14 or curtailment of operations, relocation of health services, or cessation in offering health
 217.15 services. The controlling persons of the hospital or hospital campus must participate in the
 217.16 public hearing. The public hearing must include:
- 217.17 (1) an explanation by the controlling persons of the reasons for ceasing or curtailing
 217.18 operations, relocating health services, or ceasing to offer any of the listed health services;
- 217.19 (2) a description of the actions that controlling persons will take to ensure that residents
 217.20 in the hospital's or campus's service area have continued access to the health services being
 217.21 eliminated, curtailed, or relocated;
- 217.22 (3) an opportunity for public testimony on the scheduled cessation or curtailment of
 217.23 operations, relocation of health services, or cessation in offering any of the listed health
 217.24 services, and on the hospital's or campus's plan to ensure continued access to those health
 217.25 services being eliminated, curtailed, or relocated; and
- 217.26 (4) an opportunity for the controlling persons to respond to questions from interested
 217.27 persons.
- 217.28 Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure
 217.29 to participate in a public hearing under subdivision 1b may result in issuance of a correction
 217.30 order under section 144.653, subdivision 5.
- 217.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

218.1 Sec. 52. **[144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL**
 218.2 **CAMPUS.**

218.3 Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital**
 218.4 **or hospital campus.** The controlling persons of a hospital licensed under sections 144.50
 218.5 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or
 218.6 convey the hospital or hospital campus, or voluntarily cease operations of the hospital or
 218.7 hospital campus unless the controlling persons have first made a good faith offer to sell or
 218.8 convey the hospital or hospital campus to the home rule charter or statutory city, county,
 218.9 town, or hospital district in which the hospital or hospital campus is located.

218.10 Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a
 218.11 price that does not exceed the current fair market value of the hospital or hospital campus.
 218.12 A party to whom an offer is made under subdivision 1 must accept or decline the offer
 218.13 within 60 days after receipt. If the party fails to respond within 60 days after receipt, the
 218.14 offer is deemed declined.

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

218.16 Sec. 53. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

218.17 Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim
 218.18 controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other
 218.19 location where lead hazards are identified lead-safe by complying with the lead standards
 218.20 and methods adopted under section 144.9508.

218.21 Sec. 54. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

218.22 Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic,
 218.23 medical laboratory, other facility, or individual performing blood lead analysis shall report
 218.24 the results after the analysis of each specimen analyzed, for both capillary and venous
 218.25 specimens, and epidemiologic information required in this section to the commissioner of
 218.26 health, within the time frames set forth in clauses (1) and (2):

218.27 (1) within two working days by telephone, fax, or electronic transmission as prescribed
 218.28 by the commissioner, with written or electronic confirmation within one month as prescribed
 218.29 by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms
 218.30 of lead per deciliter of whole blood; or

219.1 (2) within one month in writing or by electronic transmission as prescribed by the
 219.2 commissioner, for any capillary result or for a venous blood lead level less than 15
 219.3 micrograms of lead per deciliter of whole blood.

219.4 (b) If a blood lead analysis is performed outside of Minnesota and the facility performing
 219.5 the analysis does not report the blood lead analysis results and epidemiological information
 219.6 required in this section to the commissioner, the provider who collected the blood specimen
 219.7 must satisfy the reporting requirements of this section. For purposes of this section, "provider"
 219.8 has the meaning given in section 62D.02, subdivision 9.

219.9 (c) The commissioner shall coordinate with hospitals, medical clinics, medical
 219.10 laboratories, and other facilities performing blood lead analysis to develop a universal
 219.11 reporting form and mechanism.

219.12 Sec. 55. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

219.13 Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a,
 219.14 for purposes of this subdivision, "child" means an individual under 18 years of age.

219.15 (b) An assessing agency shall conduct a lead risk assessment of a residence, residential
 219.16 or commercial child care facility, playground, school, or other location where lead hazards
 219.17 are suspected according to the venous blood lead level and time frame set forth in clauses
 219.18 (1) to (4) for purposes of secondary prevention:

219.19 (1) within 48 hours of a child or pregnant female in the residence, residential or
 219.20 commercial child care facility, playground, school, or other location where lead hazards are
 219.21 suspected being identified to the agency as having a venous blood lead level equal to or
 219.22 greater than 60 micrograms of lead per deciliter of whole blood;

219.23 (2) within five working days of a child or pregnant female in the residence, residential
 219.24 or commercial child care facility, playground, school, or other location where lead hazards
 219.25 are suspected being identified to the agency as having a venous blood lead level equal to
 219.26 or greater than 45 micrograms of lead per deciliter of whole blood;

219.27 ~~(3) within ten working days of a child in the residence being identified to the agency as~~
 219.28 ~~having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter~~
 219.29 ~~of whole blood; or~~

219.30 ~~(4) (3) within ten working days of a child or pregnant female in the residence, residential~~
 219.31 ~~or commercial child care facility, playground, school, or other location where lead hazards~~
 219.32 ~~are suspected being identified to the agency as having a venous blood lead level equal to~~
 219.33 ~~or greater than ten micrograms of lead per deciliter of whole blood; or~~

220.1 (4) within 20 working days of a child or pregnant female in the residence, residential or
 220.2 commercial child care facility, playground, school, or other location where lead hazards are
 220.3 suspected being identified to the agency as having a venous blood lead level equal to or
 220.4 greater than five micrograms per deciliter of whole blood.

220.5 An assessing agency may refer investigations at sites other than the child's or pregnant
 220.6 female's residence to the commissioner.

220.7 ~~(b) (c)~~ Within the limits of available local, state, and federal appropriations, an assessing
 220.8 agency may also conduct a lead risk assessment for children with any elevated blood lead
 220.9 level.

220.10 ~~(e) (d)~~ In a building with two or more dwelling units, an assessing agency shall assess
 220.11 the individual unit in which the conditions of this section are met and shall inspect all
 220.12 common areas accessible to a child. If a child visits one or more other sites such as another

220.13 residence, or a residential or commercial child care facility, playground, or school, the
 220.14 assessing agency shall also inspect the other sites. The assessing agency shall have one
 220.15 additional day added to the time frame set forth in this subdivision to complete the lead risk
 220.16 assessment for each additional site.

220.17 ~~(d)~~ (c) Within the limits of appropriations, the assessing agency shall identify the known
 220.18 addresses for the previous 12 months of the child or pregnant female with venous blood
 220.19 lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms
 220.20 per deciliter for the pregnant female; notify the property owners, landlords, and tenants at
 220.21 those addresses that an elevated blood lead level was found in a person who resided at the
 220.22 property; and give them primary prevention information. Within the limits of appropriations,
 220.23 the assessing agency may perform a risk assessment and issue corrective orders in the
 220.24 properties, if it is likely that the previous address contributed to the child's or pregnant
 220.25 female's blood lead level. The assessing agency shall provide the notice required by this
 220.26 subdivision without identifying the child or pregnant female with the elevated blood lead
 220.27 level. The assessing agency is not required to obtain the consent of the child's parent or
 220.28 guardian or the consent of the pregnant female for purposes of this subdivision. This
 220.29 information shall be classified as private data on individuals as defined under section 13.02,
 220.30 subdivision 12.

220.31 ~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules
 220.32 adopted by the commissioner under section 144.9508. An assessing agency shall have lead
 220.33 risk assessments performed by lead risk assessors licensed by the commissioner according
 220.34 to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk
 221.1 assessment, the assessing agency shall begin legal proceedings to gain entry to the property
 221.2 and the time frame for conducting a lead risk assessment set forth in this subdivision no
 221.3 longer applies. A lead risk assessor or assessing agency may observe the performance of
 221.4 lead hazard reduction in progress and shall enforce the provisions of this section under
 221.5 section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with
 221.6 appropriate analytical equipment to determine the lead content, except that deteriorated
 221.7 painted surfaces or bare soil need not be tested if the property owner agrees to engage in
 221.8 lead hazard reduction on those surfaces. The lead content of drinking water must be measured
 221.9 if another probable source of lead exposure is not identified. Within a standard metropolitan
 221.10 statistical area, an assessing agency may order lead hazard reduction of bare soil without
 221.11 measuring the lead content of the bare soil if the property is in a census tract in which soil
 221.12 sampling has been performed according to rules established by the commissioner and at
 221.13 least 25 percent of the soil samples contain lead concentrations above the standard in section
 221.14 144.9508.

221.15 ~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which
 221.16 allows a property owner to contest the nature and conditions of any lead order issued by
 221.17 the assessing agency. Assessing agencies must consider appeals that propose lower cost
 221.18 methods that make the residence lead safe. The commissioner shall use the authority and
 221.19 appeal procedure granted under sections 144.989 to 144.993.

221.20 ~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency
 221.21 from charging a property owner for the cost of a lead risk assessment.

221.22 Sec. 56. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

221.23 Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment,
 221.24 shall order a property owner to perform lead hazard reduction on all lead sources that exceed
 221.25 a standard adopted according to section 144.9508. If lead risk assessments and lead orders
 221.26 are conducted at times when weather or soil conditions do not permit the lead risk assessment
 221.27 or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders
 221.28 complied with, if necessary, at the first opportunity that weather and soil conditions allow.

221.29 (b) If, after conducting a lead risk assessment, an assessing agency determines that the
 221.30 property owner's lead hazard originated from another source location, the assessing agency
 221.31 may order the responsible person of the source location to:

221.32 (1) perform lead hazard reduction at the site where the assessing agency conducted the
 221.33 lead risk assessment; and

222.1 (2) remediate the conditions at the source location that allowed the lead hazard, pollutant,
 222.2 or contaminant to migrate from the source location.

222.3 (c) For purposes of this subdivision, "pollutant or contaminant" has the meaning given
 222.4 in section 115B.02, subdivision 13, and "responsible person" has the meaning given in
 222.5 section 115B.03.

222.6 ~~(b)~~ (d) If the paint standard under section 144.9508 is violated, but the paint is intact,
 222.7 the assessing agency shall not order the paint to be removed unless the intact paint is a
 222.8 known source of actual lead exposure to a specific person. Before the assessing agency may
 222.9 order the intact paint to be removed, a reasonable effort must be made to protect the child
 222.10 and preserve the intact paint by the use of guards or other protective devices and methods.

222.11 ~~(e)~~ (e) Whenever windows and doors or other components covered with deteriorated
 222.12 lead-based paint have sound substrate or are not rotting, those components should be repaired,
 222.13 sent out for stripping or planed down to remove deteriorated lead-based paint, or covered
 222.14 with protective guards instead of being replaced, provided that such an activity is the least
 222.15 cost method. However, a property owner who has been ordered to perform lead hazard
 222.16 reduction may choose any method to address deteriorated lead-based paint on windows,
 222.17 doors, or other components, provided that the method is approved in rules adopted under
 222.18 section 144.9508 and that it is appropriate to the specific property.

222.19 ~~(f)~~ (f) Lead orders must require that any source of damage, such as leaking roofs,
 222.20 plumbing, and windows, be repaired or replaced, as needed, to prevent damage to
 222.21 lead-containing interior surfaces.

222.22 ~~(e)~~ (g) The assessing agency is not required to pay for lead hazard reduction. The
 222.23 assessing agency shall enforce the lead orders issued to a property owner under this section.

222.24 Sec. 57. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws
 222.25 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

222.26 Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that an~~
 222.27 establishment where an operating person or legal entity, either directly or through contract,
 222.28 business relationship, or common ownership with another person or entity, provides sleeping
 222.29 accommodations and assisted living services to one or more adults in the facility. Assisted
 222.30 living facility includes assisted living facility with dementia care, and does not include:

222.31 (1) emergency shelter, transitional housing, or any other residential units serving
 222.32 exclusively or primarily homeless individuals, as defined under section 116L.361;

222.33 (2) a nursing home licensed under chapter 144A;

223.1 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
 223.2 144.50 to 144.56;

223.3 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
 223.4 9520.0500 to 9520.0670, or under chapter 245D or 245G;

223.5 (5) services and residential settings licensed under chapter 245A, including adult foster
 223.6 care and services and settings governed under the standards in chapter 245D;

223.7 (6) a private home in which the residents are related by kinship, law, or affinity with the
 223.8 provider of services;

223.9 (7) a duly organized condominium, cooperative, and common interest community, or
 223.10 owners' association of the condominium, cooperative, and common interest community
 223.11 where at least 80 percent of the units that comprise the condominium, cooperative, or
 223.12 common interest community are occupied by individuals who are the owners, members, or
 223.13 shareholders of the units;

223.14 (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;

223.15 (9) a setting offering services conducted by and for the adherents of any recognized
 223.16 church or religious denomination for its members exclusively through spiritual means or
 223.17 by prayer for healing;

223.18 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
 223.19 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
 223.20 units financed by the Minnesota Housing Finance Agency that are intended to serve
 223.21 individuals with disabilities or individuals who are homeless, except for those developments
 223.22 that market or hold themselves out as assisted living facilities and provide assisted living
 223.23 services;

223.24 (11) rental housing developed under United States Code, title 42, section 1437, or United
 223.25 States Code, title 12, section 1701q;

- 223.26 (12) rental housing designated for occupancy by only elderly or elderly and disabled
 223.27 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
 223.28 families under Code of Federal Regulations, title 24, section 983.56;
- 223.29 (13) rental housing funded under United States Code, title 42, chapter 89, or United
 223.30 States Code, title 42, section 8011;
- 223.31 ~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or~~
 224.1 ~~(15) (14) any establishment that exclusively or primarily serves as a shelter or temporary~~
 224.2 shelter for victims of domestic or any other form of violence.
- 224.3 **EFFECTIVE DATE.** This section is effective August 1, 2021.
- 224.4 Sec. 58. Minnesota Statutes 2020, section 144G.54, subdivision 3, is amended to read:
- 224.5 Subd. 3. **Appeals process.** (a) The Office of Administrative Hearings must conduct an
 224.6 expedited hearing using the procedures in Minnesota Rules, parts 1400.8505 to 1400.8612,
 224.7 as soon as practicable under this section, but in no event later than 14 calendar days after
 224.8 the office receives the request, unless the parties agree otherwise or the chief administrative
 224.9 law judge deems the timing to be unreasonable, given the complexity of the issues presented.
- 224.10 (b) The hearing must be held at the facility where the resident lives, unless holding the
 224.11 hearing at that location is impractical, the parties agree to hold the hearing at a different
 224.12 location, or the chief administrative law judge grants a party's request to appear at another
 224.13 location or by telephone or interactive video.
- 224.14 (c) The hearing is not a formal contested case proceeding conducted according to the
 224.15 procedures in Minnesota Rules, parts 1400.5010 to 1400.8400, except when determined
 224.16 necessary by the chief administrative law judge.
- 224.17 (d) Parties may but are not required to be represented by counsel. The appearance of a
 224.18 party without counsel does not constitute the unauthorized practice of law.
- 224.19 (e) The hearing shall be limited to the amount of time necessary for the participants to
 224.20 expeditiously present the facts about the proposed termination. The administrative law judge
 224.21 shall issue a recommendation to the commissioner as soon as practicable, but in no event
 224.22 later than ten business days after the hearing.
- 224.23 **EFFECTIVE DATE.** This section is effective August 1, 2021.
- 224.24 Sec. 59. Minnesota Statutes 2020, section 144G.84, is amended to read:
- 224.25 **144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.**
- 224.26 (a) In addition to the minimum services required in section 144G.41, an assisted living
 224.27 facility with dementia care must also provide the following services:
- 224.28 (1) assistance with activities of daily living that address the needs of each resident with
 224.29 dementia due to cognitive or physical limitations. These services must meet or be in addition

- 224.30 to the requirements in the licensing rules for the facility. Services must be provided in a
 225.1 person-centered manner that promotes resident choice, dignity, and sustains the resident's
 225.2 abilities;
- 225.3 (2) nonpharmacological practices that are person-centered and evidence-informed;
- 225.4 (3) services to prepare and educate persons living with dementia and their legal and
 225.5 designated representatives about transitions in care and ensuring complete, timely
 225.6 communication between, across, and within settings; and
- 225.7 (4) services that provide residents with choices for meaningful engagement with other
 225.8 facility residents and the broader community.
- 225.9 (b) Each resident must be evaluated for activities according to the licensing rules of the
 225.10 facility. In addition, the evaluation must address the following:
- 225.11 (1) past and current interests;
- 225.12 (2) current abilities and skills;
- 225.13 (3) emotional and social needs and patterns;
- 225.14 (4) physical abilities and limitations;
- 225.15 (5) adaptations necessary for the resident to participate; and
- 225.16 (6) identification of activities for behavioral interventions.
- 225.17 (c) An individualized activity plan must be developed for each resident based on their
 225.18 activity evaluation. The plan must reflect the resident's activity preferences and needs.
- 225.19 (d) A selection of daily structured and non-structured activities must be provided and
 225.20 included on the resident's activity service or care plan as appropriate. Daily activity options
 225.21 based on resident evaluation may include but are not limited to:
- 225.22 (1) occupation or chore related tasks;
- 225.23 (2) scheduled and planned events such as entertainment or outings;
- 225.24 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;
- 225.25 (4) one-to-one activities that encourage positive relationships between residents and
 225.26 staff such as telling a life story, reminiscing, or playing music;
- 225.27 (5) spiritual, creative, and intellectual activities;
- 225.28 (6) sensory stimulation activities;
- 225.29 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;
 225.30 and
- 226.1 (8) a resident's individualized activity plan for regular outdoor activities activity.

226.2 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
 226.3 living facility with dementia care must be evaluated and included on the service or care
 226.4 plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

226.5 (f) Support must be offered to family and other significant relationships on a regularly
 226.6 scheduled basis but not less than quarterly.

226.7 (g) ~~Access to secured outdoor space and walkways that allow residents to enter and~~
 226.8 ~~return without staff assistance must be provided. Existing housing with services~~
 226.9 establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted
 226.10 living facility license must provide residents with regular access to outdoor space. A licensee
 226.11 with new construction on or after August 1, 2021, or a new licensee that was not previously
 226.12 registered under chapter 144D prior to August 1, 2021, must provide regular access to
 226.13 secured outdoor space on the premises of the facility. A resident's access to outdoor space
 226.14 must be in accordance with the resident's documented care plan.

226.15 **EFFECTIVE DATE.** This section is effective August 1, 2021.

101.11 Sec. 27. Minnesota Statutes 2020, section 145.32, subdivision 1, is amended to read:

101.12 Subdivision 1. **Hospital records.** The superintendent or other chief administrative officer
 101.13 of any public or private hospital, by and with the consent and approval of the board of
 101.14 directors or other governing body of the hospital, may divest the files and records of that
 101.15 hospital of any individual case records and, with that consent and approval, may destroy
 101.16 the records. The records shall first have been transferred and recorded as authorized in
 101.17 section 145.30.

101.18 Portions of individual hospital medical records that comprise an individual permanent
 101.19 medical record, as defined by the commissioner of health, shall be retained as authorized
 101.20 in section 145.30. Other portions of the individual medical record, including any
 101.21 miscellaneous documents, papers, and correspondence in connection with them, may be
 101.22 divested and destroyed after seven years without transfer to photographic film, electronic
 101.23 image, or other state-of-the-art electronic preservation technology.

101.24 All portions of individual hospital medical records of minors shall be maintained for
 101.25 seven years following the age of majority or until the patient reaches the age of majority,
 101.26 whichever occurs last, at which time the patient may request that the patient's hospital
 101.27 records be deleted.

101.28 Nothing in this section shall be construed to prohibit the retention of hospital medical
 101.29 records beyond the periods described in this section. Nor shall anything in this section be
 101.30 construed to prohibit patient access to hospital medical records as provided in sections
 101.31 144.291 to 144.298.

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

- 102.1 Sec. 28. **[145.4161] LICENSURE OF ABORTION FACILITIES.**
- 102.2 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions
- 102.3 **apply.**
- 102.4 (b) "Abortion facility" means a clinic, health center, or other facility in which the
- 102.5 **pregnancies of ten or more women known to be pregnant are willfully terminated or aborted**
- 102.6 **each month. A facility licensed as a hospital or as an outpatient surgical center pursuant to**
- 102.7 **sections 144.50 to 144.56 shall not be considered an abortion facility.**
- 102.8 (c) "Accrediting or membership organization" means a national organization that
- 102.9 **establishes evidence-based clinical standards for abortion care and accredits abortion facilities**
- 102.10 **or accepts as members abortion facilities following an application and inspection process.**
- 102.11 (d) "Commissioner" means the commissioner of health.
- 102.12 Subd. 2. **License required.** (a) Beginning July 1, 2022, no abortion facility shall be
- 102.13 **established, operated, or maintained in the state without first obtaining a license from the**
- 102.14 **commissioner according to this section.**
- 102.15 (b) A license issued under this section is not transferable or assignable and is subject to
- 102.16 **suspension or revocation at any time for failure to comply with this section.**
- 102.17 (c) If a single entity maintains abortion facilities on different premises, each facility
- 102.18 **must obtain a separate license.**
- 102.19 (d) To be eligible for licensure under this section, an abortion facility must be accredited
- 102.20 **or a member of an accrediting or membership organization or must obtain accreditation or**
- 102.21 **membership within six months of the date of the application for licensure. If the abortion**
- 102.22 **facility loses its accreditation or membership, the abortion facility must immediately notify**
- 102.23 **the commissioner.**
- 102.24 (e) The commissioner, the attorney general, an appropriate county attorney, or a woman
- 102.25 **upon whom an abortion has been performed or attempted to be performed at an unlicensed**
- 102.26 **facility may seek an injunction in district court against the continued operation of the facility.**
- 102.27 **Proceedings for securing an injunction may be brought by the attorney general or by the**
- 102.28 **appropriate county attorney.**
- 102.29 (f) Sanctions provided in this subdivision do not restrict other available sanctions.
- 102.30 Subd. 3. **Temporary license.** For new abortion facilities planning to begin operations
- 102.31 **on or after July 1, 2022, the commissioner may issue a temporary license to the abortion**
- 102.32 **facility that is valid for a period of six months from the date of issuance. The abortion facility**
- 103.1 **must submit to the commissioner an application and applicable fee for licensure as required**
- 103.2 **by subdivisions 4 and 7. The application must include the information required under**
- 103.3 **subdivision 4, clauses (1), (2), and (4), and provide documentation that the abortion facility**
- 103.4 **has submitted the application for accreditation or membership from an accrediting or**
- 103.5 **membership organization. Upon receipt of accreditation or membership verification, the**

103.6 abortion facility must submit to the commissioner the information required in subdivision
 103.7 4, clause (3), and the applicable fee under subdivision 7. The commissioner shall then issue
 103.8 a new license.

103.9 Subd. 4. **Application.** An application for a license to operate an abortion facility and
 103.10 the applicable fee under subdivision 7 must be submitted to the commissioner on a form
 103.11 provided by the commissioner and must contain:

103.12 (1) the name of the applicant;

103.13 (2) the site location of the abortion facility;

103.14 (3) documentation that the abortion facility is accredited or an approved member of an
 103.15 accrediting or membership organization, including the effective date and the expiration date
 103.16 of the accreditation or membership, and the date of the last site visit by the accrediting or
 103.17 membership organization; and

103.18 (4) any other information that the commissioner deems necessary.

103.19 Subd. 5. **Inspections.** Prior to initial licensure and at least once every two years thereafter,
 103.20 the commissioner shall perform a routine and comprehensive inspection of each abortion
 103.21 facility. Facilities shall be open at all reasonable times to an inspection authorized in writing
 103.22 by the commissioner. No notice need be given to any person prior to an inspection authorized
 103.23 by the commissioner.

103.24 Subd. 6. **Suspension, revocation, and refusal to renew.** The commissioner may refuse
 103.25 to grant or renew, or may suspend or revoke, a license on any of the grounds described in
 103.26 section 144.55, subdivision 6, paragraph (a), clause (2), (3), or (4), or upon the loss of
 103.27 accreditation or membership described in subdivision 4, clause (3). The applicant or licensee
 103.28 is entitled to notice and a hearing as described under section 144.55, subdivision 7, and a
 103.29 new license may be issued after the proper inspection of an abortion facility has been
 103.30 conducted.

103.31 Subd. 7. **Fees.** (a) The biennial license fee for abortion facilities is \$365.

103.32 (b) The temporary license fee is \$365.

103.33 (c) Fees shall be collected and deposited according to section 144.122.

104.1 Subd. 8. **Renewal.** (a) A license issued under this section expires two years from the
 104.2 date of issuance.

104.3 (b) A temporary license issued under this section expires six months from the date of
 104.4 issuance and may be renewed for one additional six-month period.

104.5 Subd. 9. **Records.** All health records maintained on each client by an abortion facility
 104.6 are subject to sections 144.292 to 144.298.

226.16 Sec. 60. [145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES
226.17 WITH YOUNG CHILDREN.

226.18 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
226.19 and have the meanings given them.

226.20 (b) "Evidence-based home visiting program" means a program that:

226.21 (1) is based on a clear, consistent program or model that is research-based and grounded
226.22 in relevant, empirically based knowledge;

226.23 (2) is linked to program-determined outcomes and is associated with a national
226.24 organization, institution of higher education, or national or state public health institute;

226.25 (3) has comprehensive home visitation standards that ensure high-quality service delivery
226.26 and continuous quality improvement;

226.27 (4) has demonstrated significant, sustained positive outcomes; and

226.28 (5) either:

226.29 (i) has been evaluated using rigorous randomized controlled research designs and the
226.30 evaluation results have been published in a peer-reviewed journal; or

227.1 (ii) is based on quasi-experimental research using two or more separate, comparable
227.2 client samples.

227.3 (c) "Evidence-informed home visiting program" means a program that:

227.4 (1) has data or evidence demonstrating effectiveness at achieving positive outcomes for
227.5 pregnant women and young children; and

227.6 (2) either:

227.7 (i) has an active evaluation of the program; or

227.8 (ii) has a plan and timeline for an active evaluation of the program to be conducted.

227.9 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
227.10 full health potential and no individual is disadvantaged from achieving this potential.

104.7 Subd. 10. **Severability.** If any one or more provision, section, subdivision, sentence,
104.8 clause, phrase, or word of this section or the application of it to any person or circumstance
104.9 is found to be unconstitutional, it is declared to be severable and the balance of this section
104.10 shall remain effective notwithstanding such unconstitutionality. The legislature intends that
104.11 it would have passed this section, and each provision, section, subdivision, sentence, clause,
104.12 phrase, or word, regardless of the fact that any one provision, section, subdivision, sentence,
104.13 clause, phrase, or word is declared unconstitutional.

104.14 Sec. 29. [145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES
104.15 WITH YOUNG CHILDREN.

104.16 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section
104.17 and have the meanings given them.

104.18 (b) "Evidence-based home visiting program" means a program that:

104.19 (1) is based on a clear, consistent program or model that is research-based and grounded
104.20 in relevant, empirically based knowledge;

104.21 (2) is linked to program-determined outcomes and is associated with a national
104.22 organization, institution of higher education, or national or state public health institute;

104.23 (3) has comprehensive home visitation standards that ensure high-quality service delivery
104.24 and continuous quality improvement;

104.25 (4) has demonstrated significant, sustained positive outcomes; and

104.26 (5) either:

104.27 (i) has been evaluated using rigorous randomized controlled research designs and the
104.28 evaluation results have been published in a peer-reviewed journal; or

104.29 (ii) is based on quasi-experimental research using two or more separate, comparable
104.30 client samples.

104.31 (c) "Evidence-informed home visiting program" means a program that:

105.1 (1) has data or evidence demonstrating effectiveness at achieving positive outcomes for
105.2 pregnant women and young children; and

105.3 (2) either:

105.4 (i) has an active evaluation of the program; or

105.5 (ii) has a plan and timeline for an active evaluation of the program to be conducted.

105.6 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
105.7 full health potential and no individual is disadvantaged from achieving this potential.

227.11 (e) "Promising practice home visiting program" means a program that has shown
 227.12 improvement toward achieving positive outcomes for pregnant women or young children.

227.13 Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall
 227.14 award grants to community health boards, nonprofit organizations, and tribal nations to start
 227.15 up or expand voluntary home visiting programs serving pregnant women and families with
 227.16 young children. Home visiting programs supported under this section shall provide voluntary
 227.17 home visits by early childhood professionals or health professionals, including but not
 227.18 limited to nurses, social workers, early childhood educators, and trained paraprofessionals.
 227.19 Grant money shall be used to:

227.20 (1) establish or expand evidence-based, evidence-informed, or promising practice home
 227.21 visiting programs that address health equity and utilize community-driven health strategies;

227.22 (2) serve families with young children or pregnant women who have high needs or are
 227.23 high-risk, including but not limited to a family with low income, a parent or pregnant woman
 227.24 with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing
 227.25 housing instability or domestic abuse; and

227.26 (3) improve program outcomes in two or more of the following areas:

227.27 (i) maternal and newborn health;

227.28 (ii) school readiness and achievement;

227.29 (iii) family economic self-sufficiency;

227.30 (iv) coordination and referral for other community resources and supports;

227.31 (v) reduction in child injuries, abuse, or neglect; or

228.1 (vi) reduction in crime or domestic violence.

228.2 (b) Grants awarded to evidence-informed and promising practice home visiting programs
 228.3 must include money to evaluate program outcomes for up to four of the areas listed in
 228.4 paragraph (a), clause (3).

228.5 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
 228.6 priority to community health boards, nonprofit organizations, and tribal nations seeking to
 228.7 expand home visiting services with community or regional partnerships.

228.8 (b) The commissioner shall allocate at least 75 percent of the grant money awarded each
 228.9 grant cycle to evidence-based home visiting programs that address health equity and up to
 228.10 25 percent of the grant money awarded each grant cycle to evidence-informed or promising
 228.11 practice home visiting programs that address health equity and utilize community-driven
 228.12 health strategies.

228.13 Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the
 228.14 annual appropriation under this section to provide training and technical assistance and to

105.8 (e) "Promising practice home visiting program" means a program that has shown
 105.9 improvement toward achieving positive outcomes for pregnant women or young children.

105.10 Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall
 105.11 award grants to community health boards, nonprofit organizations, and Tribal nations to
 105.12 start up or expand voluntary home visiting programs serving pregnant women and families
 105.13 with young children. Home visiting programs supported under this section shall provide
 105.14 voluntary home visits by early childhood professionals or health professionals, including
 105.15 but not limited to nurses, social workers, early childhood educators, and trained
 105.16 paraprofessionals. Grant money shall be used to:

105.17 (1) establish or expand evidence-based, evidence-informed, or promising practice home
 105.18 visiting programs that address health equity and utilize community-driven health strategies;

105.19 (2) serve families with young children or pregnant women who have high needs or are
 105.20 high-risk, including but not limited to a family with low income, a parent or pregnant woman
 105.21 with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing
 105.22 housing instability or domestic abuse; and

105.23 (3) improve program outcomes in two or more of the following areas:

105.24 (i) maternal and newborn health;

105.25 (ii) school readiness and achievement;

105.26 (iii) family economic self-sufficiency;

105.27 (iv) coordination and referral for other community resources and supports;

105.28 (v) reduction in child injuries, abuse, or neglect; or

105.29 (vi) reduction in crime or domestic violence.

106.1 (b) Grants awarded to evidence-informed and promising practice home visiting programs
 106.2 must include money to evaluate program outcomes for up to four of the areas listed in
 106.3 paragraph (a), clause (3).

106.4 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
 106.5 priority to community health boards, nonprofit organizations, and Tribal nations seeking to
 106.6 expand home visiting services with community or regional partnerships.

106.7 (b) The commissioner shall allocate at least 75 percent of the grant money awarded each
 106.8 grant cycle to evidence-based home visiting programs that address health equity and up to
 106.9 25 percent of the grant money awarded each grant cycle to evidence-informed or promising
 106.10 practice home visiting programs that address health equity and utilize community-driven
 106.11 health strategies.

106.12 Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the
 106.13 annual appropriation under this section to provide training and technical assistance and to

228.15 administer and evaluate the program. The commissioner may contract for training,
 228.16 capacity-building support for grantees or potential grantees, technical assistance, and
 228.17 evaluation support.

228.18 Subd. 5. Use of state general fund appropriations. Appropriations dedicated to
 228.19 establishing or expanding evidence-based home visiting programs shall, for grants awarded
 228.20 on or after July 1, 2021, be awarded according to this section. This section shall not govern
 228.21 grant awards of federal funds for home visiting programs and shall not govern grant awards
 228.22 using state general fund appropriations dedicated to establishing or expanding nurse-family
 228.23 partnership home visiting programs.

228.24 Sec. 61. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

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

228.29 Sec. 62. Minnesota Statutes 2020, section 145.894, is amended to read:

228.30 **145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.**

228.31 The commissioner of health shall:

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

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

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

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

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

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

106.14 administer and evaluate the program. The commissioner may contract for training,
 106.15 capacity-building support for grantees or potential grantees, technical assistance, and
 106.16 evaluation support.

106.17 Subd. 5. Use of state general fund appropriations. Appropriations dedicated to
 106.18 establishing or expanding evidence-based home visiting programs shall, for grants awarded
 106.19 on or after July 1, 2021, be awarded according to this section. This section shall not govern
 106.20 grant awards of federal funds for home visiting programs and shall not govern grant awards
 106.21 using state general fund appropriations dedicated to establishing or expanding nurse-family
 106.22 partnership home visiting programs.

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

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

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

229.26 (10) determine, on July 1 of each year, the number of pregnant women participating in
 229.27 each special supplemental food program for women, infants, and children (WIC) and, in
 229.28 1986, 1987, and 1988, at the commissioner's discretion, designate a different food program
 229.29 deliverer if the current deliverer fails to increase the participation of pregnant women in the
 229.30 program by at least ten percent over the previous year's participation rate;

229.31 (11) promulgate all rules necessary to carry out the provisions of sections 145.891 to
 229.32 145.897; and

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

230.3 Sec. 63. Minnesota Statutes 2020, section 145.897, is amended to read:

230.4 **145.897 VOUCHERS FOOD BENEFITS.**

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

230.10 Sec. 64. Minnesota Statutes 2020, section 145.899, is amended to read:

230.11 **145.899 WIC VOUCHERS FOOD BENEFITS FOR ORGANICS.**

230.12 ~~Vouchers~~ Food benefits for the special supplemental nutrition program for women,
 230.13 infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable
 230.14 food. The commissioner of health shall regularly evaluate the list of WIC allowable food
 230.15 in accordance with federal requirements and shall add to the list any organic WIC allowable
 230.16 foods determined to be cost-neutral.

230.17 Sec. 65. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

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

230.23 representative of the subject of the data, when the subject of the data is a woman who died
 230.24 during a pregnancy or within 12 months of a fetal death, a live birth, or other termination
 230.25 of a pregnancy.

230.26 The commissioner has access only to medical data and health records related to deaths
 230.27 that occur on or after July 1, 2000, including the names of the providers, clinics, or other
 230.28 health services such as family home visiting programs; the women, infants, and children
 230.29 (WIC) program; prescription monitoring programs; and behavioral health services, where
 230.30 care was received before, during, or related to the pregnancy or death. The commissioner
 230.31 has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital
 230.32 discharge data, for the purpose of providing the name and location of any pre-pregnancy,
 231.1 prenatal, or other care received by the subject of the data up to one year after the end of the
 231.2 pregnancy.

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

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

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

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

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

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

231.23 Sec. 66. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

231.24 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source
 231.25 records under subdivision 2, including identifying information on individual providers, data
 231.26 subjects, or their children, and data derived by the commissioner under subdivision 3 for
 231.27 the purpose of carrying out maternal death studies, are classified as confidential data on

231.28 individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3,
 231.29 and 13.10, subdivision 1, paragraph (a).

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

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

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

106.23 Sec. 30. Minnesota Statutes 2020, section 145.902, is amended to read:

106.24 **145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES;**
 106.25 **IMMUNITY.**

106.26 Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means a hospital
 106.27 licensed under sections 144.50 to 144.56, including the hospital where the newborn was
 106.28 born, a health care provider who provides urgent care medical services, or an ambulance
 106.29 service licensed under chapter 144E dispatched in response to a 911 call from a mother or
 106.30 a person with the mother's permission to relinquish a newborn infant.

106.31 (b) A safe place shall receive a newborn left with an employee on the premises of the
 106.32 safe place during its hours of operation, provided that:

107.1 (1) the newborn was born within seven days of being left at the safe place, as determined
 107.2 within a reasonable degree of medical certainty; and

107.3 (2) the newborn is left in an unharmed condition.

107.4 (c) The safe place must not inquire as to the identity of the mother or the person leaving
 107.5 the newborn or call the police, provided the newborn is unharmed when presented to the
 107.6 hospital. The safe place may ask the mother or the person leaving the newborn about the
 107.7 medical history of the mother or newborn and if the newborn may have lineage to an Indian
 107.8 Tribe and, if known, the name of the Tribe but the mother or the person leaving the newborn
 107.9 is not required to provide any information. The safe place may provide the mother or the
 107.10 person leaving the newborn with information about how to contact relevant social service
 107.11 agencies.

107.12 (d) A safe place that is a health care provider who provides urgent care medical services
 107.13 shall dial 911, advise the dispatcher that the call is being made from a safe place for
 107.14 newborns, and ask the dispatcher to send an ambulance or take other appropriate action to
 107.15 transport the newborn to a hospital. An ambulance with whom a newborn is left shall
 107.16 transport the newborn to a hospital for care. Hospitals must receive a newborn left with a
 107.17 safe place and make the report as required in subdivision 2.

107.18 Subd. 2. **Reporting.** (a) Within 24 hours of receiving a newborn under this section, the
 107.19 hospital must inform the responsible social service agency that a newborn has been left at
 107.20 the hospital, but must not do so in the presence of the mother or the person leaving the
 107.21 newborn. The hospital must provide necessary care to the newborn pending assumption of
 107.22 legal responsibility by the responsible social service agency pursuant to section 260C.139,
 107.23 subdivision 5.

107.24 (b) Within five days of receiving a newborn under this section, a hospital shall report
 107.25 the newborn to the Office of Vital Records pursuant to section 144.216, subdivision 3. If a
 107.26 hospital receives a safe place newborn under section 145.902 and it is known that the child's
 107.27 record of birth was registered because the newborn was born at that hospital, the hospital
 107.28 shall report the newborn to the Office of Vital Records and identify the child's birth record.
 107.29 The state registrar shall issue a replacement birth record for the child pursuant to section
 107.30 144.218, subdivision 6.

107.31 Subd. 3. **Immunity.** (a) A safe place with responsibility for performing duties under
 107.32 this section, and any employee, doctor, ambulance personnel, or other medical professional
 107.33 working at the safe place, are immune from any criminal liability that otherwise might result
 108.1 from their actions, if they are acting in good faith in receiving a newborn, and are immune
 108.2 from any civil liability that otherwise might result from merely receiving a newborn.

108.3 (b) A safe place performing duties under this section, or an employee, doctor, ambulance
 108.4 personnel, or other medical professional working at the safe place who is a mandated reporter
 108.5 under chapter 260E, is immune from any criminal or civil liability that otherwise might
 108.6 result from the failure to make a report under that section if the person is acting in good
 108.7 faith in complying with this section.

108.8 **EFFECTIVE DATE.** This section is effective August 1, 2021.

108.9 Sec. 31. **[145A.145] NURSE-FAMILY PARTNERSHIP PROGRAMS.**

108.10 (a) The commissioner of health shall award expansion grants to community health boards
 108.11 and tribal nations to expand existing nurse-family partnership programs. Grant funds must
 108.12 be used to start up, expand, or sustain nurse-family partnership programs in the county,
 108.13 reservation, or region to serve families in accordance with the Nurse-Family Partnership
 108.14 Service Office nurse-family partnership model. The commissioner shall award grants to
 108.15 community health boards, nonprofit organizations, or tribal nations in metropolitan and
 108.16 rural areas of the state.

232.10 Sec. 67. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

232.11 Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance,
232.12 the chemical structure of which is substantially similar to the chemical structure of a
232.13 controlled substance in Schedule I or II:

232.14 (1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system
232.15 that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic
232.16 effect on the central nervous system of a controlled substance in Schedule I or II; or

232.17 (2) with respect to a particular person, if the person represents or intends that the substance
232.18 have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is
232.19 substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect
232.20 on the central nervous system of a controlled substance in Schedule I or II.

232.21 (b) "Analog" does not include:

232.22 (1) a controlled substance;

232.23 (2) any substance for which there is an approved new drug application under the Federal
232.24 Food, Drug, and Cosmetic Act; ~~or~~

232.25 (3) with respect to a particular person, any substance, if an exemption is in effect for
232.26 investigational use, for that person, as provided by United States Code, title 21, section 355,
232.27 and the person is registered as a controlled substance researcher as required under section
232.28 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the
232.29 exemption and registration; or

232.30 (4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus
232.31 cannabis or in the resinous extractives of the plant.

233.1 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
233.2 committed on or after that date.

233.3 Sec. 68. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:

233.4 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.

233.5 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
233.6 following substances, including their analogs, isomers, esters, ethers, salts, and salts of

108.17 (b) Priority for all grants shall be given to nurse-family partnership programs that provide
108.18 services through a Minnesota health care program-enrolled provider that accepts medical
108.19 assistance. Priority for grants to rural areas shall be given to community health boards,
108.20 nonprofit organizations, and tribal nations that start up, expand, or sustain services within
108.21 regional partnerships that provide the nurse-family partnership program.

108.22 (c) Funding available under this section may only be used to supplement, not to replace,
108.23 funds being used for nurse-family partnership home visiting services as of June 30, 2015.

- 233.7 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
233.8 and salts is possible;
- 233.9 (1) acetylmethadol;
- 233.10 (2) allylprodine;
- 233.11 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
233.12 acetate);
- 233.13 (4) alphameprodine;
- 233.14 (5) alphamethadol;
- 233.15 (6) alpha-methylfentanyl benzethidine;
- 233.16 (7) betacetylmethadol;
- 233.17 (8) betameprodine;
- 233.18 (9) betamethadol;
- 233.19 (10) betaprodine;
- 233.20 (11) clonitazene;
- 233.21 (12) dextromoramide;
- 233.22 (13) diampromide;
- 233.23 (14) diethylambutene;
- 233.24 (15) difenoxin;
- 233.25 (16) dimenoxadol;
- 233.26 (17) dimepheptanol;
- 233.27 (18) dimethylambutene;
- 233.28 (19) dioxaphetyl butyrate;
- 234.1 (20) dipipanone;
- 234.2 (21) ethylmethylthiambutene;
- 234.3 (22) etonitazene;
- 234.4 (23) etoxeridine;
- 234.5 (24) furethidine;
- 234.6 (25) hydroxypethidine;

- 234.7 (26) ketobemidone;
- 234.8 (27) levomoramide;
- 234.9 (28) levophenacylmorphane;
- 234.10 (29) 3-methylfentanyl;
- 234.11 (30) acetyl-alpha-methylfentanyl;
- 234.12 (31) alpha-methylthiofentanyl;
- 234.13 (32) benzylfentanyl beta-hydroxyfentanyl;
- 234.14 (33) beta-hydroxy-3-methylfentanyl;
- 234.15 (34) 3-methylthiofentanyl;
- 234.16 (35) thenylfentanyl;
- 234.17 (36) thiofentanyl;
- 234.18 (37) para-fluorofentanyl;
- 234.19 (38) morpheridine;
- 234.20 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- 234.21 (40) noracymethadol;
- 234.22 (41) norlevorphanol;
- 234.23 (42) normethadone;
- 234.24 (43) norpipanone;
- 234.25 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- 234.26 (45) phenadoxone;
- 234.27 (46) phenampromide;
- 235.1 (47) phenomorphan;
- 235.2 (48) phenoperidine;
- 235.3 (49) piritramide;
- 235.4 (50) proheptazine;
- 235.5 (51) properidine;
- 235.6 (52) propiram;
- 235.7 (53) racemoramide;

- 235.8 (54) tilidine;
- 235.9 (55) trimeperidine;
- 235.10 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);
- 235.11 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
- 235.12 methylbenzamide(U47700);
- 235.13 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanyl fentanyl);
- 235.14 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);
- 235.15 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropyl
- 235.16 fentanyl);
- 235.17 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide (butyryl fentanyl);
- 235.18 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);
- 235.19 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
- 235.20 fentanyl);
- 235.21 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);
- 235.22 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);
- 235.23 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
- 235.24 (para-chloroisobutyryl fentanyl);
- 235.25 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
- 235.26 fentanyl);
- 235.27 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
- 235.28 (para-methoxybutyryl fentanyl);
- 235.29 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);
- 236.1 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
- 236.2 fentanyl or para-fluoroisobutyryl fentanyl);
- 236.3 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
- 236.4 acryloylfentanyl);
- 236.5 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
- 236.6 fentanyl);
- 236.7 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
- 236.8 or 2-fluorofentanyl);
- 236.9 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
- 236.10 (tetrahydrofuranyl fentanyl); and

- 236.11 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
- 236.12 esters and ethers, meaning any substance not otherwise listed under another federal
- 236.13 Administration Controlled Substance Code Number or not otherwise listed in this section,
- 236.14 and for which no exemption or approval is in effect under section 505 of the Federal Food,
- 236.15 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
- 236.16 to fentanyl by one or more of the following modifications:
- 236.17 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
- 236.18 or not further substituted in or on the monocycle;
- 236.19 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo,
- 236.20 haloalkyl, amino, or nitro groups;
- 236.21 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether,
- 236.22 hydroxyl, halo, haloalkyl, amino, or nitro groups;
- 236.23 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
- 236.24 substituted in or on the aromatic monocycle; or
- 236.25 (v) replacement of the N-propionyl group by another acyl group.
- 236.26 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
- 236.27 and salts of isomers, unless specifically excepted or unless listed in another schedule,
- 236.28 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 236.29 (1) acetorphine;
- 236.30 (2) acetyldihydrocodeine;
- 236.31 (3) benzylmorphine;
- 237.1 (4) codeine methylbromide;
- 237.2 (5) codeine-n-oxide;
- 237.3 (6) cyprenorphine;
- 237.4 (7) desomorphine;
- 237.5 (8) dihydromorphine;
- 237.6 (9) drotebanol;
- 237.7 (10) etorphine;
- 237.8 (11) heroin;
- 237.9 (12) hydromorphanol;
- 237.10 (13) methyl-desorphine;
- 237.11 (14) methyl-dihydromorphine;

- 237.12 (15) morphine methylbromide;
- 237.13 (16) morphine methylsulfonate;
- 237.14 (17) morphine-n-oxide;
- 237.15 (18) myrophine;
- 237.16 (19) nicocodeine;
- 237.17 (20) nicomorphine;
- 237.18 (21) normorphine;
- 237.19 (22) pholcodine; and
- 237.20 (23) thebacon.
- 237.21 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
- 237.22 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
- 237.23 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
- 237.24 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
- 237.25 possible:
- 237.26 (1) methylenedioxy amphetamine;
- 237.27 (2) methylenedioxymethamphetamine;
- 237.28 (3) methylenedioxy-N-ethylamphetamine (MDEA);
- 238.1 (4) n-hydroxy-methylenedioxyamphetamine;
- 238.2 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);
- 238.3 (6) 2,5-dimethoxyamphetamine (2,5-DMA);
- 238.4 (7) 4-methoxyamphetamine;
- 238.5 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;
- 238.6 (9) alpha-ethyltryptamine;
- 238.7 (10) bufotenine;
- 238.8 (11) diethyltryptamine;
- 238.9 (12) dimethyltryptamine;
- 238.10 (13) 3,4,5-trimethoxyamphetamine;
- 238.11 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);
- 238.12 (15) ibogaine;

- 238.13 (16) lysergic acid diethylamide (LSD);
- 238.14 (17) mescaline;
- 238.15 (18) parahexyl;
- 238.16 (19) N-ethyl-3-piperidyl benzilate;
- 238.17 (20) N-methyl-3-piperidyl benzilate;
- 238.18 (21) psilocybin;
- 238.19 (22) psilocyn;
- 238.20 (23) tenocyclidine (TCP or TCP);
- 238.21 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- 238.22 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- 238.23 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- 238.24 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- 238.25 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- 238.26 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- 238.27 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- 239.1 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- 239.2 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- 239.3 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- 239.4 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- 239.5 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- 239.6 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- 239.7 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);
- 239.8 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
- 239.9 (2-CB-FLY);
- 239.10 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- 239.11 (40) alpha-methyltryptamine (AMT);
- 239.12 (41) N,N-diisopropyltryptamine (DiPT);
- 239.13 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);

- 239.14 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);
- 239.15 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- 239.16 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- 239.17 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- 239.18 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- 239.19 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);
- 239.20 (49) 5-methoxy- α -methyltryptamine (5-MeO-AMT);
- 239.21 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- 239.22 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- 239.23 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);
- 239.24 (53) 5-methoxy- α -ethyltryptamine (5-MeO-AET);
- 239.25 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- 239.26 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- 239.27 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- 240.1 (57) methoxetamine (MXE);
- 240.2 (58) 5-iodo-2-aminoindane (5-IAI);
- 240.3 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- 240.4 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- 240.5 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- 240.6 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- 240.7 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);
- 240.8 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- 240.9 (65) N,N-Dipropyltryptamine (DPT);
- 240.10 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- 240.11 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- 240.12 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- 240.13 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);

- 240.14 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethylorketamine,
240.15 ethketamine, NENK);
- 240.16 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);
- 240.17 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and
- 240.18 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).
- 240.19 (e) Peyote. All parts of the plant presently classified botanically as *Lophophora williamsii*
240.20 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,
240.21 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,
240.22 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
240.23 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
240.24 Church, and members of the American Indian Church are exempt from registration. Any
240.25 person who manufactures peyote for or distributes peyote to the American Indian Church,
240.26 however, is required to obtain federal registration annually and to comply with all other
240.27 requirements of law.
- 240.28 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
240.29 another schedule, any material compound, mixture, or preparation which contains any
241.1 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
241.2 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 241.3 (1) mecloqualone;
- 241.4 (2) methaqualone;
- 241.5 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;
- 241.6 (4) flunitrazepam;
- 241.7 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
241.8 methoxyketamine);
- 241.9 (6) tianeptine;
- 241.10 (7) clonazepam;
- 241.11 (8) etizolam;
- 241.12 (9) flubromazolam; and
- 241.13 (10) flubromazepam.
- 241.14 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
241.15 material compound, mixture, or preparation which contains any quantity of the following
241.16 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
241.17 analogs, salts, isomers, and salts of isomers is possible:
- 241.18 (1) aminorex;

- 241.19 (2) cathinone;
- 241.20 (3) fenethylamine;
- 241.21 (4) methcathinone;
- 241.22 (5) methylaminorex;
- 241.23 (6) N,N-dimethylamphetamine;
- 241.24 (7) N-benzylpiperazine (BZP);
- 241.25 (8) methylmethcathinone (mephedrone);
- 241.26 (9) 3,4-methylenedioxy-N-methylcathinone (methylone);
- 241.27 (10) methoxymethcathinone (methedrone);
- 241.28 (11) methylenedioxypropylone (MDPV);
- 242.1 (12) 3-fluoro-N-methylcathinone (3-FMC);
- 242.2 (13) methylethcathinone (MEC);
- 242.3 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- 242.4 (15) dimethylmethcathinone (DMMC);
- 242.5 (16) fluoroamphetamine;
- 242.6 (17) fluoromethamphetamine;
- 242.7 (18) α -methylaminobutyrophenone (MABP or buphedrone);
- 242.8 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);
- 242.9 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- 242.10 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
- 242.11 naphyrone);
- 242.12 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- 242.13 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);
- 242.14 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- 242.15 (25) 4-methyl-N-ethylcathinone (4-MEC);
- 242.16 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- 242.17 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- 242.18 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);

- 242.19 (29) 4-fluoro-N-methylcathinone (4-FMC);
- 242.20 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);
- 242.21 (31) alpha-pyrrolidinobutiophenone (α -PBP);
- 242.22 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- 242.23 (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);
- 242.24 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);
- 242.25 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);
- 242.26 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);
- 242.27 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);
- 243.1 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);
- 243.2 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
- 243.3 and
- 243.4 (40) any other substance, except bupropion or compounds listed under a different
- 243.5 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
- 243.6 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
- 243.7 compound is further modified in any of the following ways:
- 243.8 (i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy,
- 243.9 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
- 243.10 system by one or more other univalent substituents;
- 243.11 (ii) by substitution at the 3-position with an acyclic alkyl substituent;
- 243.12 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
- 243.13 methoxybenzyl groups; or
- 243.14 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.
- 243.15 (h) ~~Marijuana~~, Synthetic tetrahydrocannabinols, and synthetic cannabinoids. Unless
- 243.16 specifically excepted or unless listed in another schedule, any ~~natural or~~ synthetic material,
- 243.17 compound, mixture, or preparation that contains any quantity of the following substances,
- 243.18 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
- 243.19 the existence of the isomers, esters, ethers, or salts is possible;
- 243.20 ~~(1) marijuana;~~
- 243.21 ~~(2) (1) synthetic tetrahydrocannabinols naturally contained in a plant of the genus~~
- 243.22 ~~Cannabis~~, that are the synthetic equivalents of the substances contained in the cannabis
- 243.23 plant or in the resinous extractives of the plant, or synthetic substances with similar chemical
- 243.24 structure and pharmacological activity to those substances contained in the plant or resinous

- 243.25 extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans
 243.26 tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;
- 243.27 ~~(2)~~ (2) synthetic cannabinoids, including the following substances:
- 243.28 (i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole
 243.29 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
 243.30 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
 243.31 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
 244.1 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
 244.2 naphthoylindoles include, but are not limited to:
- 244.3 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);
- 244.4 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);
- 244.5 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);
- 244.6 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);
- 244.7 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);
- 244.8 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);
- 244.9 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);
- 244.10 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);
- 244.11 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);
- 244.12 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).
- 244.13 (ii) Naphthylmethylinindoles, which are any compounds containing a
 244.14 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the
 244.15 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
 244.16 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further
 244.17 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
 244.18 ring to any extent. Examples of naphthylmethylinindoles include, but are not limited to:
- 244.19 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);
- 244.20 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).
- 244.21 (iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole
 244.22 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
 244.23 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
 244.24 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any
 244.25 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
 244.26 naphthoylpyrroles include, but are not limited to,
 244.27 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

244.28 (iv) Naphthylmethylenes, which are any compounds containing a naphthylideneindene
 244.29 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
 244.30 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or
 244.31 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
 245.1 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
 245.2 naphthylmethylenes include, but are not limited to,
 245.3 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

245.4 (v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole
 245.5 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
 245.6 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or
 245.7 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
 245.8 extent, whether or not substituted in the phenyl ring to any extent. Examples of
 245.9 phenylacetylindoles include, but are not limited to:

245.10 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

245.11 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

245.12 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

245.13 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

245.14 (vi) Cyclohexylphenols, which are compounds containing a
 245.15 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
 245.16 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
 245.17 1-(N-methyl-2-piperidiny)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted
 245.18 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
 245.19 limited to:

245.20 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

245.21 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol

245.22 (Cannabicyclohexanol or CP 47,497 C8 homologue);

245.23 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
 245.24 -phenol (CP 55,940).

245.25 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
 245.26 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
 245.27 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidiny)methyl or
 245.28 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
 245.29 extent and whether or not substituted in the phenyl ring to any extent. Examples of
 245.30 benzoylindoles include, but are not limited to:

245.31 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);

245.32 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);

- 246.1 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
246.2 48,098 or Pravadoline).
- 246.3 (viii) Others specifically named:
- 246.4 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
246.5 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);
- 246.6 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
246.7 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);
- 246.8 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
246.9 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);
- 246.10 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);
- 246.11 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
246.12 (XLR-11);
- 246.13 (F) 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
246.14 (AKB-48(APINACA));
- 246.15 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
246.16 (5-Fluoro-AKB-48);
- 246.17 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);
- 246.18 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);
- 246.19 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
246.20 (AB-PINACA);
- 246.21 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
246.22 1H-indazole-3-carboxamide (AB-FUBINACA);
- 246.23 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
246.24 indazole-3-carboxamide(AB-CHMINACA);
- 246.25 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate
246.26 (5-fluoro-AMB);
- 246.27 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);
- 246.28 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone
246.29 (FUBIMINA);
- 247.1 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
247.2 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);
- 247.3 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
247.4 -1H-indole-3-carboxamide (5-fluoro-ABICA);

- 247.5 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
 247.6 -1H-indole-3-carboxamide;
- 247.7 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
 247.8 -1H-indazole-3-carboxamide;
- 247.9 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate;
- 247.10 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
 247.11 H-indazole-3-carboxamide (MAB-CHMINACA);
- 247.12 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
 247.13 (ADB-PINACA);
- 247.14 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);
- 247.15 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
 247.16 3-carboxamide. (APP-CHMINACA);
- 247.17 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and
- 247.18 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).
- 247.19 (ix) Additional substances specifically named:
- 247.20 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
 247.21 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);
- 247.22 (B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide
 247.23 (4-CN-Cumyl-Butinaca);
- 247.24 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);
- 247.25 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1
 247.26 H-indazole-3-carboxamide (5F-ABPINACA);
- 247.27 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
 247.28 (MDMB CHMICA);
- 247.29 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
 247.30 (5F-ADB; 5F-MDMB-PINACA); and
- 248.1 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
 248.2 1H-indazole-3-carboxamide (ADB-FUBINACA).
- 248.3 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
 248.4 for human consumption.
- 248.5 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
 248.6 committed on or after that date.

- 248.7 Sec. 69. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:
- 248.8 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.
- 248.9 (b) Unless specifically excepted or unless listed in another schedule, any of the following
- 248.10 substances whether produced directly or indirectly by extraction from substances of vegetable
- 248.11 origin or independently by means of chemical synthesis, or by a combination of extraction
- 248.12 and chemical synthesis:
- 248.13 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or
- 248.14 opiate.
- 248.15 (i) Excluding:
- 248.16 (A) apomorphine;
- 248.17 (B) thebaine-derived butorphanol;
- 248.18 (C) dextrophan;
- 248.19 (D) nalbuphine;
- 248.20 (E) nalmeffene;
- 248.21 (F) naloxegol;
- 248.22 (G) naloxone;
- 248.23 (H) naltrexone; and
- 248.24 (I) their respective salts;
- 248.25 (ii) but including the following:
- 248.26 (A) opium, in all forms and extracts;
- 248.27 (B) codeine;
- 248.28 (C) dihydroetorphine;
- 248.29 (D) ethylmorphine;
- 249.1 (E) etorphine hydrochloride;
- 249.2 (F) hydrocodone;
- 249.3 (G) hydromorphone;
- 249.4 (H) metopon;
- 249.5 (I) morphine;
- 249.6 (J) oxycodone;

- 249.7 (K) oxymorphone;
- 249.8 (L) thebaine;
- 249.9 (M) oripavine;
- 249.10 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
- 249.11 or identical with any of the substances referred to in clause (1), except that these substances
- 249.12 shall not include the isoquinoline alkaloids of opium;
- 249.13 (3) opium poppy and poppy straw;
- 249.14 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
- 249.15 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
- 249.16 and derivatives), and any salt, compound, derivative, or preparation thereof which is
- 249.17 chemically equivalent or identical with any of these substances, except that the substances
- 249.18 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
- 249.19 do not contain cocaine or ecgonine;
- 249.20 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
- 249.21 or powder form which contains the phenanthrene alkaloids of the opium poppy).
- 249.22 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
- 249.23 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
- 249.24 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
- 249.25 chemical designation:
- 249.26 (1) alfentanil;
- 249.27 (2) alphaprodine;
- 249.28 (3) anileridine;
- 249.29 (4) bezitramide;
- 249.30 (5) bulk dextropropoxyphene (nondosage forms);
- 250.1 (6) carfentanil;
- 250.2 (7) dihydrocodeine;
- 250.3 (8) dihydromorphinone;
- 250.4 (9) diphenoxylate;
- 250.5 (10) fentanyl;
- 250.6 (11) isomethadone;
- 250.7 (12) levo-alpha-acetylmethadol (LAAM);
- 250.8 (13) levomethorphan;

- 250.9 (14) levorphanol;
- 250.10 (15) metazocine;
- 250.11 (16) methadone;
- 250.12 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;
- 250.13 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
- 250.14 acid;
- 250.15 (19) pethidine;
- 250.16 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;
- 250.17 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;
- 250.18 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;
- 250.19 (23) phenazocine;
- 250.20 (24) piminodine;
- 250.21 (25) racemethorphan;
- 250.22 (26) racemorphan;
- 250.23 (27) remifentanil;
- 250.24 (28) sufentanil;
- 250.25 (29) tapentadol;
- 250.26 (30) 4-Anilino-N-phenethylpiperidine.
- 251.1 (d) Unless specifically excepted or unless listed in another schedule, any material,
- 251.2 compound, mixture, or preparation which contains any quantity of the following substances
- 251.3 having a stimulant effect on the central nervous system:
- 251.4 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
- 251.5 (2) methamphetamine, its salts, isomers, and salts of its isomers;
- 251.6 (3) phenmetrazine and its salts;
- 251.7 (4) methylphenidate;
- 251.8 (5) lisdexamfetamine.
- 251.9 (e) Unless specifically excepted or unless listed in another schedule, any material,
- 251.10 compound, mixture, or preparation which contains any quantity of the following substances
- 251.11 having a depressant effect on the central nervous system, including its salts, isomers, and

- 251.12 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
 251.13 within the specific chemical designation:
- 251.14 (1) amobarbital;
 251.15 (2) glutethimide;
 251.16 (3) secobarbital;
 251.17 (4) pentobarbital;
 251.18 (5) phencyclidine;
 251.19 (6) phencyclidine immediate precursors:
 251.20 (i) 1-phenylcyclohexylamine;
 251.21 (ii) 1-piperidinocyclohexanecarbonitrile;
 251.22 (7) phenylacetone.
 251.23 (f) Cannabis and cannabinoids:
 251.24 (1) nabilone;
 251.25 (2) unless specifically excepted or unless listed in another schedule, any natural material,
 251.26 compound, mixture, or preparation that contains any quantity of the following substances,
 251.27 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
 251.28 the existence of the isomers, esters, ethers, or salts is possible:
- 251.29 (i) marijuana; and
 252.1 (ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the
 252.2 resinous extractives of the plant; and
- 252.3 ~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral
 252.4 solution in a drug product approved for marketing by the United States Food and Drug
 252.5 Administration.
- 252.6 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
 252.7 committed on or after that date.
- 252.8 Sec. 70. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:
- 252.9 Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except
 252.10 as allowed under section 152.29, no person may dispense a controlled substance included
 252.11 in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a
 252.12 doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a
 252.13 doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully
 252.14 licensed to prescribe in this state or by a practitioner licensed to prescribe controlled
 252.15 substances by the state in which the prescription is issued, and having a current federal Drug

252.16 Enforcement Administration registration number. The prescription must either be printed
 252.17 or written in ink and contain the handwritten signature of the prescriber or be transmitted
 252.18 electronically or by facsimile as permitted under subdivision 1. Provided that in emergency
 252.19 situations, as authorized by federal law, such drug may be dispensed upon oral prescription
 252.20 reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained
 252.21 in conformity with section 152.101. No prescription for a Schedule II substance may be
 252.22 refilled.

252.23 Sec. 71. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to
 252.24 read:

252.25 Subd. 5. **Exception.** References in this section to Schedule II controlled substances do
 252.26 not extend to marijuana or tetrahydrocannabinols.

252.27 Sec. 72. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to
 252.28 read:

252.29 Subd. 6. **Exception.** References in this section to Schedule II controlled substances do
 252.30 not extend to marijuana or tetrahydrocannabinols.

253.1 Sec. 73. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

253.2 Subd. 3. **Limits on applicability.** This section does not apply to:

253.3 (1) a physician's treatment of an individual for chemical dependency resulting from the
 253.4 use of controlled substances in Schedules II to V of section 152.02;

253.5 (2) the prescription or administration of controlled substances in Schedules II to V of
 253.6 section 152.02 to an individual whom the physician knows to be using the controlled
 253.7 substances for nontherapeutic purposes;

253.8 (3) the prescription or administration of controlled substances in Schedules II to V of
 253.9 section 152.02 for the purpose of terminating the life of an individual having intractable
 253.10 pain; ~~or~~

253.11 (4) the prescription or administration of a controlled substance in Schedules II to V of
 253.12 section 152.02 that is not a controlled substance approved by the United States Food and
 253.13 Drug Administration for pain relief; or

253.14 (5) the administration of medical cannabis under sections 152.22 to 152.37.

253.15 Sec. 74. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
 253.16 read:

253.17 Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by
 253.18 the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

253.19 Sec. 75. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

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

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

253.24 (2) pill;

253.25 (3) vaporized delivery method with use of liquid or oil but which does not require the

253.26 use of dried leaves or plant form; or;

253.27 (4) combustion with use of dried raw cannabis; or

253.28 ~~(4)~~ (5) any other method, ~~excluding smoking,~~ approved by the commissioner.

253.29 (b) This definition includes any part of the genus cannabis plant prior to being processed
253.30 into a form allowed under paragraph (a), that is possessed by a person while that person is
254.1 engaged in employment duties necessary to carry out a requirement under sections 152.22
254.2 to 152.37 for a registered manufacturer or a laboratory under contract with a registered
254.3 manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp
254.4 grower as permitted under section 152.29, subdivision 1, paragraph (b).

254.5 **EFFECTIVE DATE.** This section is effective the earlier of (1) March 1, 2022, or (2)
254.6 a date, as determined by the commissioner of health, by which (i) the rules adopted or
254.7 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
254.8 independent laboratories under contract with the manufacturers have the necessary procedures
254.9 and equipment in place to perform the required testing of dried raw cannabis. If this section
254.10 is effective before March 1, 2022, the commissioner shall provide notice of that effective
254.11 date to the public.

254.12 Sec. 76. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

254.13 Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means
254.14 a person who:

254.15 (1) is at least 18 years old;

254.16 (2) does not have a conviction for a disqualifying felony offense;

254.17 (3) has been approved by the commissioner to assist a patient who ~~has been identified~~
254.18 ~~by a health care practitioner as developmentally or physically disabled and therefore requires~~
254.19 assistance in administering medical cannabis or obtaining medical cannabis from a
254.20 distribution facility ~~due to the disability;~~ and

254.21 (4) is authorized by the commissioner to assist the patient with the use of medical
254.22 cannabis.

254.23 Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
 254.24 read:

254.25 Subd. 13a. **Tribal medical cannabis program.** "Tribal medical cannabis program"
 254.26 means a medical cannabis program operated by a federally recognized Indian Tribe located
 254.27 within the state that has been recognized by the commissioner of health in accordance with
 254.28 section 152.25, subdivision 5.

255.1 Sec. 78. Minnesota Statutes 2020, section 152.23, is amended to read:

255.2 **152.23 LIMITATIONS.**

255.3 (a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not
 255.4 prevent the imposition of any civil, criminal, or other penalties for:

255.5 (1) undertaking any task under the influence of medical cannabis that would constitute
 255.6 negligence or professional malpractice;

255.7 (2) possessing or engaging in the use of medical cannabis:

255.8 (i) on a school bus or van;

255.9 (ii) on the grounds of any preschool or primary or secondary school;

255.10 (iii) in any correctional facility; or

255.11 (iv) on the grounds of any child care facility or home day care;

255.12 (3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision
 255.13 6;

255.14 (i) on any form of public transportation;

255.15 (ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke
 255.16 would be inhaled by a minor child; or

255.17 (iii) in any public place, including any indoor or outdoor area used by or open to the
 255.18 general public or a place of employment as defined under section 144.413, subdivision 1b;
 255.19 and

255.20 (4) operating, navigating, or being in actual physical control of any motor vehicle,
 255.21 aircraft, train, or motorboat, or working on transportation property, equipment, or facilities
 255.22 while under the influence of medical cannabis.

255.23 (b) Nothing in sections 152.22 to 152.37 require the medical assistance and
 255.24 MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with
 255.25 the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide
 255.26 coverage for all services related to treatment of an enrollee's qualifying medical condition
 255.27 if the service is covered under chapter 256B or 256L.

256.1 Sec. 79. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
 256.2 read:

256.3 Subd. 5. **Tribal medical cannabis programs.** Upon the request of an Indian Tribe
 256.4 operating a Tribal medical cannabis program, the commissioner shall determine if the
 256.5 standards for the Tribal medical cannabis program meet or exceed the standards required
 256.6 under sections 152.22 to 152.37 in terms of qualifying for the medical cannabis program,
 256.7 allowable forms of medical cannabis, production and distribution requirements, product
 256.8 safety and testing, and security measures. If the commissioner determines that the Tribal
 256.9 medical cannabis program meets or exceeds the standards in sections 152.22 to 152.37, the
 256.10 commissioner shall recognize the Tribal medical cannabis program and shall post the Tribal
 256.11 medical cannabis programs that have been recognized by the commissioner on the
 256.12 Department of Health's website.

256.13 Sec. 80. Minnesota Statutes 2020, section 152.26, is amended to read:

256.14 **152.26 RULEMAKING.**

256.15 (a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules
 256.16 for which notice is published in the State Register before January 1, 2015, may be adopted
 256.17 using the process in section 14.389.

256.18 (b) The commissioner may adopt or amend rules, using the procedure in section 14.386,
 256.19 paragraph (a), to implement the addition of dried raw cannabis as an allowable form of
 256.20 medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section
 256.21 14.386, paragraph (b), does not apply to these rules.

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

256.23 Sec. 81. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

256.24 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
 256.25 for enrollment into the registry program. The application shall be available to the patient
 256.26 and given to health care practitioners in the state who are eligible to serve as health care
 256.27 practitioners. The application must include:

256.28 (1) the name, mailing address, and date of birth of the patient;

256.29 (2) the name, mailing address, and telephone number of the patient's health care
 256.30 practitioner;

257.1 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
 257.2 any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse
 257.3 will be acting as a caregiver;

257.4 (4) a copy of the certification from the patient's health care practitioner that is dated
 257.5 within 90 days prior to submitting the application ~~which that certifies that the patient has~~
 257.6 ~~been diagnosed with a qualifying medical condition and, if applicable, that, in the health~~

257.7 ~~care practitioner's medical opinion, the patient is developmentally or physically disabled~~
 257.8 ~~and, as a result of that disability, the patient requires assistance in administering medical~~
 257.9 ~~cannabis or obtaining medical cannabis from a distribution facility; and~~

257.10 (5) all other signed affidavits and enrollment forms required by the commissioner under
 257.11 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
 257.12 paragraph (c).

257.13 (b) The commissioner shall require a patient to resubmit a copy of the certification from
 257.14 the patient's health care practitioner on a yearly basis and shall require that the recertification
 257.15 be dated within 90 days of submission.

257.16 (c) The commissioner shall develop a disclosure form and require, as a condition of
 257.17 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

257.18 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
 257.19 employee of any state agency, may not be held civilly or criminally liable for any injury,
 257.20 loss of property, personal injury, or death caused by any act or omission while acting within
 257.21 the scope of office or employment under sections 152.22 to 152.37; and

257.22 (2) the patient's acknowledgment that enrollment in the patient registry program is
 257.23 conditional on the patient's agreement to meet all of the requirements of sections 152.22 to
 257.24 152.37.

257.25 Sec. 82. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

257.26 Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a
 257.27 designated caregiver for a patient if ~~the patient's health care practitioner has certified that~~
 257.28 ~~the patient, in the health care practitioner's medical opinion, is developmentally or physically~~
 257.29 ~~disabled and, as a result of that disability, the patient requires assistance in administering~~
 257.30 ~~medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver~~
 257.31 ~~has agreed, in writing, to be the patient's designated caregiver. As a condition of registration~~
 257.32 ~~as a designated caregiver, the commissioner shall require the person to:~~

257.33 (1) be at least 18 years of age;

258.1 (2) agree to only possess the patient's medical cannabis for purposes of assisting the
 258.2 patient; and

258.3 (3) agree that if the application is approved, the person will not be a registered designated
 258.4 caregiver for more than ~~one patient, unless the six registered patients at one time. Patients~~
 258.5 ~~who reside in the same residence shall count as one patient.~~

258.6 (b) The commissioner shall conduct a criminal background check on the designated
 258.7 caregiver prior to registration to ensure that the person does not have a conviction for a
 258.8 disqualifying felony offense. Any cost of the background check shall be paid by the person
 258.9 seeking registration as a designated caregiver. A designated caregiver must have the criminal
 258.10 background check renewed every two years.

258.11 (c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered
 258.12 as a designated caregiver from also being enrolled in the registry program as a patient and
 258.13 possessing and using medical cannabis as a patient.

258.14 Sec. 83. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

258.15 Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees,
 258.16 and signed disclosure, the commissioner shall enroll the patient in the registry program and
 258.17 issue the patient and patient's registered designated caregiver or parent, legal guardian, or
 258.18 spouse, if applicable, a registry verification. The commissioner shall approve or deny a
 258.19 patient's application for participation in the registry program within 30 days after the
 258.20 commissioner receives the patient's application and application fee. ~~The commissioner may~~
 258.21 ~~approve applications up to 60 days after the receipt of a patient's application and application~~
 258.22 ~~fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be
 258.23 denied if the patient:

258.24 (1) does not have certification from a health care practitioner that the patient has been
 258.25 diagnosed with a qualifying medical condition;

258.26 (2) has not signed and returned the disclosure form required under subdivision 3,
 258.27 paragraph (c), to the commissioner;

258.28 (3) does not provide the information required; or

258.29 ~~(4) has previously been removed from the registry program for violations of section~~
 258.30 ~~152.30 or 152.33; or~~

258.31 ~~(5) (4) provides false information.~~

259.1 (b) The commissioner shall give written notice to a patient of the reason for denying
 259.2 enrollment in the registry program.

259.3 (c) Denial of enrollment into the registry program is considered a final decision of the
 259.4 commissioner and is subject to judicial review under the Administrative Procedure Act
 259.5 pursuant to chapter 14.

259.6 (d) A patient's enrollment in the registry program may only be revoked upon the death
 259.7 of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a
 259.8 patient's enrollment in the registry program has been revoked due to a violation of section
 259.9 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the
 259.10 patient's enrollment was revoked. The commissioner shall process the application in
 259.11 accordance with this section.

259.12 (e) The commissioner shall develop a registry verification to provide to the patient, the
 259.13 health care practitioner identified in the patient's application, and to the manufacturer. The
 259.14 registry verification shall include:

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

259.16 (2) the patient registry number assigned to the patient; and

259.17 (3) the name and date of birth of the patient's registered designated caregiver, if any, or

259.18 the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or

259.19 spouse will be acting as a caregiver.

259.20 (f) The commissioner shall not deny a patient's application for participation in the registry

259.21 program or revoke a patient's enrollment in the registry program solely because the patient

259.22 is also enrolled in a Tribal medical cannabis program.

259.23 Sec. 84. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

259.24 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in

259.25 the registry program, a health care practitioner shall:

259.26 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers

259.27 from a qualifying medical condition, and, if so determined, provide the patient with a

259.28 certification of that diagnosis;

259.29 (2) determine whether a patient is developmentally or physically disabled and, as a result

259.30 of that disability, the patient requires assistance in administering medical cannabis or

259.31 obtaining medical cannabis from a distribution facility, and, if so determined, include that

259.32 determination on the patient's certification of diagnosis;

260.1 (3) advise patients, registered designated caregivers, and parents, legal guardians, or

260.2 spouses who are acting as caregivers of the existence of any nonprofit patient support groups

260.3 or organizations;

260.4 (4) (3) provide explanatory information from the commissioner to patients with qualifying

260.5 medical conditions, including disclosure to all patients about the experimental nature of

260.6 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the

260.7 proposed treatment; the application and other materials from the commissioner; and provide

260.8 patients with the Tennessen warning as required by section 13.04, subdivision 2; and

260.9 (5) (4) agree to continue treatment of the patient's qualifying medical condition and

260.10 report medical findings to the commissioner.

260.11 (b) Upon notification from the commissioner of the patient's enrollment in the registry

260.12 program, the health care practitioner shall:

260.13 (1) participate in the patient registry reporting system under the guidance and supervision

260.14 of the commissioner;

260.15 (2) report health records of the patient throughout the ongoing treatment of the patient

260.16 to the commissioner in a manner determined by the commissioner and in accordance with

260.17 subdivision 2;

260.18 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying

260.19 medical condition and, if so, issue the patient a new certification of that diagnosis; and

- 260.20 (4) otherwise comply with all requirements developed by the commissioner.
- 260.21 (c) A health care practitioner may conduct a patient assessment to issue a recertification
- 260.22 as required under paragraph (b), clause (3), via telemedicine as defined under section
- 260.23 62A.671, subdivision 9.
- 260.24 (d) Nothing in this section requires a health care practitioner to participate in the registry
- 260.25 program.
- 260.26 Sec. 85. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:
- 260.27 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight
- 260.28 distribution facilities, which may include the manufacturer's single location for cultivation,
- 260.29 harvesting, manufacturing, packaging, and processing but is not required to include that
- 260.30 location. The commissioner shall designate the geographical service areas to be served by
- 260.31 each manufacturer based on geographical need throughout the state to improve patient
- 260.32 access. A manufacturer shall not have more than two distribution facilities in each
- 261.1 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
- 261.2 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
- 261.3 and processing of medical cannabis shall be conducted. This location may be one of the
- 261.4 manufacturer's distribution facility sites. The additional distribution facilities may dispense
- 261.5 medical cannabis and medical cannabis products but may not contain any medical cannabis
- 261.6 in a form other than those forms allowed under section 152.22, subdivision 6, and the
- 261.7 manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or
- 261.8 processing at the other distribution facility sites. Any distribution facility operated by the
- 261.9 manufacturer is subject to all of the requirements applying to the manufacturer under sections
- 261.10 152.22 to 152.37, including, but not limited to, security and distribution requirements.
- 261.11 (b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may
- 261.12 acquire hemp products produced by a hemp processor. A manufacturer may manufacture
- 261.13 or process hemp and hemp products into an allowable form of medical cannabis under
- 261.14 section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under
- 261.15 this paragraph ~~is~~ are subject to the same quality control program, security and testing
- 261.16 requirements, and other requirements that apply to medical cannabis under sections 152.22
- 261.17 to 152.37 and Minnesota Rules, chapter 4770.
- 261.18 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
- 261.19 commissioner, subject to any additional requirements set by the commissioner, for purposes
- 261.20 of testing medical cannabis manufactured or hemp or hemp products acquired by the medical
- 261.21 cannabis manufacturer as to content, contamination, and consistency to verify the medical
- 261.22 cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory
- 261.23 testing shall be paid by the manufacturer.
- 261.24 (d) The operating documents of a manufacturer must include:
- 261.25 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
- 261.26 record keeping;

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

261.30 (3) procedures for the delivery and transportation of hemp between hemp growers and
 261.31 manufacturers and for the delivery and transportation of hemp products between hemp
 261.32 processors and manufacturers.

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

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

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

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

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

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

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

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

262.26 (m) Before a manufacturer acquires hemp from a hemp grower or hemp products from
 262.27 a hemp processor, the manufacturer must verify that the hemp grower or hemp processor
 262.28 has a valid license issued by the commissioner of agriculture under chapter 18K.

262.29 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
 262.30 medical cannabis plant from cultivation through testing and point of sale, the commissioner
 262.31 shall conduct at least one unannounced inspection per year of each manufacturer that includes
 262.32 inspection of:

262.33 (1) business operations;

263.1 (2) physical locations of the manufacturer's manufacturing facility and distribution
 263.2 facilities;

263.3 (3) financial information and inventory documentation, including laboratory testing
 263.4 results; and

263.5 (4) physical and electronic security alarm systems.

263.6 Sec. 86. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

263.7 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
 263.8 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
 263.9 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
 263.10 cannabis or medical cannabis products that have been cultivated, harvested, manufactured,
 263.11 packaged, and processed by that manufacturer to another registered manufacturer for the
 263.12 other manufacturer to distribute.

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

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

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

263.18 (2) verify that the person requesting the distribution of medical cannabis is the patient,
 263.19 the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse
 263.20 listed in the registry verification using the procedures described in section 152.11, subdivision
 263.21 2d;

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

263.23 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
 263.24 chapter 151 has consulted with the patient to determine the proper dosage for the individual
 263.25 patient after reviewing the ranges of chemical compositions of the medical cannabis and
 263.26 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
 263.27 consultation may be conducted remotely using a by secure videoconference, telephone, or
 263.28 other remote means, so long as the employee providing the consultation is able to confirm
 263.29 the identity of the patient, the consultation occurs while the patient is at a distribution facility,
 263.30 and the consultation adheres to patient privacy requirements that apply to health care services
 263.31 delivered through telemedicine. A pharmacist consultation under this clause is not required

263.32 when a manufacturer is distributing medical cannabis to a patient according to a
 264.1 patient-specific dosage plan established with that manufacturer and is not modifying the
 264.2 dosage or product being distributed under that plan and the medical cannabis is distributed
 264.3 by a pharmacy technician;

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

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

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

264.11 (iii) the patient's registry identification number;

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

264.13 (v) the dosage; and

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

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

264.20 (e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only
 264.21 to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian,
 264.22 or spouse of a patient age 21 or older.

264.23 **EFFECTIVE DATE.** Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2)
 264.24 a date, as determined by the commissioner of health, by which (i) the rules adopted or
 264.25 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
 264.26 independent laboratories under contract with the manufacturers have the necessary procedures
 264.27 and equipment in place to perform the required testing of dried raw cannabis. If this section
 264.28 is effective before March 1, 2022, the commissioner shall provide notice of that effective
 264.29 date to the public.

265.1 Sec. 87. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
 265.2 read:

265.3 Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute
 265.4 medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or
 265.5 spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

265.6 (1) distribution facility staff receive payment and distribute medical cannabis in a
 265.7 designated zone that is as close as feasible to the front door of the distribution facility;

265.8 (2) the manufacturer ensures that the receipt of payment and distribution of medical
 265.9 cannabis are visually recorded by a closed-circuit television surveillance camera at the
 265.10 distribution facility and provides any other necessary security safeguards;

265.11 (3) the manufacturer does not store medical cannabis outside a restricted access area at
 265.12 the distribution facility, and distribution facility staff transport medical cannabis from a
 265.13 restricted access area at the distribution facility to the designated zone for distribution only
 265.14 after confirming that the patient, designated caregiver, or parent, guardian, or spouse has
 265.15 arrived in the designated zone;

265.16 (4) the payment and distribution of medical cannabis take place only after a pharmacist
 265.17 consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

265.18 (5) immediately following distribution of medical cannabis, distribution facility staff
 265.19 enter the transaction in the state medical cannabis registry information technology database;
 265.20 and

265.21 (6) immediately following distribution of medical cannabis, distribution facility staff
 265.22 take the payment received into the distribution facility.

265.23 Sec. 88. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
 265.24 read:

265.25 Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota
 265.26 Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls
 265.27 of medical cannabis plants or incorporate them with a greater quantity of nonconsumable
 265.28 solid waste before transporting root balls to another location for disposal. For purposes of
 265.29 this subdivision, "root ball" means a compact mass of roots formed by a plant and any
 265.30 attached growing medium.

266.1 Sec. 89. Minnesota Statutes 2020, section 152.31, is amended to read:

266.2 **152.31 DATA PRACTICES.**

266.3 (a) Government data in patient files maintained by the commissioner and the health care
 266.4 practitioner, and data submitted to or by a medical cannabis manufacturer, are private data
 266.5 on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in
 266.6 section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13
 266.7 and complying with a request from the legislative auditor or the state auditor in the
 266.8 performance of official duties. The provisions of section 13.05, subdivision 11, apply to a
 266.9 registration agreement entered between the commissioner and a medical cannabis
 266.10 manufacturer under section 152.25.

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

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

266.17 Sec. 90. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

266.18 Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
 266.19 lease to and may not otherwise penalize a person solely for the person's status as a patient
 266.20 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
 266.21 would violate federal law or regulations or cause the school or landlord to lose a monetary
 266.22 or licensing-related benefit under federal law or regulations.

266.23 (b) For the purposes of medical care, including organ transplants, a registry program
 266.24 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
 266.25 equivalent of the authorized use of any other medication used at the discretion of a physician
 266.26 or advanced practice registered nurse and does not constitute the use of an illicit substance
 266.27 or otherwise disqualify a patient from needed medical care.

266.28 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
 266.29 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
 266.30 may not discriminate against a person in hiring, termination, or any term or condition of
 266.31 employment, or otherwise penalize a person, if the discrimination is based upon either of
 266.32 the following:

267.1 (1) the person's status as a patient enrolled in the registry program under sections 152.22
 267.2 to 152.37; or

267.3 (2) a patient's positive drug test for cannabis components or metabolites, unless the
 267.4 patient used, possessed, or was impaired by medical cannabis on the premises of the place
 267.5 of employment or during the hours of employment.

267.6 (d) An employee who is required to undergo employer drug testing pursuant to section
 267.7 181.953 may present verification of enrollment in the patient registry as part of the employee's
 267.8 explanation under section 181.953, subdivision 6.

267.9 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
 267.10 time with a minor child solely based on the person's status as a patient enrolled in the registry
 267.11 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
 267.12 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
 267.13 behavior is such that it creates an unreasonable danger to the safety of the minor as
 267.14 established by clear and convincing evidence.

267.15 (f) This subdivision applies to any person enrolled in a Tribal medical cannabis program
267.16 to the same extent as if the person was enrolled in the registry program under sections 152.22
267.17 to 152.37.

108.24 Sec. 32. Minnesota Statutes 2020, section 157.22, is amended to read:

108.25 **157.22 EXEMPTIONS.**

108.26 This chapter does not apply to:

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

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

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

109.3 (4) any person, firm, or corporation whose principal mode of business is licensed under
109.4 sections 28A.04 and 28A.05, is exempt at that premises from licensure as a food or beverage
109.5 establishment; provided that the holding of any license pursuant to sections 28A.04 and
109.6 28A.05 shall not exempt any person, firm, or corporation from the applicable provisions of
109.7 this chapter or the rules of the state commissioner of health relating to food and beverage
109.8 service establishments;

109.9 (5) family day care homes and group family day care homes governed by sections
109.10 245A.01 to 245A.16;

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

109.12 (7) fraternal, sportsman, or patriotic organizations that are tax exempt under section
109.13 501(c)(3), 501(c)(4), 501(c)(6), 501(c)(7), 501(c)(10), or 501(c)(19) of the Internal Revenue
109.14 Code of 1986, or organizations related to, affiliated with, or supported by such fraternal,
109.15 sportsman, or patriotic organizations for events held in the building or on the grounds of
109.16 the organization and at which home-prepared food is donated by organization members for
109.17 sale at the events, provided:

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

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

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

109.22 (8) food not prepared at an establishment and brought in by individuals attending a
109.23 potluck event for consumption at the potluck event. An organization sponsoring a potluck
109.24 event under this clause may advertise the potluck event to the public through any means.

- 109.25 Individuals who are not members of an organization sponsoring a potluck event under this
 109.26 clause may attend the potluck event and consume the food at the event. Licensed food
 109.27 establishments other than schools cannot be sponsors of potluck events. A school may
 109.28 sponsor and hold potluck events in areas of the school other than the school's kitchen,
 109.29 provided that the school's kitchen is not used in any manner for the potluck event. For
 109.30 purposes of this clause, "school" means a public school as defined in section 120A.05,
 109.31 subdivisions 9, 11, 13, and 17, or a nonpublic school, church, or religious organization at
 109.32 which a child is provided with instruction in compliance with sections 120A.22 and 120A.24.
 109.33 Potluck event food shall not be brought into a licensed food establishment kitchen;
- 110.1 (9) a home school in which a child is provided instruction at home;
- 110.2 (10) school concession stands serving commercially prepared, nonpotentially hazardous
 110.3 foods, as defined in Minnesota Rules, chapter 4626;
- 110.4 (11) group residential facilities of ten or fewer beds licensed by the commissioner of
 110.5 human services under Minnesota Rules, chapter 2960, provided the facility employs or
 110.6 contracts with a certified food manager under Minnesota Rules, part 4626.2015;
- 110.7 (12) food served at fund-raisers or community events, including fellowship meals,
 110.8 conducted in the building or on the grounds of a faith-based organization, or made available
 110.9 for curbside pickup or for delivery to members of the faith-based organization or the
 110.10 community in which the faith-based organization serves, provided that a certified food
 110.11 manager, or a volunteer trained in a food safety course, trains the food preparation workers
 110.12 in safe food handling practices. This exemption does not apply to faith-based organizations
 110.13 at the state agricultural society or county fairs or to faith-based organizations that choose
 110.14 to apply for a license;
- 110.15 (13) food service events conducted following a disaster for purposes of feeding disaster
 110.16 relief staff and volunteers serving commercially prepared, nonpotentially hazardous foods,
 110.17 as defined in Minnesota Rules, chapter 4626;
- 110.18 (14) chili or soup served at a chili or soup cook-off fund-raiser conducted by a
 110.19 community-based nonprofit organization, provided:
- 110.20 (i) the municipality where the event is located approves the event;
- 110.21 (ii) the sponsoring organization must develop food safety rules and ensure that participants
 110.22 follow these rules; and
- 110.23 (iii) if the food is not prepared in a kitchen that is licensed or inspected, a visible sign
 110.24 or placard must be posted that states: "These products are homemade and not subject to
 110.25 state inspection."
- 110.26 Foods exempt under this clause must be labeled to accurately reflect the name and
 110.27 address of the person preparing the foods; and
- 110.28 (15) a special event food stand or a seasonal temporary food stand provided;

267.18 Sec. 91. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to
 267.19 read:

267.20 Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in
 267.21 section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain
 267.22 a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

267.23 (b) An applicant under this subdivision must:

267.24 (1) provide the applicant's full name, date of birth, and sex;

267.25 (2) provide the applicant's height in feet and inches, weight in pounds, and eye color;

267.26 (3) submit a certified copy of a birth certificate issued by a government bureau of vital
 267.27 statistics or equivalent agency in the applicant's state of birth, which must bear the raised
 267.28 or authorized seal of the issuing government entity; and

267.29 (4) submit a statement verifying that the applicant is a homeless youth who resides in
 267.30 Minnesota that is signed by:

268.1 (i) an employee of a human services agency receiving public funding to provide services
 268.2 to homeless youth, runaway youth, youth with mental illness, or youth with substance use
 268.3 disorders; or

268.4 (ii) staff at a school who provide services to homeless youth or a school social worker.

268.5 (c) For a noncompliant identification card under this subdivision:

268.6 (1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06,
 268.7 subdivision 2; and

268.8 (2) a driver's license agent must not impose a filing fee under section 171.061, subdivision
 268.9 4.

268.10 (d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply
 268.11 for an identification card under this subdivision.

268.12 **EFFECTIVE DATE.** This section is effective the day following final enactment for
 268.13 application and issuance of Minnesota identification cards on and after January 1, 2022.

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

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

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

268.14 Sec. 92. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:

268.15 Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the
 268.16 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
 268.17 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
 268.18 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
 268.19 256L, child care assistance programs, and emergency assistance programs under section
 268.20 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
 268.21 (1) to (5):

268.22 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
 268.23 willfully false statement or representation, by intentional concealment of any material fact,
 268.24 or by impersonation or other fraudulent device, assistance or the continued receipt of
 268.25 assistance, to include child care assistance or ~~vouchers~~ food benefits produced according
 268.26 to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365,
 268.27 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater
 268.28 than that to which the person is entitled;

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

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

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

269.8 Sec. 93. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

269.9 Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after
 269.10 federal approval, whichever is later, medical assistance covers lead risk assessments provided
 269.11 by a lead risk assessor who is licensed by the commissioner of health under section 144.9505
 269.12 and employed by an assessing agency as defined in section 144.9501. Medical assistance
 269.13 covers a onetime on-site investigation of a recipient's home or primary residence to determine
 269.14 the existence of lead so long as the recipient is under the age of 21 and has a venous blood
 269.15 lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

269.16 (b) Medical assistance reimbursement covers the lead risk assessor's time to complete
 269.17 the following activities:

269.18 (1) gathering samples;

269.19 (2) interviewing family members;

269.20 (3) gathering data, including meter readings; and

269.21 (4) providing a report with the results of the investigation and options for reducing
269.22 lead-based paint hazards.

269.23 Medical assistance coverage of lead risk assessment does not include testing of
269.24 environmental substances such as water, paint, or soil or any other laboratory services.
269.25 Medical assistance coverage of lead risk assessments is not included in the capitated services
269.26 for children enrolled in health plans through the prepaid medical assistance program and
269.27 the MinnesotaCare program.

269.28 (c) Payment for lead risk assessment must be cost-based and must meet the criteria for
269.29 federal financial participation under the Medicaid program. The rate must be based on
269.30 allowable expenditures from cost information gathered. Under section 144.9507, subdivision
269.31 5, federal medical assistance funds may not replace existing funding for lead-related activities.
269.32 The nonfederal share of costs for services provided under this subdivision must be from
270.1 state or local funds and is the responsibility of the agency providing the risk assessment.
270.2 When the risk assessment is conducted by the commissioner of health, the state share must
270.3 be from appropriations to the commissioner of health for this purpose. Eligible expenditures
270.4 for the nonfederal share of costs may not be made from federal funds or funds used to match
270.5 other federal funds. Any federal disallowances are the responsibility of the agency providing
270.6 risk assessment services.

270.7 Sec. 94. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

270.8 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,
270.9 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260
270.10 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable
270.11 asbestos-containing material on other facility components, or, if linear feet or square feet
270.12 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or
270.13 off all facility components in one facility. In the case of single or multifamily residences,
270.14 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than
270.15 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater
270.16 than six but less than 160 square feet of friable asbestos-containing material on other facility
270.17 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot
270.18 but less than 35 cubic feet of friable asbestos-containing material on or off all facility
270.19 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~
270.20 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~
270.21 ~~single family residences and buildings with no more than four dwelling units.~~
270.22 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,
270.23 or encapsulation operations; and an air quality monitoring specified in rule to assure that
270.24 the abatement and adjacent areas are not contaminated with asbestos fibers during the project
270.25 and after completion.

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

111.4 Sec. 33. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

111.5 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,
111.6 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260
111.7 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable
111.8 asbestos-containing material on other facility components, or, if linear feet or square feet
111.9 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or
111.10 off all facility components in one facility. In the case of single or multifamily residences,
111.11 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than
111.12 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater
111.13 than six but less than 160 square feet of friable asbestos-containing material on other facility
111.14 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot
111.15 but less than 35 cubic feet of friable asbestos-containing material on or off all facility
111.16 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~
111.17 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~
111.18 ~~single family residences and buildings with no more than four dwelling units.~~
111.19 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,
111.20 or encapsulation operations; and an air quality monitoring specified in rule to assure that
111.21 the abatement and adjacent areas are not contaminated with asbestos fibers during the project
111.22 and after completion.

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

270.28 Sec. 95. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

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

271.1 Sec. 96. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

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

271.9 Sec. 97. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

271.10 Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person
271.11 shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs
271.12 of the asbestos-related work. For asbestos-related work performed in single or multifamily
271.13 residences, of greater than ten but less than 260 linear feet of asbestos-containing material
271.14 on pipes, or greater than six but less than 160 square feet of asbestos-containing material
271.15 on other facility components, a person shall pay a project permit fee of \$35 to the
271.16 commissioner.

271.17 Sec. 98. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision
271.18 4, is amended to read:

271.19 Subd. 4. **Housing with services establishment registration; conversion to an assisted**
271.20 **living facility license.** (a) Housing with services establishments registered under chapter
271.21 144D, providing home care services according to chapter 144A to at least one resident, and
271.22 intending to provide assisted living services on or after August 1, 2021, must submit an
271.23 application for an assisted living facility license in accordance with section 144G.12 no
271.24 later than June 1, 2021. The commissioner shall consider the application in accordance with
271.25 section 144G.16 144G.15.

271.26 (b) Notwithstanding the housing with services contract requirements identified in section
271.27 144D.04, any existing housing with services establishment registered under chapter 144D
271.28 that does not intend to convert its registration to an assisted living facility license under this
271.29 chapter must provide written notice to its residents at least 60 days before the expiration of
271.30 its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

271.31 (1) state that the housing with services establishment does not intend to convert to an
271.32 assisted living facility;

272.1 (2) include the date when the housing with services establishment will no longer provide
272.2 housing with services;

111.25 Sec. 34. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

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

111.29 Sec. 35. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

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

112.5 Sec. 36. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

112.6 Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person
112.7 shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs
112.8 of the asbestos-related work. For asbestos-related work performed in single or multifamily
112.9 residences, of greater than ten but less than 260 linear feet of asbestos-containing material
112.10 on pipes, or greater than six but less than 160 square feet of asbestos-containing material
112.11 on other facility components, a person shall pay a project permit fee of \$35 to the
112.12 commissioner.

272.3 (3) include the name, e-mail address, and phone number of the individual associated
 272.4 with the housing with services establishment that the recipient of home care services may
 272.5 contact to discuss the notice;

272.6 (4) include the contact information consisting of the phone number, e-mail address,
 272.7 mailing address, and website for the Office of Ombudsman for Long-Term Care and the
 272.8 Office of Ombudsman for Mental Health and Developmental Disabilities; and

272.9 (5) for residents who receive home and community-based waiver services under section
 272.10 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time
 272.11 that it is provided to the resident.

272.12 (c) A housing with services registrant that obtains an assisted living facility license, but
 272.13 does so under a different business name as a result of reincorporation, and continues to
 272.14 provide services to the recipient, is not subject to the 60-day notice required under paragraph
 272.15 (b). However, the provider must otherwise provide notice to the recipient as required under
 272.16 sections 144D.04 and 144D.045, as applicable, and section 144D.09.

272.17 (d) All registered housing with services establishments providing assisted living under
 272.18 sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility
 272.19 license under this chapter.

272.20 (e) Effective August 1, 2021, any housing with services establishment registered under
 272.21 chapter 144D that has not converted its registration to an assisted living facility license
 272.22 under this chapter is prohibited from providing assisted living services.

272.23 **EFFECTIVE DATE.** This section is effective retroactively from December 17, 2020.

272.24 Sec. 99. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION**
 272.25 **ADVISORY GROUP.**

272.26 The commissioner of health shall appoint an individual who is an expert on vaccine
 272.27 disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than
 272.28

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

273.1 Sec. 100. **REVIEW OF COVID-19 MEASURES.**

273.2 Subdivision 1. **Review.** The commissioner may contract with an independent third-party
 273.3 entity that includes epidemiologists to conduct a review of measures to prevent and control
 273.4 the spread of COVID-19.

273.5 Subd. 2. **Costs.** If this review is performed, the commissioner may contract for the
 273.6 performance of this review using existing resources, including federal funds that are available
 273.7 for or that may be used for this purpose.

273.8 Subd. 3. **Report.** No later than 30 days after completion of the review, the commissioner
 273.9 may provide a report to the chairs and ranking minority members of the legislative

273.10 committees with jurisdiction over health policy and data practices and the Legislative
 273.11 Commission on Data Practices and Personal Data. Results of the review shall be public
 273.12 data. The report shall de-identify any information used in the report. The report may be
 273.13 submitted as required under Minnesota Statutes, section 3.195. Findings from the review
 273.14 may be used to help develop strategies for improving COVID-19 prevention and control
 273.15 measures.

273.16 Sec. 101. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL**
 273.17 **USE OF CANNABIS.**

273.18 By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement
 273.19 Administration's Office of Diversion Control for an exception under Code of Federal
 273.20 Regulations, title 21, section 1307.03, and request formal written acknowledgment that the
 273.21 listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances
 273.22 in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section
 273.23 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota
 273.24 Statutes, sections 152.22 to 152.37. The application shall include the presumption in
 273.25 Minnesota Statutes, section 152.32, subdivision 1.

273.26 Sec. 102. **LEGISLATIVE AUDITOR EXAMINATION OF PATIENT DISCHARGES**
 273.27 **FROM HOSPITALS TO NURSING HOMES.**

273.28 Subdivision 1. **Topic to consider for evaluation.** (a) The Legislative Audit Commission
 273.29 shall consider as a topic for evaluation by the legislative auditor during the next evaluation
 273.30 cycle, an examination of patient discharges from hospitals to nursing homes during the
 273.31 COVID-19 pandemic. If the Legislative Audit Commission chooses this topic for evaluation
 273.32 according to Minnesota Statutes, section 3.97, subdivision 3a, the legislative auditor shall
 273.33 review and analyze at least the following:

274.1 (1) the number of patients discharged from hospitals to nursing homes during the
 274.2 COVID-19 pandemic;

274.3 (2) the effects of these patient discharges on the discharged patients and nursing home
 274.4 residents, including the effect on the numbers of positive COVID-19 cases of nursing home
 274.5 residents and employees whose cases may be traced to discharged patients and on the number
 274.6 of hospitalizations and deaths of nursing home residents due to COVID-19 whose cases
 274.7 may be traced to discharged patients;

274.8 (3) whether these patient discharges occurred in compliance with federal and state agency
 274.9 rules or guidance in effect when the discharges took place, including rules or guidance on
 274.10 testing patients for COVID-19 prior to and following discharge, quarantine following
 274.11 discharge of patients with an unknown COVID-19 infection status at discharge, isolation
 274.12 following discharge of patients infected with COVID-19, and other COVID-19 infection
 274.13 control measures;

274.14 (4) for patient discharges that did not comply with federal and state agency rules or
 274.15 guidance, the effect of failing to comply with such rules or guidance, including the effect

274.16 on the health of patients discharged to nursing homes and on the health of residents of
 274.17 nursing homes to which patients were discharged; and

274.18 (5) the impact of these patient discharges on reimbursement received by hospitals and
 274.19 nursing homes for care provided to these patients.

274.20 (b) If chosen for evaluation, the legislative auditor shall conduct this examination using
 274.21 existing resources, including federal funds that are available for or that may be used for this
 274.22 purpose.

274.23 Subd. 2. **Cooperation.** If this evaluation is conducted, the commissioner of health, the
 274.24 commissioner of human services, hospitals, and nursing homes must cooperate with this
 274.25 examination and must provide the legislative auditor with access to data and records
 274.26 necessary to perform this examination.

274.27 Subd. 3. **Report.** By January 15, 2022, the legislative auditor shall submit a written
 274.28 report on this evaluation according to Minnesota Statutes, section 3.974, if this evaluation
 274.29 is conducted.

274.30 Sec. 103. **MENTAL HEALTH CULTURAL COMMUNITY CONTINUING**
 274.31 **EDUCATION GRANT PROGRAM.**

274.32 The commissioner of health shall develop a grant program, in consultation with the
 274.33 relevant mental health licensing boards, to provide for the continuing education necessary
 275.1 for social workers, marriage and family therapists, psychologists, and professional clinical
 275.2 counselors who are members of communities of color or underrepresented communities,
 275.3 as defined in Minnesota Statutes, section 148E.010, subdivision 20, and who work for
 275.4 community mental health providers, to become supervisors for individuals pursuing licensure
 275.5 in mental health professions.

275.6 Sec. 104. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM**
 275.7 **ALL-PAYER CLAIMS DATABASE.**

275.8 The commissioner of health shall develop recommendations to expand access to data
 275.9 in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional
 275.10 outside entities for public health or research purposes. In the recommendations, the
 275.11 commissioner must address an application process for outside entities to access the data,
 275.12 how the department will exercise ongoing oversight over data use by outside entities,
 275.13 purposes for which the data may be used by outside entities, establishment of a data access
 275.14 committee to advise the department on selecting outside entities that may access the data,
 275.15 and steps outside entities must take to protect data held by those entities from unauthorized
 275.16 use. Following development of these recommendations, an outside entity that accesses data
 275.17 in compliance with these recommendations may publish results that identify hospitals,
 275.18 clinics, and medical practices so long as no individual health professionals are identified
 275.19 and the commissioner finds the data to be accurate, valid, and suitable for publication for
 275.20 such use. The commissioner shall submit these recommendations by December 15, 2021,

275.21 to the chairs and ranking minority members of the legislative committees with jurisdiction
 275.22 over health policy and civil law.

275.23 Sec. 105. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND**
 275.24 **EDUCATION GRANT PROGRAM.**

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

275.30 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
 275.31 for proposal process to community-based, nonprofit organizations that serve ethnic
 275.32 communities and that focus on public health outreach to Black, Indigenous, and people of
 275.33 color communities on the issue of skin lightening products and chemical exposure from
 276.1 these products. Priority in awarding grants shall be given to organizations that have
 276.2 historically provided services to ethnic communities on the skin lightening and chemical
 276.3 exposure issue for the past three years.

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

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

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

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

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

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

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

276.16 (b) The grant application must include:

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

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

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

276.20 Sec. 106. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT**
 276.21 **PROGRAM.**

276.22 Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot
 276.23 program to aid in the reduction of trauma resulting from gun violence and address the root
 276.24 causes of gun violence by making the following resources available to professionals and
 276.25 organizations in health care, public health, mental health, social service, law enforcement,
 276.26 and victim advocacy and other professionals who are most likely to encounter individuals
 276.27 who have been victims, witnesses, or perpetrators of gun violence occurring in a community,
 276.28 or in a domestic or other setting:

276.29 (1) training on recognizing trauma as both a result and a cause of gun violence;

276.30 (2) developing skills to address the effects of trauma on individuals and family members;

277.1 (3) investments in community-based organizations to enable high-quality, targeted
 277.2 services to individuals in need. This may include resources for additional training, hiring
 277.3 of specialized staff needed to address trauma-related issues, management information
 277.4 systems to facilitate data collection, and expansion of existing programming;

277.5 (4) replication and expansion of effective community-based gun violence prevention
 277.6 initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to
 277.7 connect at-risk individuals to mental health services, job readiness programs, and employment
 277.8 opportunities; and

277.9 (5) education campaigns and outreach materials to educate communities, organizations,
 277.10 and the public about the relationship between trauma and gun violence.

277.11 (b) The pilot program shall address the traumatic effects of gun violence exposure using
 277.12 a holistic treatment modality.

277.13 Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from
 277.14 an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop
 277.15 protocols and program guidelines that address resources and training to be used by
 277.16 professionals who encounter individuals who have perpetrated or been impacted by gun
 277.17 violence. Educational, training, and outreach material must be culturally appropriate for the
 277.18 community and provided in multiple languages for those with limited English language
 277.19 proficiency. The materials developed must address necessary responses by local, state, and
 277.20 other governmental entities tasked with addressing gun violence. The protocols must include
 277.21 a method of informing affected communities and local governments representing those
 277.22 communities on effective strategies to target community, domestic, and other forms of gun
 277.23 violence.

277.24 (b) The commissioner may enter into contractual agreements with community-based
 277.25 organizations or experts in the field to perform any of the activities under this section.

277.26 Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the
277.27 progress of the pilot program to the chairs and ranking minority members of the committees
277.28 with jurisdiction over health and public safety.

277.29 Sec. 107. **REVISOR INSTRUCTION.**

277.30 The revisor of statutes shall amend the section headnote for Minnesota Statutes, section
277.31 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE
277.32 MEASUREMENT."

278.1 Sec. 108. **REPEALER.**

278.2 Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1;
278.3 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

112.13 Sec. 37. **DIRECTION TO MODIFY MARRIAGE LICENSE APPLICATIONS.**

112.14 A local registrar or a designee of the county board shall delete from the county's marriage
112.15 license application any space or other manner in which the applicant is required to specify
112.16 the applicant's race.