ARTICLE I

DEPARTMENT OF HEALTH FINANCE

Section 1. [62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.

Subdivision 1. Requirements. (a) Each health provider and health facility shall comply with Division BB, Title I of the Consolidated Appropriations Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted under that act, to the extent that it imposes requirements that apply in this state but are not required under the laws of this state. This section does not require compliance with any provision of the No Surprises Act before January 1, 2022.

(b) For the purposes of this section, "provider" or "facility" means any health care provider or facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject to relevant provisions of the No Surprises Act.

Subd. 2. Compliance and investigations. (a) The commissioner of health shall, to the extent practicable, seek the cooperation of health care providers and facilities in obtaining compliance with this section.

(b) A person who believes a health care provider or facility has not complied with the requirements of the No Surprises Act or this section may file a complaint with the commissioner of health. Complaints filed under this section must be filed in writing, either on paper or electronically. The commissioner may prescribe additional procedures for the filing of complaints.

(c) The commissioner may also conduct compliance reviews to determine whether health care providers and facilities are complying with this section.

(d) The commissioner shall investigate complaints filed under this section. The commissioner may prioritize complaint investigations, compliance reviews, and the collection of any possible civil monetary penalties under paragraph (g), clause (2), based on factors such as repeat complaints or violations, the seriousness of the complaint or violation, and other factors as determined by the commissioner.

(e) The commissioner shall inform the health care provider or facility of the complaint or findings of a compliance review and shall provide an opportunity for the health care provider or facility to submit information the health care provider or facility considers relevant to further review and investigation of the complaint or the findings of the compliance review. The health care provider or facility must submit any such information to the commissioner within 30 days of receipt of notification of a complaint or compliance review under this section.

(f) If, after reviewing any information described in paragraph (e) and the results of any investigation, the commissioner determines that the provider or facility has not violated this
section, the commissioner shall notify the provider or facility as well as any relevant complainant.

(g) If, after reviewing any information described in paragraph (e) and the results of any investigation, the commissioner determines that the provider or facility is in violation of this section, the commissioner shall notify the provider or facility and take the following steps:

(1) in cases of noncompliance with this section, the commissioner shall first attempt to achieve compliance through successful remediation on the part of the noncompliant provider or facility including completion of a corrective action plan or other agreement; and

(2) if, after taking the action in clause (1) compliance has not been achieved, the commissioner of health shall notify the provider or facility that the provider or facility is in violation of this section and that the commissioner is imposing a civil monetary penalty. If the commissioner determines that more than one health care provider or facility was responsible for a violation, the commissioner may impose a civil money penalty against each health care provider or facility. The amount of a civil money penalty shall be up to $100 for each violation, but shall not exceed $25,000 for identical violations during a calendar year; and

(3) no civil money penalty shall be imposed under this section for violations that occur prior to January 1, 2023. Warnings must be issued and any compliance issues must be referred to the federal government for enforcement pursuant to the federal No Surprises Act or other applicable federal laws and regulations.

(h) A health care provider or facility may contest whether the finding of facts constitute a violation of this section according to the contested case proceeding in sections 14.57 to 14.62, subject to appeal according to sections 14.63 to 14.68.

(i) When steps in paragraphs (b) to (h) have been completed as needed, the commissioner shall notify the health care provider or facility and, if the matter arose from a complaint, the complainant regarding the disposition of complaint or compliance review.

(j) Civil money penalties imposed and collected under this subdivision shall be deposited into the general fund and are appropriated to the commissioner of health for the purposes of this section, including the provision of compliance reviews and technical assistance.

(k) Any compliance and investigative action taken by the department under this section shall only include potential violations that occur on or after the effective date of this section.

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

Sec. 2. Minnesota Statutes 2020, section 62Q.021, is amended by adding a subdivision to read:

Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider, and health facility shall comply with Division BB, Title I of the Consolidated Appropriations
Act, 2021, also known as the "No Surprises Act," including any federal regulations adopted under that act, to the extent that it imposes requirements that apply in this state but are not required under the laws of this state. This section does not require compliance with any provision of the No Surprises Act before the effective date provided for that provision in the Consolidated Appropriations Act. The commissioner shall enforce this subdivision.

Sec. 3. Minnesota Statutes 2020, section 62Q.55, subdivision 5, is amended to read:

Subd. 5. Coverage restrictions or limitations. If emergency services are provided by a nonparticipating provider, with or without prior authorization, the health plan company shall not impose coverage restrictions or limitations that are more restrictive than apply to emergency services received from a participating provider. Cost-sharing requirements that apply to emergency services received out-of-network must be the same as the cost-sharing requirements that apply to services received in-network and shall count toward the in-network deductible. All coverage and charges for emergency services must comply with all requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

Sec. 4. Minnesota Statutes 2020, section 62Q.556, is amended to read:

62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

Subdivision 1. Unauthorized provider services. Nonparticipating provider balance billing prohibition. (a) Except as provided in paragraph (c) (b), unauthorized provider services occur when an enrollee receives services:

1. from a nonparticipating provider at a participating hospital or ambulatory surgical center, as described by Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act;

2. (1) due to the unavailability of a participating provider;

3. (ii) by a nonparticipating provider without the enrollee's knowledge;

4. (iii) due to the need for unforeseen services arising at the time the services are being rendered;

5. (2) from a participating provider that sends a specimen taken from the enrollee in the participating provider's practice setting to a nonparticipating laboratory, pathologist, or other medical testing facility;

6. (b) Unauthorized provider services do not include emergency services as defined in section 62Q.55, subdivision 3.

7. (3) from a nonparticipating provider or facility providing emergency services as defined in section 62Q.55, subdivision 3, and other services as described in the requirements of
Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

(b) The services described in paragraph (a), clause clauses (1) and (2), as defined in Division BB, Title I of the Consolidated Appropriations Act, 2021, and any federal regulations adopted under that act, are not unauthorized provider services subject to balance billing if the enrollee gives advance informed consent to the prior to receiving services from the nonparticipating provider acknowledging that the use of a provider, or the services to be rendered, may result in costs not covered by the health plan. The informed consent must comply with all requirements of Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

Subd. 2. Prohibition Cost-sharing requirements and independent dispute resolution.

(a) An enrollee's financial responsibility for the unauthorized nonparticipating provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and coverage limitations, as those applicable to services received by the enrollee from a participating provider. A health plan company must apply any enrollee cost sharing requirements, including co-payments, deductibles, and coinsurance, for unauthorized provider services to the enrollee's annual out-of-pocket limit to the same extent payments to a participating provider would be applied.

(b) A health plan company must attempt to negotiate the reimbursement, less any applicable enrollee cost sharing under paragraph (a), for the unauthorized provider services with the nonparticipating provider. If a health plan company's and nonparticipating provider's attempts to negotiate reimbursement for the health care services do not result in a resolution, the health plan company or provider may elect to refer the matter for binding arbitration, chosen in accordance with paragraph (c). A nondisclosure agreement must be executed by both parties prior to engaging an arbitrator in accordance with this section. The cost of arbitration must be shared equally between the parties and nonparticipating provider. If there is no agreement, either party may initiate open negotiations of disputed amounts. If there is no agreement, either party may initiate the federal independent dispute resolution process pursuant to Division BB, Title I of the Consolidated Appropriations Act, 2021, including any federal regulations adopted under that act.

(c) The commissioner of health, in consultation with the commissioner of the Bureau of Mediation Services, must develop a list of professionals qualified in arbitration, for the purpose of resolving disputes between a health plan company and nonparticipating provider arising from the payment for unauthorized provider services. The commissioner of health shall publish the list on the Department of Health website, and update the list as appropriate.

(d) The arbitrator must consider relevant information, including the health plan company's payments to other nonparticipating providers for the same services, the circumstances and complexity of the particular case, and the usual and customary rate for the service based on information available in a database in a national, independent, not-for-profit corporation.
8.24 and similar fees received by the provider for the same services from other health plans in
8.25 which the provider is nonparticipating, in reaching a decision.
8.26 Subd. 3. Annual data reporting. (a) Beginning April 1, 2023, a health plan company
8.27 must report annually to the commissioner:
8.28 (1) the total number of claims and total billed and paid amount for nonparticipating
8.29 provider services, by service and provider type, submitted to the health plan in the prior
8.30 calendar year; and
8.31 (2) the total number of enrollee complaints received regarding the rights and protections
8.32 established by Division BBI, Title I of the Consolidated Appropriations Act, 2021, including
8.33 any federal regulations adopted under that act, in the prior calendar year.
9.1 (b) The commissioners of commerce and health may develop the form and manner for
9.2 health plan companies to comply with paragraph (a).
9.3 Subd. 4. Enforcement. (a) Any provider or facility, including a health care provider or
9.4 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject
9.5 to relevant provisions of the No Surprises Act is subject to the requirements of this section.
9.6 (b) The commissioner of commerce or health may enforce this section.
9.7 (c) If the commissioner of health has cause to believe that any hospital or facility licensed
9.8 under chapter 144 has violated this section, the commissioner may investigate, examine,
9.9 and otherwise enforce this section pursuant to chapter 144 or may refer the potential violation
9.10 to the relevant licensing board with regulatory authority over the provider.
9.11 (d) If a health-related licensing board has cause to believe that a provider has violated
9.12 this section, it may further investigate and enforce the provisions of this section pursuant
9.13 to chapter 214.
9.14 Sec. 5. Minnesota Statutes 2020, section 62Q.56, subdivision 2, is amended to read:
9.15 Subd. 2. Change in health plans. (a) If an enrollee is subject to a change in health plans,
9.16 the enrollee's new health plan company must provide, upon request, authorization to receive
9.17 services that are otherwise covered under the terms of the new health plan through the
9.18 enrollee's current provider:
9.19 (1) for up to 120 days if the enrollee is engaged in a current course of treatment for one
9.20 or more of the following conditions:
9.21 (i) an acute condition;
9.22 (ii) a life-threatening mental or physical illness;
9.23 (iii) pregnancy beyond the first trimester of pregnancy;
(iv) a physical or mental disability defined as an inability to engage in one or more major
life activities, provided that the disability has lasted or can be expected to last for at least
one year, or can be expected to result in death; or
(v) a disabling or chronic condition that is in an acute phase; or
(2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected
lifetime of 180 days or less.

For all requests for authorization under this paragraph, the health plan company must grant
the request for authorization unless the enrollee does not meet the criteria provided in this
paragraph.

(b) The health plan company shall prepare a written plan that provides a process for
coverage determinations regarding continuity of care of up to 120 days for new enrollees
who request continuity of care with their former provider, if the new enrollee:
(1) is receiving culturally appropriate services and the health plan company does not
have a provider in its preferred provider network with special expertise in the delivery of
those culturally appropriate services within the time and distance requirements of section
62D.124, subdivision 1; or
(2) does not speak English and the health plan company does not have a provider in its
preferred provider network who can communicate with the enrollee, either directly or through
an interpreter, within the time and distance requirements of section 62D.124, subdivision
1.

The written plan must explain the criteria that will be used to determine whether a need for
continuity of care exists and how it will be provided.

(c) This subdivision applies only to group coverage and continuation and conversion
coverage, and applies only to changes in health plans made by the employer.

Sec. 6. Minnesota Statutes 2020, section 62Q.73, subdivision 7, is amended to read:
Subd. 7. Standards of review. (a) For an external review of any issue in an adverse
determination that does not require a medical necessity determination, the external review
must be based on whether the adverse determination was in compliance with the enrollee's
health benefit plan and any applicable state and federal law.
(b) For an external review of any issue in an adverse determination by a health plan
company licensed under chapter 62D that requires a medical necessity determination, the
external review must determine whether the adverse determination was consistent with the
definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.
(c) For an external review of any issue in an adverse determination by a health plan
company, other than a health plan company licensed under chapter 62D, that requires a
medical necessity determination, the external review must determine whether the adverse
determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.

(d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records, the attending physician, advanced practice registered nurse, or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

Sec. 7. Minnesota Statutes 2020, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. Non-claims-based payments. (a) Beginning in 2024, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner all non-claims-based payments made to health care providers. The data shall be submitted in a form, manner, and frequency specified by the commissioner. Non-claims-based payments are payments to health care providers designed to pay for value of health care services over volume of health care services and include alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments. Non-claims-based payments submitted under this subdivision must, to the extent possible, be attributed to a health care provider in the same manner in which claims-based data are attributed to a health care provider and, where appropriate, must be combined with data collected under subdivisions 4 and 5 in analyses of health care spending.

(b) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.

(c) The commissioner shall consult with health plan companies, hospitals, and health care providers in developing the data reported under this subdivision and standardized reporting forms.

Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

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

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;
2 to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

3 to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

4 to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities;

5 to compile one or more public use files of summary data or tables that must:

   (i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

   (ii) not identify individual patients, payers, or providers;

   (iii) be updated by the commissioner, at least annually, with the most current data available;

   (iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

   (v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Sec. 9. Minnesota Statutes 2020, section 62U.10, subdivision 7, is amended to read:

Subd. 7. Outcomes reporting; savings determination. (a) Beginning November 1, 2016, and each November 1 thereafter, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent
calendar year available. The commissioner shall determine the difference between the
projected and actual spending for each health indicator and for each year, and determine
the savings attributable to changes in these health indicators. The assumptions and research
methods used to calculate actual spending must be determined to be appropriate by an
independent actuarial consultant. If the actual spending is less than the projected spending,
the commissioner, in consultation with the commissioners of human services and management
and budget, shall use the proportion of spending for state-administered health care programs
to total private and public health care spending for each health indicator for the calendar
year two years before the current calendar year to determine the percentage of the calculated
aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions
4 and, 5, and 5b, to complete the activities required under this section, but may only report
publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Subd. 17a. Temporary boring. "Temporary boring" means an excavation that is 15 feet or
more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored,
flushed, driven, dug, jetted, or otherwise constructed to:

1. conduct physical, chemical, or biological testing of groundwater, including
   groundwater quality monitoring installed in a water supply well;
2. monitor or measure physical, chemical, radiological, or biological parameters of
   earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or
   resistance utilizes the convective flow of groundwater as the primary medium of heat
   exchange;
3. measure groundwater levels, including use of a piezometer contains potable water
   as the heat transfer fluid; and
4. determine groundwater flow direction or velocity operates using nonconsumptive
   recirculation.

A submerged closed loop heat exchanger also includes submersible pumps, a heat exchanger
device, piping, and other necessary appurtenances.
Sec. 2. Minnesota Statutes 2020, section 103I.005, is amended by adding a subdivision to read:

Subd. 17b. Temporary boring. "Temporary boring" means an excavation that is 15 feet or more in depth, is sealed within 72 hours of the time of construction, and is drilled, cored, washed, driven, dug, jetted, or otherwise constructed to:

(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring;

(2) monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance;

(3) measure groundwater levels, including use of a piezometer; and

(4) determine groundwater flow direction or velocity.

Sec. 3. Minnesota Statutes 2020, section 103I.005, subdivision 20a, is amended to read:

Subd. 20a. Water supply well. "Water supply well" means a well that is not a dewatering well or environmental well and includes wells used:

(1) for potable water supply;

(2) for irrigation;

(3) for agricultural, commercial, or industrial water supply;

(4) for heating or cooling; and

(5) for containing a submerged closed loop heat exchanger; and

(6) for testing water yield for irrigation, commercial or industrial uses, residential supply, or public water supply.

Sec. 4. [103I.631] INSTALLATION OF A SUBMERGED CLOSED LOOP HEAT EXCHANGER.

Subdivision 1. Installation. Notwithstanding any other provision of law, the commissioner must allow the installation of a submerged closed loop heat exchanger in a water supply well. A project may consist of more than one water supply well on a particular site.

Subd. 2. Setbacks. Water supply wells used only for the nonpotable purpose of providing heating and cooling using a submerged closed loop heat exchanger are exempt from isolation distance requirements greater than ten feet.

Subd. 3. Construction. The screened interval of a water supply well constructed to contain a submerged closed loop heat exchanger completed within a single aquifer may be
Sec. 10. [115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND
WASTEWATER TREATMENT FACILITIES.

Subdivision 1. Purpose; membership. The advisory council on water supply systems
and wastewater treatment facilities shall advise the commissioners of health and the Pollution
Control Agency regarding classification of water supply systems and wastewater treatment
facilities, qualifications and competency evaluation of water supply system operators and
wastewater treatment facility operators, and additional laws, rules, and procedures that may
be desirable for regulating the operation of water supply systems and of wastewater treatment
facilities. The advisory council is composed of 11 voting members, of whom:

1(one member must be from the Department of Health, Division of Environmental
Health, appointed by the commissioner of health;

(2) one member must be from the Pollution Control Agency, appointed by the
commissioner of the Pollution Control Agency;

(3) three members must be certified water supply system operators, appointed by the
commissioner of health, one of whom must represent a nonmunicipal community or
nontransient noncommunity water supply system;

(4) three members must be certified wastewater treatment facility operators, appointed
by the commissioner of the Pollution Control Agency;

(5) one member must be a representative from an organization representing municipalities,
appointed by the commissioner of health with the concurrence of the commissioner of the
Pollution Control Agency; and

(6) two members must be members of the public who are not associated with water
supply systems or wastewater treatment facilities. One must be appointed by the
commissioner of health and the other by the commissioner of the Pollution Control Agency.
Consideration should be given to one of these members being a representative of academia
knowledgeable in water or wastewater matters.

Subd. 2. Geographic representation. At least one of the water supply system operators
and at least one of the wastewater treatment facility operators must be from outside the
seven-county metropolitan area, and one wastewater treatment facility operator must be
from the Metropolitan Council.

Subd. 4. Permits. A submerged closed loop heat exchanger is not subject to the permit
requirements in this chapter.

Subd. 5. Variances. A variance is not required to install or operate a submerged closed
loop heat exchanger.
Subd. 3. Terms; compensation. The terms of the appointed members and the compensation and removal of all members are governed by section 15.059.

Subd. 4. Officers. When new members are appointed to the council, a chair must be elected at the next council meeting. The Department of Health representative shall serve as secretary of the council.

Sec. 5. Minnesota Statutes 2020, section 144.057, subdivision 1, is amended to read:

Subdivision 1. Background studies required. (a) Except as specified in paragraph (b), the commissioner of health shall contract with the commissioner of human services to conduct background studies of:

1. individuals providing services that have direct contact, as defined under section 254.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

2. individuals specified in section 254.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

3. all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 254.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

4. individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

5. controlling persons of a supplemental nursing services agency, as defined under section 144A.70; and
(6) license applicants, owners, managerial officials, and controlling individuals who are
required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a
background study under chapter 245C, regardless of the licensure status of the license
applicant, owner, managerial official, or controlling individual.

(b) The commissioner of human services shall not conduct a background study on any
individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license
issued by a health-related licensing board as defined in section 214.01, subdivision 2, and
has completed the criminal background check as required in section 214.075. An entity that
is affiliated with individuals who meet the requirements of this paragraph must separate
those individuals from the entity’s roster for NETStudy 2.0.

(c) If a facility or program is licensed by the Department of Human Services and subject
to the background study provisions of chapter 245C and is also licensed by the Department
of Health, the Department of Human Services is solely responsible for the background
studies of individuals in the jointly licensed programs.

EFFECTIVE DATE. This section is effective the day following final enactment.
(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with disabilities program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals: $7,655 plus $16 per bed
- Non-JCAHO and non-AOA hospitals: $5,280 plus $250 per bed
- Nursing homes: $183 plus $91 per bed until June 30, 2018. $183 plus $100 per bed between July 1, 2018, and June 30, 2020. $183 plus $105 per bed beginning July 1, 2020.

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, supervised living facilities, assisted living facilities, and assisted living facilities with dementia care at the following levels:

- Outpatient surgical centers: $3,712
- Boarding care homes: $183 plus $91 per bed
- Supervised living facilities: $183 plus $91 per bed.
- Assisted living facilities with dementia care: $3,000 plus $100 per resident.
- Assisted living facilities: $2,000 plus $75 per resident.

Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017, or later.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

- Prospective payment surveys for hospitals: $900
- Swing bed surveys for nursing homes: $1,200
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<tr>
<th>Provider Category</th>
<th>Number</th>
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<tbody>
<tr>
<td>Psychiatric hospitals</td>
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<tr>
<td>Rural health facilities</td>
<td>1,100</td>
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<tr>
<td>Portable x-ray providers</td>
<td>500</td>
</tr>
<tr>
<td>Home health agencies</td>
<td>1,800</td>
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<tr>
<td>Outpatient therapy agencies</td>
<td>800</td>
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<tr>
<td>End stage renal dialysis providers</td>
<td>2,100</td>
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<tr>
<td>Independent therapists</td>
<td>800</td>
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<tr>
<td>Comprehensive rehabilitation outpatient facilities</td>
<td>1,200</td>
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<tr>
<td>Hospice providers</td>
<td>1,700</td>
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<tr>
<td>Ambulatory surgical providers</td>
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<td>Hospitals</td>
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<th>Provider Category</th>
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<td>Other provider categories or additional resurveys required to complete initial certification</td>
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These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

Notwithstanding section 16A.1283, the commissioner may adjust the fees assessed on assisted living facilities and assisted living facilities with dementia care under paragraph (d), in a revenue-neutral manner in accordance with the requirements of this paragraph:

1. A facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent lower than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise more than 50 percent of the facility's capacity in the calendar year prior to the year in which the renewal application is submitted; and

2. A facility seeking to renew a license shall pay a renewal fee in an amount that is up to ten percent higher than the applicable fee in paragraph (d) if residents who receive home and community-based waiver services under chapter 256S and section 256B.49 comprise less than 50 percent of the facility's capacity during the calendar year prior to the year in which the renewal application is submitted.
The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a method for determining capacity thresholds in this paragraph in consultation with the commissioner of human services and must coordinate the administration of this paragraph with the commissioner of human services for purposes of verification.

The commissioner shall charge hospitals an annual licensing base fee of $1,150 per hospital, plus an additional $15 per licensed bed/bassinet fee. Revenue shall be deposited to the state government special revenue fund and credited toward trauma hospital designations under sections 144.605 and 144.6071.

Sec. 12. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. Definitions. (a) For purposes of this section, the following definitions apply. (b) "Acupuncture practitioner" means an individual licensed to practice acupuncture under chapter 147B. (c) "Advanced dental therapist" means an individual who is licensed as a dental therapist under section 150A.06, and who is certified as an advanced dental therapist under section 150A.106. (d) "Advanced practice provider" means a nurse practitioner, nurse-midwife, nurse anesthetist, clinical nurse specialist, or physician assistant. (e) "Alcohol and drug counselor" means an individual who is licensed as an alcohol and drug counselor under chapter 148F. (f) "Dental therapist" means an individual who is licensed as a dental therapist under section 150A.06. (g) "Dentist" means an individual who is licensed to practice dentistry. (h) "Designated rural area" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud. (i) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years. (j) "Mental health professional" means an individual providing clinical services in the treatment of mental illness who is qualified in at least one of the ways specified in section 245.462, subdivision 18. (k) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.
"Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

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

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

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

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

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

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

"Public health employee" means an individual working in a local, Tribal, or state public health department.

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

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

"Underserved patient population" means patients who are state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303.

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

Sec. 13. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 2, is amended to read:

Subd. 2. Creation of account. (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:
(1) for medical residents, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or in underserved urban communities, agreeing to provide at least 25 percent of the provider's yearly patient encounters to patients in an underserved patient population, or specializing in the area of pediatric psychiatry;

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

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

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

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

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303, or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(7) for mental health professionals agreeing to provide up to 768 hours per year of clinical supervision in their designated field; and

(8) for public health employees serving in a local, Tribal, or state public health department in an area of high need as determined by the commissioner.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.
Sec. 14. Minnesota Statutes 2021 Supplement, section 144.1501, subdivision 3, is amended to read:

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

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

2. submit an application to the commissioner of health.

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

(c) An applicant selected to participate who is a public health employee is eligible for loan forgiveness within three years after completion of required training. An applicant selected to participate who is a nurse and who agrees to teach according to subdivision 2, paragraph (a), clause (3), must sign a contract to agree to teach for a minimum of two years.

Sec. 15. Minnesota Statutes 2020, section 144.1501, subdivision 4, is amended to read:

Subd. 4. Loan forgiveness. (a) The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. In considering applications from applicants who are mental health professionals, the commissioner shall give preference to applicants who work in rural or culturally specific organizations. In considering applications from all other applicants, the commissioner shall give preference to applicants who document diverse cultural competencies. Except as provided in paragraph (b), the commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities, physicians agreeing to provide at least 25 percent of the physician's yearly patient encounters to patients in an underserved patient population, and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining
funds may be allocated proportionally among the other eligible professions according to
the vacancy rate for each profession in the required geographic area, patient group, or facility
type specified in subdivision 2. Applicants are responsible for securing their own qualified
educational loans. The commissioner shall select participants based on their suitability for
practice serving the required geographic area or facility type specified in subdivision 2, as
indicated by experience or training. The commissioner shall give preference to applicants
closest to completing their training. Except as specified in paragraph (c), for each year that
a participant meets the service obligation required under subdivision 3, up to a maximum
of four years, the commissioner shall make annual disbursements directly to the participant
equivalent to 15 percent of the average educational debt for indebted graduates in their
profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

(b) The commissioner shall distribute available funds for loan forgiveness for public health employees according to areas of high need as determined by the commissioner.

(c) For each year that a participant who is a nurse and who has agreed to teach according to subdivision 2 meets the teaching obligation required in subdivision 3, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average annual educational debt for indebted graduates in the nursing profession in the year closest to the participant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans.

Subd. 5. Penalty for nonfulfillment. If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2, an account in the special revenue fund. The balance of the account does not expire and is appropriated to the commissioner of health for health professional education loan forgiveness awards under this section. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.
Sec. 17. [44.1584] HOSPITAL NURSING LOAN FORGIVENESS PROGRAM.

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

(b) "Nurse" means an individual who is licensed as a registered nurse and who is providing direct patient care in a nonprofit hospital.

(c) "PSLF program" means the federal Public Student Loan Forgiveness program established under Code of Federal Regulations, title 34, section 685.21.

Subd. 2. Eligibility. (a) To be eligible to participate in the hospital nursing loan forgiveness program, a nurse must be:

(1) enrolled in the PSLF program;

(2) employed full time as a registered nurse by a nonprofit hospital that is an eligible employer under the PSLF program; and

(3) providing direct care to patients at the nonprofit hospital.

(b) An applicant for loan forgiveness must submit to the commissioner of health:

(1) a completed application on forms provided by the commissioner;

(2) proof that the applicant is enrolled in the PSLF program;

and

(3) confirmation that the applicant is employed full time as a registered nurse by a nonprofit hospital and is providing direct patient care.

(c) The applicant selected to participate must sign a contract to agree to continue to provide direct patient care as a registered nurse at a nonprofit hospital for the repayment period of the participant's eligible loan under the PSLF program.

Subd. 3. Loan forgiveness. (a) The commissioner of health shall select applicants each year for participation in the hospital nursing loan forgiveness program, within limits of available funding. Applicants are responsible for applying for and maintaining eligibility for the PSLF program.

(b) For each year that a participant meets the eligibility requirements described in subdivision 2, the commissioner shall make an annual disbursement directly to the participant in an amount equal to the minimum loan payments required to be paid by the participant under the participant's repayment plan under the PSLF program for the previous loan year. Before receiving the annual loan repayment disbursement, the participant must complete and return to the commissioner a confirmation of practice form provided by the commissioner, verifying that the participant continues to meet the eligibility requirements under subdivision 2.
(c) The participant must provide the commissioner with verification that the full amount
of loan repayment disbursement received by the participant has been applied toward the
loan for which forgiveness is sought under the PSLF program.

Subd. 4. Penalty for nonfulfillment. If a participant does not fulfill the required
minimum commitment of service as required under subdivision 2, or the secretary of
education determines that the participant does not meet eligibility requirements for the PSLF
program, the commissioner shall collect from the participant the total amount paid to the
participant under the hospital nursing loan forgiveness program plus interest at a rate
established according to section 270C.40. The commissioner shall deposit the money
collected in the health care access fund to be credited to the health professional education
loan forgiveness program account established in section 144.1501, subdivision 2. The
commissioner shall allow waivers of all or part of the money owed to the commissioner as
a result of a nonfulfillment penalty if emergency circumstances prevent fulfillment of the
service commitment or if the PSLF program is discontinued before the participant's service
commitment is fulfilled.

Sec. 18. Minnesota Statutes 2020, section 144.1505, is amended to read:

144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION
AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM

Subdivision 1. Definitions. For purposes of this section, the following definitions apply:

(1) "eligible advanced practice registered nurse program" means a program that is located
in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
advanced practice registered nurse program by the Commission on Collegiate Nursing
Education or by the Accreditation Commission for Education in Nursing, or is a candidate
for accreditation;

(2) "eligible dental program" means a dental residency training program that is located
in Minnesota and is currently accredited by the accrediting body or is a candidate for
accreditation;

(3) "eligible dental therapy program" means a dental therapy education program or
advanced dental therapy education program that is located in Minnesota and is either:
(i) approved by the Board of Dentistry; or
(ii) currently accredited by the Commission on Dental Accreditation;

(4) "eligible mental health professional program" means a program that is located
in Minnesota and is listed as a mental health professional program by the appropriate
accrediting body for clinical social work, psychology, marriage and family therapy, or
licensed professional clinical counseling, or is a candidate for accreditation;
"eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education; "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or is a candidate for accreditation; "eligible physician program" means a physician residency training program that is located in Minnesota and is currently accredited by the accrediting body or is a candidate for accreditation; "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under section 245.462, subdivision 18; and "project" means a project to establish or expand clinical training for physician assistants, advanced practice registered nurses, pharmacists, physicians, dentists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota.

Subd. 2. Health professionals clinical training expansion grant program. (a) The commissioner of health shall award health professional training site grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement expanded clinical training. A planning grant shall not exceed $75,000, and a training grant shall not exceed $150,000 for the first year, $100,000 for the second year, and $50,000 for the third year per program.

(b) Funds may be used for:

1. establishing or expanding clinical training for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota;
2. recruitment, training, and retention of students and faculty;
3. connecting students with appropriate clinical training sites, internships, practicums, or externship activities;
4. travel and lodging for students;
5. faculty, student, and preceptor salaries, incentives, or other financial support;
6. development and implementation of cultural competency training; and
7. evaluations;
(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional training program; and
(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 2a. Health professional rural and underserved clinical rotations grant program. (a) The commissioner of health shall award health professional training site grants to eligible physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry, dental therapy, and mental health professional programs to augment existing clinical training programs by adding rural and underserved rotations or clinical training experiences, such as credential or certificate rural tracks or other specialized training. For physician and dentist training, the expanded training must include rotations in primary care settings such as community clinics, hospitals, health maintenance organizations, or practices in rural communities.

(b) Funds may be used for:
(1) establishing or expanding rotations and clinical trainings;
(2) recruitment, training, and retention of students and faculty;
(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;
(4) travel and lodging for students;
(5) faculty, student, and preceptor salaries, incentives, or other financial support;
(6) development and implementation of cultural competency training;
(7) evaluations;
(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand training programs; and
(9) supporting clinical education in which trainees are part of a primary care team model.

Subd. 3. Applications. Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional, physician, and dental programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization. Applicants applying under subdivision 2a must also include information...
about the length of training and training site settings, the geographic locations of rural sites, and rural populations expected to be served.

Subd. 4. Consideration of applications. The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. Program oversight. The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application and rural locations if applicable under subdivision 2b, other relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 19 [144.1507] PRIMARY CARE RURAL RESIDENCY TRAINING GRANT PROGRAM.

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

(b) "Eligible program" means a program that meets the following criteria:

1. is located in Minnesota;
2. trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery; and
3. is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation.

(c) "Rural residency training program" means a residency program that utilizes local clinics and community hospitals and that provides an initial year of training in an existing accredited residency program in Minnesota. The subsequent years of the residency program are based in rural communities with specialty rotations in nearby regional medical centers.

(d) "Eligible project" means a project to establish and maintain a rural residency training program.
Subd. 2. Rural residency training program. (a) The commissioner of health shall award rural residency training program grants to eligible programs to plan and implement rural residency training programs. A rural residency training program grant shall not exceed $250,000 per resident per year for the first year of planning and development, and $225,000 for each of the following years.

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

(1) planning related to establishing an accredited rural residency training program;

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

(3) establishing new rural residency training programs;

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

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to a new rural residency training program;

(7) training site improvements, fees, equipment, and supplies required for a new rural residency training program; and

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

Subd. 3. Applications for rural residency training program grants. (a) Eligible programs seeking a grant shall apply to the commissioner. Applications must include: (1) the number of new primary care rural residency training program slots planned, under development, or under contract; (2) a description of the training program, including the location of the established residency program and rural training sites; (3) a description of the project, including all costs associated with the project; (4) all sources of funds for the project; (5) detailed uses of all funds for the project; (6) the results expected; and (7) a plan to seek federal funding for graduate medical education for the site if eligible.

(b) The applicant must describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals in the organization.

Subd. 4. Consideration of grant applications. The commissioner shall review each application to determine if the residency program application is complete, if the proposed rural residency program and residency slots are eligible for a grant, and if the program is eligible for federal graduate medical education funding, and when funding becomes available. The commissioner shall award grants to support training programs in family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, and general surgery.
Subd. 5. *Program oversight.* During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Appropriations made to the program do not cancel and are available until expended.

Sec. 20. [144.1508] MENTAL HEALTH PROVIDER SUPERVISION GRANT PROGRAM.

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

(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.

(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. Grant program established. The commissioner of health shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 3 to fund supervision of interns and clinical trainees who are working toward becoming a licensed mental health professional and to subsidize the costs of mental health professional licensing applications and examination fees for clinical trainees.

Subd. 3. Eligible providers. In order to be eligible for a grant under this section, a mental health provider must:

1. provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or
2. primarily serve persons from communities of color or underrepresented communities.

Subd. 4. Application; grant award. A mental health provider seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner shall review each application to determine if the application is complete, the mental health provider is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

Subd. 5. Allowable uses of grant funds. A mental health provider must use grant funds received under this section for one or more of the following:

1. to pay for direct supervision hours for interns and clinical trainees, in an amount up to $7,500 per intern or clinical trainee;
(2) to establish a program to provide supervision to multiple interns or clinical trainees; or
(3) to pay mental health professional licensing application and examination fees for clinical trainees.

Subd. 6. Program oversight. During the grant period, the commissioner may require grant recipients to provide the commissioner with information necessary to evaluate the program.

Sec. 21. [144.1509] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM.

Subd. 1. Definitions.
(a) For purposes of this section, the following terms have the meanings given.
(b) "Mental health professional" means an individual with a qualification specified in section 245I.04, subdivision 2.
(c) "Underrepresented community" has the meaning given in section 148E.010, subdivision 20.

Subd. 2. Grant program established. A mental health professional scholarship program is established to assist mental health providers in funding employee scholarships for master's level education programs in order to create a pathway to becoming a mental health professional.

Subd. 3. Provision of grants. The commissioner of health shall award grants to licensed or certified mental health providers who meet the criteria in subdivision 4 to provide tuition reimbursement for master's level programs and certain related costs for individuals who have worked for the mental health provider for at least the past two years in one or more of the following roles:
(1) a mental health behavioral aide who meets a qualification in section 245I.04, subdivision 16;
(2) a mental health certified family peer specialist who meets the qualifications in section 245I.04, subdivision 12;
(3) a mental health certified peer specialist who meets the qualifications in section 245I.04, subdivision 10;
(4) a mental health practitioner who meets a qualification in section 245I.04, subdivision 4;
(5) a mental health rehabilitation worker who meets the qualifications in section 245I.04, subdivision 14.
(6) an individual employed in a role in which the individual provides face-to-face client services at a mental health center or certified community behavioral health center; or

(7) a staff person who provides care or services to residents of a residential treatment facility.

Subd. 4. Eligibility. In order to be eligible for a grant under this section, a mental health provider must:

(1) primarily provide at least 25 percent of the provider's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; or

(2) primarily serve people from communities of color or underrepresented communities.

Subd. 5. Request for proposals. The commissioner must publish a request for proposals in the State Register specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, the maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

Subd. 6. Application requirements. An eligible provider seeking a grant under this section must submit an application to the commissioner. An application must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the mental health provider to enhance the education of its workforce; the process the mental health provider will use to determine which employees will be eligible for scholarships; any other funding sources for scholarships; the amount of funding sought for the scholarship program; a proposed budget detailing how funds will be spent; and plans to retain eligible employees after completion of the education program.

Subd. 7. Selection process. The commissioner shall determine a maximum award amount for grants and shall select grant recipients based on the information provided in the grant application, including the demonstrated need for the applicant provider to enhance the education of its workforce, the proposed process to select employees for scholarships, the applicant's proposed budget, and other criteria as determined by the commissioner. The commissioner shall give preference to grant applicants who work in rural or culturally specific organizations.

Subd. 8. Grant agreements. Notwithstanding any law or rule to the contrary, funds awarded to a grant recipient in a grant agreement do not lapse until the grant agreement expires.
Subd. 9. Allowable uses of grant funds. A mental health provider receiving a grant under this section must use the grant funds for one or more of the following:

1. to provide employees with tuition reimbursement for a master's level program in a discipline that will allow the employee to qualify as a mental health professional; or
2. for resources and supports, such as child care and transportation, that allow an employee to attend a master's level program specified in clause (1).

Subd. 10. Reporting requirements. A mental health provider receiving a grant under this section shall submit to the commissioner an invoice for reimbursement and a report, on a schedule determined by the commissioner and using a form supplied by the commissioner. The report must include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the recipient's name, current position, amount awarded, educational institution attended, name of the educational program, and expected or actual program completion date.

Sec. 22. [144.1511] CLINICAL HEALTH CARE TRAINING.

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

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body that reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

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

(d) "Clinical medical education program" means the accredited clinical training of physicians, medical students and residents, doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice registered nurses, clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, certified nurse midwives, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, community health workers, and other medical professions as determined by the commissioner.

(e) "Eligible entity" means an organization that is located in Minnesota, provides a clinical medical education experience, and hosts students, residents or other trainee types as determined by the commissioner and are from an accredited Minnesota teaching program and institution.

(f) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota and which is accountable to the accrediting body.
(g) "Trainee" means a student, resident, fellow, or other postgraduate involved in a clinical medical education program from an accredited Minnesota teaching program and institution.

(h) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are training in Minnesota at an entity with either currently active medical assistance enrollment status and a National Provider Identification (NPI) number or documentation that they provide sliding fee services. Training may occur in an inpatient or ambulatory patient care setting or alternative setting as determined by the commissioner. Training that occurs in nursing facility settings is not eligible for funding under this section.

Subd. 2. Application process. (a) An eligible entity hosting clinical trainees from a clinical medical education program and teaching institution is eligible for funds under subdivision 3 if the entity:

(1) is funded in part by sliding fee scale services or enrolled in the Minnesota health care program;

(2) faces increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in rural or underserved areas of Minnesota.

(b) An entity hosting a clinical medical education program for advanced practice nursing is eligible for funds under subdivision 3 if the program meets the eligibility requirements in paragraph (a) and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota State Colleges and Universities system or a member of the Minnesota Private College Council.

(c) An application must be submitted to the commissioner by an eligible entity or teaching institution and contain the following information:

(1) the official name and address and the site address of the clinical medical education program where eligible trainees are hosted;

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

(3) for each applicant: (i) the type and specialty orientation of trainees in the program; (ii) the name, entity address, and medical assistance provider number and national provider identification number of each training site used in the program, as appropriate; (iii) the federal tax identification number of each training site, where available; (iv) the total number of trainees at each training site; (v) the total number of eligible trainee FTEs at each site; and (vi) other supporting information the commissioner deems necessary.
An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 3. Distribution of funds. (a) The commissioner may distribute funds for clinical training in areas of Minnesota and for professions listed in subdivision 1, paragraph (d) determined by the commissioner as a high need area and profession shortage. The commissioner shall annually distribute medical education funds to qualifying applicants under this section based on costs to train, service level needs, and profession or training site shortages. Use of funds is limited to related clinical training costs for eligible programs.

(b) To ensure the quality of clinical training, eligible entities must demonstrate that they hold contracts in good standing with eligible educational institutions that specify the terms, expectations, and outcomes of the clinical training conducted at sites. Funds shall be distributed in an administrative process determined by the commissioner to be efficient.

Subd. 4. Report. (a) Teaching institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible entity. If the teaching institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) Teaching institutions receiving funds under this section must provide any other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

Sec. 23. Minnesota Statutes 2020, section 144.383, is amended to read:

144.383 AUTHORITY OF COMMISSIONER; SAFE DRINKING WATER.

In order to ensure safe drinking water in all public water supplies, the commissioner has the following powers:

(a) To approve the site, design, and construction and alteration of all public water supplies and, for community and nontransient noncommunity water systems as defined in Code of Federal Regulations, title 40, section 141.2, to approve documentation that demonstrates the technical, managerial, and financial capacity of those systems to comply with rules adopted under this section;

(b) To enter the premises of a public water supply, or part thereof, to inspect the facilities and records kept pursuant to rules promulgated by the commissioner, to conduct sanitary surveys and investigate the standard of operation and service delivered by public water supplies;

(c) To contract with community health boards as defined in section 145A.02, subdivision 5, for routine surveys, inspections, and testing of public water supply quality;
To develop an emergency plan to protect the public when a decline in water quality or quantity creates a serious health risk, and to issue emergency orders if a health risk is imminent;

To promulgate rules, pursuant to chapter 14 but no less stringent than federal regulation, which may include the granting of variances and exemptions; and

To maintain a database of lead service lines, provide technical assistance to community water systems, and ensure the lead service inventory data is accessible to the public with relevant educational materials about health risks related to lead and ways to reduce exposure.

Sec. 24. Minnesota Statutes 2020, section 144.554, is amended to read:

144.554 HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.

For hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

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Department of Health Finance
Senate Language
House Language UES4410-2

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Sec. 25. [144.7051] DEFINITIONS.

Subdivision 1. Applicability. For the purposes of sections 144.7051 to 144.7059, the terms defined in this section have the meanings given.

Subd. 2. Commissioner. "Commissioner" means the commissioner of health.

Subd. 3. Daily staffing schedule. "Daily staffing schedule" means the actual number of full-time equivalent nonmanagerial care staff assigned to an inpatient care unit and providing care in that unit during a 24-hour period and the actual number of patients assigned to each direct care registered nurse present and providing care in the unit.

Subd. 4. Direct care registered nurse. "Direct care registered nurse" means a registered nurse, as defined in section 148.171, subdivision 20, who is nonsupervisory and nonmanagerial and who directly provides nursing care to patients more than 60 percent of the time.

Subd. 5. Hospital. "Hospital" means any setting that is licensed as a hospital under sections 144.50 to 144.56.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 26. [144.7053] HOSPITAL NURSE STAFFING COMMITTEES.

Subdivision 1. Hospital nurse staffing committee required. Each hospital must establish and maintain a functioning hospital nurse staffing committee. A hospital may assign the functions and duties of a hospital nurse staffing committee to an existing committee, provided the existing committee meets the membership requirements applicable to a hospital nurse staffing committee.

Subd. 2. Committee membership. (a) At least 35 percent of the committee's membership must be direct care registered nurses typically assigned to a specific unit for an entire shift, and at least 15 percent of the committee’s membership must be other direct care workers typically assigned to a specific unit for an entire shift. Direct care registered nurses and other direct care workers who are members of a collective bargaining unit shall be appointed or elected to the committee according to the guidelines of the applicable collective bargaining agreement. If there is no collective bargaining agreement, direct care registered nurses shall be elected to the committee by direct care registered nurses employed by the hospital, and other direct care workers shall be elected to the committee by other direct care workers employed by the hospital.

(b) The hospital shall appoint no more than 50 percent of the committee's membership.

Subd. 3. Compensation. A hospital must treat participation in committee meetings by any hospital employee as scheduled work time and compensate each committee member at the employee's existing rate of pay. A hospital must relieve all direct care registered nurse
members of the hospital nurse staffing committee of other work duties during the times at
which the committee meets.

Subd. 4. Meeting frequency. Each hospital nurse staffing committee must meet at least
quarterly.

Subd. 5. Committee duties. (a) Each hospital nurse staffing committee shall create,
implement, continuously evaluate, and update as needed evidence-based written core staffing
plans to guide the creation of daily staffing schedules for each inpatient care unit of the
hospital.

(b) Each hospital nurse staffing committee must:

(1) establish a secure and anonymous method for any hospital employee or patient to
submit directly to the committee any concerns related to safe staffing;

(2) review each concern related to safe staffing submitted directly to the committee;

(3) review the documentation of compliance maintained by the hospital under section
144.7056, subdivision 5;

(4) conduct a trend analysis of the data related to all reported concerns regarding safe
staffing;

(5) develop a mechanism for tracking and analyzing staffing trends within the hospital;

(6) submit to the commissioner a nurse staffing report; and

(7) record in the committee minutes for each meeting a summary of the discussions and
recommendations of the committee. Each committee must maintain the minutes, records,
and distributed materials for five years.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 27. Minnesota Statutes 2020, section 144.7055, is amended to read:

144.7055 HOSPITAL CORE STAFFING PLAN REPORTS.

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

(b) "Core staffing plan" means the projected number of full-time equivalent
nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit
a plan described in subdivision 2.

(c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses,
and other health care workers, which may include but is not limited to nursing assistants,
nursing aides, patient care technicians, and patient care assistants, who perform
nonmanagerial direct patient care functions for more than 50 percent of their scheduled
hours on a given patient care unit.
"Inpatient care unit" or "unit" means a designated inpatient area for assigning patients and staff for which a distinct staffing plan daily staffing schedule exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

(4) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

(5) "Patient acuity tool" means a system for measuring an individual patient’s need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.

Subd. 2. Hospital core staffing report plans. (a) The chief nursing executive or nursing designee hospital nurse staffing committee of every reporting hospital in Minnesota under section 144.50 must develop a core staffing plan for each patient inpatient care unit.

(b) Core staffing plans shall specify all of the following:

(1) the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to each patient inpatient care unit for each 24-hour period;

(2) the maximum number of patients on each inpatient care unit for whom a direct care registered nurse can be assigned and for whom a licensed practical nurse or certified nursing assistant can typically safely care;

(3) criteria for determining when circumstances exist on each inpatient care unit such that a direct care nurse cannot safely care for the typical number of patients and when assigning a lower number of patients to each nurse on the inpatient unit would be appropriate;

(4) a procedure for each inpatient care unit to make shift-to-shift adjustments in staffing levels when such adjustments are required by patient acuity and nursing intensity in the unit;

(5) a contingency plan for each inpatient unit to safely address circumstances in which patient care needs unexpectedly exceed the staffing resources provided for in a daily staffing schedule. A contingency plan must include a method to quickly identify for each daily staffing schedule additional direct care registered nurses who are available to provide direct care on the inpatient care unit; and

(6) strategies to enable direct care registered nurses to take breaks to which they are entitled under law or under an applicable collective bargaining agreement.

(c) Core staffing plans must ensure that:
(1) the person creating a daily staffing schedule has sufficiently detailed information to create a daily staffing schedule that meets the requirements of the plan;

(2) daily staffing nurse schedules do not rely on assigning individual nonmanagerial care staff to work overtime hours in excess of 16 hours in a 24-hour period or to work consecutive 24-hour periods requiring 16 or more hours;

(3) a direct care registered nurse is not required or expected to perform functions outside the nurse's professional license;

(4) light duty direct care registered nurses are given appropriate assignments; and

(5) daily staffing schedules do not interfere with applicable collective bargaining agreements.

Subd. 2a. Development of hospital core staffing plans.

(a) Prior to submitting or completing or updating the core staffing plan, as required in subdivision 3, hospitals shall consult with representatives of the hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan and the expected average number of patients upon which the core staffing plan is based.

(b) When developing a core staffing plan, a hospital nurse staffing committee must consider all of the following:

(1) the individual needs and expected census of each inpatient care unit;

(2) unit-specific patient acuity, including fall risk and behaviors requiring intervention, such as physical aggression toward self or others, or destruction of property;

(3) unit-specific demands on direct care registered nurses' time, including: frequency of admissions, discharges, and transfers; frequency and complexity of patient evaluations and assessments; frequency and complexity of nursing care planning; planning for patient discharge; assessing for patient referral; patient education; and implementing infectious disease protocols;

(4) the architecture and geography of the inpatient care unit, including the placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;

(5) mechanisms and procedures to provide for one-to-one patient observation for patients on psychiatric or other units;

(6) the stress under which direct care nurses are placed when required to work extreme amounts of overtime, such as shifts in excess of 12 hours or multiple consecutive double shifts;

(7) the need for specialized equipment and technology on the unit;
(8) other special characteristics of the unit or community patient population, including age, cultural and linguistic diversity and needs, functional ability, communication skills, and other relevant social and socioeconomic factors;

(9) the skill mix of personnel other than direct care registered nurses providing or supporting direct patient care on the unit;

(10) mechanisms and procedures for identifying additional registered nurses who are available for direct patient care when patients’ unexpected needs exceed the planned workload for direct care staff, and

(11) demands on direct care registered nurses’ time not directly related to providing direct care on a unit, such as involvement in quality improvement activities, professional development, service to the hospital, including serving on the hospital nurse staffing committee, and service to the profession.

Subd. 3. Standard electronic reporting developed of core staffing plans. (a) Hospitals Each hospital must submit the core staffing plans approved by the hospital’s nurse staffing committee to the Minnesota Hospital Association by January 1, 2014. The Minnesota Hospital Association shall include each reporting hospital’s core staffing plans on the Minnesota Hospital Association's Minnesota Hospital Quality Report website by April 1, 2014. Hospitals shall submit to the Minnesota Hospital Association any substantial changes to the core staffing plan within 30 days of the approval of the updates by the hospital’s nurse staffing committee or of amendment through arbitration. The Minnesota Hospital Association shall update the Minnesota Hospital Quality Report website with the updated core staffing plans within 30 days of receipt of the updated plan.

(b) The Minnesota Hospital Association shall include on its website for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit. Hospitals must submit the direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly thereafter.

Subd. 5. Mandatory submission of core staffing plan to commissioner. Each hospital must submit the core staffing plans and any updates to the commissioner on the same schedule described in subdivision 3. Core staffing plans held by the commissioner are public.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 28. [144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS. Subdivision 1. Plan implementation required. A hospital must implement the core staffing plans approved by a majority vote of the hospital nurse staffing committee.

Subd. 2. Public posting of core staffing plans. A hospital must post the core staffing plan for the inpatient care unit in a public area on the unit.
Subd. 3. Public posting of compliance with plan. For each publicly posted core staffing plan, a hospital must post a notice stating whether the current staffing on the unit complies with the hospital's core staffing plan for that unit. The public notice of compliance must include a list of the number of nonmanagerial care staff working on the unit during the current shift and the number of patients assigned to each direct care registered nurse working on the unit during the current shift. The list must enumerate the nonmanagerial care staff by health care worker type. The public notice of compliance must be posted immediately adjacent to the publicly posted core staffing plan.

Subd. 4. Public distribution of core staffing plan and notice of compliance. (a) A hospital must include with the posted materials described in subdivisions 2 and 3, a statement that individual copies of the posted materials are available upon request to any patient on the unit or to any visitor of a patient on the unit. The statement must include specific instructions for obtaining copies of the posted materials.

(b) A hospital must, within four hours after the request, provide individual copies of all the posted materials described in subdivisions 2 and 3 to any patient on the unit or to any visitor of a patient on the unit who requests the materials.

Subd. 5. Documentation of compliance. Each hospital must document compliance with its core staffing plans and maintain records demonstrating compliance for each inpatient care unit for five years. Each hospital must provide its hospital nurse staffing committee with access to all documentation required under this subdivision.

Subd. 6. Dispute resolution. (a) If hospital management objects to a core staffing plan approved by a majority vote of the hospital nurse staffing committee, the hospital may elect to attempt to amend the core staffing plan through arbitration.

(b) During an ongoing dispute resolution process, a hospital must continue to implement the core staffing plan as written and approved by the hospital nurse staffing committee.

(c) If the dispute resolution process results in an amendment to the core staffing plan, the hospital must implement the amended core staffing plan.

EFFECTIVE DATE. This section is effective June 1, 2024.

Sec. 29. [144.7059] RETALIATION PROHIBITED.

Neither a hospital or nor a health-related licensing board may retaliate against or discipline a hospital employee regulated by the health-related licensing board, either formally or informally, for:

(1) challenging the process by which a hospital nurse staffing committee is formed or conducts its business;

(2) challenging a core staffing plan approved by a hospital nurse staffing committee;
(3) objecting to or submitting a grievance related to a patient assignment that leads to a
direct care registered nurse violating medical restrictions recommended by the nurse's
medical provider; or
(4) submitting a report of unsafe staffing conditions.

EFFECTIVE DATE. This section is effective April 1, 2024.

Sec. 30. [144.8611] DRUG OVERDOSE AND SUBSTANCE ABUSE PREVENTION.

Subd. 1. Strategies. The commissioner of health shall support collaboration and
coordination between state and community partners to develop, refine, and expand
comprehensive funding to address the drug overdose epidemic by implementing three
strategies: (1) regional multidisciplinary overdose prevention teams to implement overdose
prevention in local communities and local public health organizations; (2) enhance supportive
services for the homeless who are at risk of overdose by providing emergency and short-term
housing subsidies through the Homeless Overdose Prevention Hub; and (3) enhance employer
resources to promote health and well-being of employees through the recovery friendly
workplace initiative. These strategies address the underlying social conditions that impact
health status.

Subd. 2. Regional teams. The commissioner of health shall establish community-based
prevention grants and contracts for the eight regional multidisciplinary overdose prevention
teams. These teams shall be geographically aligned with the eight emergency medical
services regions described in section 144E.52. The regional teams shall implement prevention
programs, policies, and practices that are specific to the challenges and responsive to the
data of the region.

Subd. 3. Homeless Overdose Prevention Hub. The commissioner of health shall
establish a community-based grant to enhance supportive services for the homeless who
are at risk of overdose by providing emergency and short-term housing subsidies through
the Homeless Overdose Prevention Hub. The Homeless Overdose Prevention Hub serves
primarily urban American Indians in Minneapolis and Saint Paul and is managed by the
Native American Community Clinic.

Subd. 4. Workplace health. The commissioner of health shall establish a grants and
contracts program to strengthen the recovery friendly workplace initiative. This initiative
helps create work environments that promote employee health, safety, and well-being by:
(1) preventing abuse and misuse of drugs in the first place; (2) providing training to
employers; and (3) reducing stigma and supporting recovery for people seeking services
and who are in recovery.

Subd. 5. Eligible grantees. (a) Organizations eligible to receive grant funding under
subdivision 4 include not-for-profit agencies or organizations with existing organizational
structure, capacity, trainers, facilities, and infrastructure designed to deliver model workplace
policies and practices, that have training and education for employees, supervisors, and

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executive leadership of companies, businesses, and industry; and that have the ability to
evaluate the three goals of the workplace initiative specified in subdivision 4.

(b) At least one organization may be selected for a grant under subdivision 4 with
statewide reach and influence. Up to five smaller organizations may be selected to reach
specific geographic or population groups.

Subd. 6. Evaluation. The commissioner of health shall design, conduct, and evaluate
each of the components of the drug overdose and substance abuse prevention program using
measures such as mortality, morbidity, homelessness, workforce wellness, employee
retention, and program reach.

Subd. 7. Report. Grantees must report grant program outcomes to the commissioner on
the forms and according to the timelines established by the commissioner.

Sec. 31. Minnesota Statutes 2020, section 144.9501, subdivision 9, is amended to read:

Subd. 9. Elevated blood lead level. "Elevated blood lead level" means a diagnostic
blood lead test with a result that is equal to or greater than 3.5 micrograms of lead per
deciliter of whole blood in any person, unless the commissioner finds that a lower
concentration is necessary to protect public health.

Sec. 32. [144.9981] CLIMATE RESILIENCY.

Subdivision 1. Climate resiliency program. The commissioner of health shall implement
a climate resiliency program to:

1. increase awareness of climate change;
2. track the public health impacts of climate change and extreme weather events;
3. provide technical assistance and tools that support climate resiliency to local public
    health organizations, Tribal health organizations, soil and water conservation districts, and
    other local governmental and nongovernmental organizations; and
4. coordinate with the commissioners of the Pollution Control Agency, natural resources,
    agriculture, and other state agencies in climate resiliency related planning and
    implementation.

Subd. 2. Grants authorized; allocation. (a) The commissioner of health shall manage
a grant program for the purpose of climate resiliency planning. The commissioner shall
award grants through a request for proposals process to local public health organizations,
Tribal health organizations, soil and water conservation districts, or other local organizations
for planning for the health impacts of extreme weather events and developing adaptation
actions. Priority shall be given to small rural water systems and organizations incorporating
the needs of private water supplies into their planning. Priority shall also be given to
organizations that serve communities that are disproportionately impacted by climate change.
(b) Grantees must use the funds to develop a plan or implement strategies that will reduce
the risk of health impacts from extreme weather events. The grant application must include:
(1) a description of the plan or project for which the grant funds will be used;
(2) a description of the pathway between the plan or project and its impacts on health;
(3) a description of the objectives, a work plan, and a timeline for implementation; and
(4) the community or group the grant proposes to focus on.
the virus that causes COVID-19. Long COVID is also called post COVID, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

Subd. 2. Statewide monitoring. The commissioner of health shall establish a program to conduct community needs assessments, perform epidemiologic studies, and establish a population-based surveillance system to address long COVID. The purposes of these assessments, studies, and surveillance system are to:

1. monitor trends in incidence, prevalence, mortality, care management, health outcomes, quality of life, and needs of individuals with long COVID and to detect potential public health problems, predict risks, and assist in investigating long COVID health disparities;
2. more accurately target intervention resources for communities and patients and their families;
3. inform health professionals and citizens about risks, early detection, and treatment of long COVID known to be elevated in their communities; and
4. promote high quality studies to provide better information for long COVID prevention and control and to address public concerns and questions about long COVID.

Subd. 3. Partnerships. The commissioner of health shall, in consultation with health care professionals, the Department of Human Services, local public health organizations, health insurers, employers, schools, long COVID survivors, and community organizations serving people at high risk of long COVID, routinely identify priority actions and activities to address the need for communication, services, resources, tools, strategies, and policies to support long COVID survivors and their families.

Subd. 4. Grants and contracts. The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions, including through community-based grants and contracts.

Subd. 5. Grant recipient and contractor eligibility. The commissioner of health shall award contracts and competitive grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino, LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within such groups.

Subd. 6. Grants and contracts authorized. The commissioner of health shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID, their caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, local and Tribal public health, and other entities deemed necessary.
Sec. 34. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 6. National Suicide Prevention Lifeline number. The National Suicide Prevention Lifeline is expanded to improve the quality of care and access to behavioral health crisis services and to further health equity and save lives.

Sec. 35. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 7. Definitions. (a) For the purposes of this section, the following terms have the meanings given:

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

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

(d) "National Suicide Prevention Lifeline" means a national network of certified local crisis centers maintained by the federal Substance Abuse and Mental Health Services Administration that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, seven days a week.

(e) "988 administrator" means the administrator of the 988 National Suicide Prevention Lifeline.

(f) "988 Hotline" or "Lifeline Center" means a state-identified center that is a member of the National Suicide Prevention Lifeline network that responds to statewide or regional 988 contacts.

(g) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary of Veterans Affairs under United States Code, title 38, section 170F(h).

Sec. 36. Minnesota Statutes 2020, section 145.56, is amended by adding a subdivision to read:

Subd. 8. 988 National Suicide Prevention Lifeline. (a) The commissioner of health shall administer the designated lifeline and oversee a Lifeline Center or a network of Lifeline Centers to answer contacts from individuals accessing the National Suicide Prevention Lifeline 24 hours per day, seven days per week.

(b) The designated Lifeline Center(s) shall:

(1) have an active agreement with the administrator of the 988 National Suicide Prevention Lifeline for participation within the network;

(2) meet the 988 administrator requirements and best practice guidelines for operational and clinical standards;
(3) provide data, report, and participate in evaluations and related quality improvement activities as required by the 988 administrator and the department; 

(4) use technology that is interoperable across crisis and emergency response systems used in the state, such as 911 systems, emergency medical services, and the National Suicide Prevention Lifeline; 

(5) deploy crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 administrator and the department; 

(6) actively collaborate with local mobile crisis teams to coordinate linkages for persons contacting the 988 Hotline for ongoing care needs; 

(7) offer follow-up services to individuals accessing the Lifeline Center that are consistent with guidance established by the 988 administrator and the department; and 

(8) meet the requirements set by the 988 administrator and the department for serving high risk and specialized populations.

(c) The department shall collaborate with the National Suicide Prevention Lifeline and Veterans Crisis Line networks for the purpose of ensuring consistency of public messaging about 988 services.

Sec. 37. [145.871] UNIVERSAL, VOLUNTARY HOME VISITING PROGRAM.

Subdivision 1. Grant program. (a) The commissioner of health shall award grants to eligible individuals and entities to establish voluntary home visiting services to families expecting or caring for an infant, including families adopting an infant. The following individuals and entities are eligible for a grant under this section: community health boards; nonprofit organizations; Tribal Nations; and health care providers, including doulas, community health workers, perinatal health educators, early childhood family education home visiting providers, nurses, community health technicians, and local public health nurses.

(b) The grant money awarded under this section must be used to establish home visiting services that:

(1) provide a range of one to six visits that occur prenatally or within the first four months of the expected birth or adoption of an infant; and

(2) improve outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency; and

(iv) coordination and referral for other community resources and supports.
(v) reduction in child injuries, abuse, or neglect; or
(vi) reduction in crime or domestic violence.

(c) The commissioner shall ensure that the voluntary home visiting services established under this section are available to all families residing in the state by June 30, 2025. In awarding grants prior to the home visiting services being available statewide, the commissioner shall prioritize applicants serving high-risk or high-need populations of pregnant women and families with infants, including populations with insufficient access to prenatal care, high incidence of mental illness or substance use disorder, low socioeconomic status, and other factors as determined by the commissioner.

Subd. 2. Home visiting services. (a) The home visiting services provided under this section must, at a minimum:

(1) offer information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services in the community;

(2) provide information on and referrals to health care services, including information on and assistance in applying for health care coverage for which the child or family may be eligible, and provide information on the availability of group prenatal care, preventative services, developmental assessments, and public assistance programs as appropriate;

(3) include an assessment of the physical, social, and emotional factors affecting the family and provide information and referrals to address each family's identified needs;

(4) connect families to additional resources available in the community, including early care and education programs, health or mental health services, family literacy programs, employment agencies, and social services, as needed;

(5) utilize appropriate racial, ethnic, and cultural approaches to providing home visiting services; and

(6) be voluntary and free of charge to families.

(b) Home visiting services under this section may be provided through telephone or video communication when the commissioner determines the methods are necessary to protect the health and safety of individuals receiving the visits and the home visiting workforce.

Subd. 3. Administrative costs. The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance, to administer the program, and to conduct ongoing evaluations of the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.
Sec. 38. Minnesota Statutes 2020, section 145.924, is amended to read:

145.924 AIDS PREVENTION GRANTS.

(a) The commissioner may award grants to community health boards as defined in section 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide evaluation and counseling services to populations at risk for acquiring human immunodeficiency virus infection, including, but not limited to, minorities, adolescents, intravenous drug users, and homosexual men.

(b) The commissioner may award grants to agencies experienced in providing services to communities of color, for the design of innovative outreach and education programs for targeted groups within the community who may be at risk of acquiring the human immunodeficiency virus infection, including intravenous drug users and their partners, adolescents, gay and bisexual individuals and women. Grants shall be awarded on a request for proposal basis and shall include funds for administrative costs. Priority for grants shall be given to agencies or organizations that have experience in providing service to the particular community which the grantee proposes to serve; that have policy makers representative of the targeted population; that have experience in dealing with issues relating to HIV/AIDS; and that have the capacity to deal effectively with persons of differing sexual orientations. For purposes of this paragraph, the "communities of color" are: the American-Indian community; the Hispanic community; the African-American community; and the Asian-Pacific community.

(c) All state grants awarded under this section for programs targeted to adolescents shall include the promotion of abstinence from sexual activity and drug use.

(d) The commissioner may manage a program and award grants to agencies experienced in syringe services programs for expanding access to harm reduction services and improving linkages to care to prevent HIV/AIDS, hepatitis, and other infectious diseases for those experiencing homelessness or housing instability.

Sec. 39. [145.9271] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.

Subdivision 1. Establishment. The commissioner of health shall establish the community solutions for a healthy child development grant program. The purposes of the program are to:

(1) improve child development outcomes related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Service’s early childhood systems reform effort that include: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments, by funding community-based solutions for challenges that are identified by the affected communities;
(2) reduce racial disparities in children's health and development from prenatal to grade 3; and

(3) promote racial and geographic equity.

Subd. 2. Commissioner's duties. The commissioner of health shall:

(1) develop a request for proposals for the healthy child development grant program in consultation with the community solutions advisory council established in subdivision 3;

(2) provide outreach, technical assistance, and program development support to increase capacity for new and existing service providers in order to better meet statewide needs, particularly in greater Minnesota and areas where services to reduce health disparities have not been established;

(3) review responses to requests for proposals, in consultation with the community solutions advisory council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the Children's Cabinet on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the community solutions advisory council, focused on outcomes that grantees agree to achieve;

(6) provide grantees with access to data to assist grantees in establishing and implementing effective community-led solutions;

(7) maintain data on outcomes reported by grantees; and

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. Community solutions advisory council; establishment; duties; compensation. (a) The commissioner of health shall establish a community solutions advisory council. By October 1, 2022, the commissioner shall convene a 12-member community solutions advisory council. Members of the advisory council are:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents who are Black, indigenous, or nonwhite people of color with children under nine years of age;
(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians;

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

c) The community solutions advisory council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

d) Each advisory council member shall be compensated as provided in section 15.059, subdivision 3.

Subd. 4. Eligible grantees. Organizations eligible to receive grant funding under this section include:

(1) organizations or entities that work with Black, indigenous, and non-Black people of color communities;

(2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care and Development Block Grant Act of 1990; and

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. Strategic consideration and priority of proposals; eligible populations; grant awards. (a) The commissioner, in consultation with the community solutions advisory council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of
(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by Black and other nonwhite people of color and serving Black and nonwhite communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including Tribal nations and Tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

c) The advisory council may recommend additional strategic considerations and priorities to the commissioner.

d) The first round of grants must be awarded no later than April 15, 2023.

Subd. 6. Geographic distribution of grants. To the extent possible, the commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black, nonwhite people of color, and American Indians than the state average.

Subd. 7. Report. Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 40. [145.9272] LEAD TESTING AND REMEDIATION GRANT PROGRAM; SCHOOLS, CHILD CARE CENTERS, FAMILY CHILD CARE PROVIDERS.

Subdivision 1. Establishment; purpose. The commissioner of health shall establish a grant program to test drinking water at licensed child care centers and licensed family child care providers for the presence of lead and to remediate identified sources of lead in drinking water at schools, licensed child care centers, and licensed family child care providers.

Subd. 2. Grant awards. (a) The commissioner shall award grants through a request for proposals process to schools, licensed child care centers, and licensed family child care providers. The commissioner shall award grants in the following order of priority:
(1) statewide testing of drinking water in licensed child care centers and licensed family
child care providers for the presence of lead and remediating identified sources of lead in
these settings; and

(2) remediating identified sources of lead in drinking water in schools.

(b) The commissioner shall prioritize grant awards for the purposes specified in paragraph
(a), clause (1) or (2), to settings with higher levels of lead detected in water samples, with
evidence of lead service lines or lead plumbing materials, or that serve or are in school
districts that serve disadvantaged communities.

Subd. 3. Uses of grant funds. Licensed child care centers and licensed family child care
providers must use grant funds under this section to test their drinking water for lead;
remediate sources of lead contamination within the building, including lead service lines
and premises plumbing; and implement best practices for water management within the
building. Schools must use grant funds under this section to remediate sources of lead
contamination within the building and implement best practices for water management
within the building.

Sec. 41. [145.9274] REPORTS; SCHOOL TEST RESULTS AND REMEDIATION
EFFORTS FOR LEAD IN DRINKING WATER.

(a) School districts and charter schools must report to the commissioner of health in a
form and manner determined by the commissioner:

(1) test results regarding the presence of lead in drinking water in the school district's
or charter school's buildings; and

(2) information on remediation efforts to address lead in drinking water, if a test reveals
lead in drinking water in an amount above 15 parts per billion.

(b) The commissioner must post on the department website and annually update the test
results and information on remediation efforts reported under paragraph (a). The
commissioner must post test results and remediation efforts by school site.

Sec. 42. [145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND
EDUCATION GRANT PROGRAM.

Subdivision 1. Grant program. The commissioner of health shall award grants through
a request for proposal process to community-based organizations that serve ethnic
communities and focus on public health outreach to Black and people of color communities
on the issues of colorism, skin-lightening products, and chemical exposures from these
products. Priority in awarding grants shall be given to organizations that have historically
provided services to ethnic communities on the skin-lightening and chemical exposure issue
for the past four years.
Subd. 2. Uses of grant funds. Grant recipients must use grant funds awarded under this section to conduct public awareness and education activities that are culturally specific and community-based and that focus on:

(1) increasing public awareness and providing education on the health dangers associated with using skin-lightening creams and products that contain mercury and hydroquinone and are manufactured in other countries, brought into this country, and sold illegally online or in stores; the dangers of exposure to mercury through dermal absorption, inhalation, hand-to-mouth contact, and contact with individuals who have used these skin-lightening products; the health effects of mercury poisoning, including the permanent effects on the central nervous system and kidneys; and the dangers to mothers and infants of using these products or being exposed to these products during pregnancy and while breastfeeding;

(2) identifying products that contain mercury and hydroquinone by testing skin-lightening products;

(3) developing a train the trainer curriculum to increase community knowledge and influence behavior changes by training community leaders, cultural brokers, community health workers, and educators;

(4) continuing to build the self-esteem and overall wellness of young people who are using skin-lightening products or are at risk of starting the practice of skin lightening; and

(5) building the capacity of community-based organizations to continue to combat skin-lightening practices and chemical exposure.

Subdivision 1. Establishment. The commissioner of health shall support collaboration and coordination between state and community partners to develop, refine, and expand the community health workers profession across the state equipping them to address health needs and to improve health outcomes by addressing the social conditions that impact health status. Community health professionals' work expands beyond health care to bring health and racial equity into public safety, social services, youth and family services, schools, neighborhood associations, and more.

Subd. 2. Grants authorized; eligibility. The commissioner of health shall establish a community-based grant to expand and strengthen the community health workers workforce across the state. The grantee must be a not-for-profit community organization serving, convening, and supporting community health workers (CHW) statewide.

Subd. 3. Evaluation. The commissioner of health shall design, conduct, and evaluate the CHW initiative using measures of workforce capacity, employment opportunity, reach of services, and return on investment, as well as descriptive measures of the extent CHW models as they compare with the national community health workers' landscape. These more proximal measures are collected and analyzed as foundational to longer-term change.
in social determinants of health and rates of death and injury by suicide, overdose, firearms, alcohol, and chronic disease.

Subd. 4. Report. Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 44. [145.9283] REDUCING HEALTH DISPARITIES AMONG PEOPLE WITH DISABILITIES; GRANTS.

Subdivision 1. Goal and establishment. The commissioner of health shall support collaboration and coordination between state and community partners to address equity barriers to health care and preventative services for chronic diseases among people with disabilities. The commissioner of health, in consultation with the Olmstead Implementation Office, Department of Human Services, Board on Aging, health care professionals, local public health organizations, and other community organizations that serve people with disabilities, shall routinely identify priorities and action steps to address identified gaps in services, resources, and tools.

Subd. 2. Assessment and tracking. The commissioner of health shall conduct community needs assessments and establish a health surveillance and tracking plan in collaboration with community and organizational partners to identify and address health disparities.

Subd. 3. Grants authorized. The commissioner of health shall establish community-based grants to support establishing inclusive evidence-based chronic disease prevention and management services to address identified gaps and disparities.

Subd. 4. Technical assistance. The commissioner of health shall provide and evaluate training and capacity-building technical assistance on accessible preventive health care for public health and health care providers of chronic disease prevention and management programs and services.

Subd. 5. Report. Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 45. [145.9292] PUBLIC HEALTH AMERICORPS.

The commissioner may award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members. The organization awarded the grant shall provide the commissioner with any information needed by the commissioner to evaluate the program in the form and at the timelines specified by the commissioner.

Sec. 46. [145.987] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.

Subdivision 1. Purposes. The purposes of the Healthy Beginnings, Healthy Families Act are to: (1) address the significant disparities in early childhood outcomes and increase the number of children who are school ready through establishing the Minnesota collaborative to prevent infant mortality; (2) sustain the Help Me Connect online navigator; (3) improve universal access to developmental and social-emotional screening and follow-up; and (4)
sustain and expand the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota collaborative to prevent infant mortality.** (a) The Minnesota collaborative to prevent infant mortality is established. The goals of the Minnesota collaborative to prevent infant mortality program are to:

1. Build a statewide multisectoral partnership including the state government, local public health organizations, Tribes, the private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, and other nonwhite communities, and rural populations;
2. Address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and
3. Promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes;

(b) The commissioner of health shall establish a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

Subd. 3. **Grants authorized.** (a) The commissioner of health shall award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally relevant activities to improve infant health by reducing preterm births, sleep-related infant deaths, and congenital abnormalities and by addressing social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. Grants shall be awarded to all federally recognized Tribal governments whose proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 2 and other requirements of this section. An eligible applicant must submit an application to the commissioner of health on a form designated by the commissioner and by the deadline established by the commissioner. The commissioner shall award grants to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities shall:

1. Address the leading cause or causes of infant mortality;
2. Be based on community input;
3. Be focused on policy, systems, and environmental changes that support infant health; and
(d) address the health disparities and inequities that are experienced in the grantee’s community.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications under this subdivision, the commissioner shall establish criteria including but not limited to: (1) the eligibility of the project; (2) the applicant’s thoroughness and clarity in describing the infant health issues grant funds are intended to address; (3) a description of the applicant’s proposed project; (4) a description of the population demographics and service area of the proposed project; and (5) evidence of efficiencies and effectiveness gained through collaborative efforts.

(d) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 4. Technical assistance. (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

(b) For the purposes of carrying out the grant program under subdivision 3, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and to provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

(4) communications, convening, and sharing lessons learned; and

(5) health equity.

Subd. 5. Help Me Connect. The Help Me Connect online navigator is established. The goal of Help Me Connect is to connect pregnant and parenting families with young children from birth to eight years of age with services in their local communities that support healthy child development and family well-being. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this subdivision.

Subd. 6. Duties of Help Me Connect. (a) Help Me Connect shall facilitate collaboration across sectors covering child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support early detection, intervention, and knowledge about local resources; and
(2) linking children and families to appropriate community-based services.

(b) Help Me Connect shall provide community outreach that includes support for and participation in the help me connect system, including disseminating information and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health and human services and resources, and other appropriate early childhood information.

(c) Help Me Connect shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) Help Me Connect shall provide a centralized mechanism that facilitates provider-to-provider referrals to community resources and monitors referrals to ensure that families are connected to services.

(e) Help Me Connect shall collect program evaluation data to increase the understanding of all aspects of the current and ongoing system under this section, including identification of gaps in service, barriers to finding and receiving appropriate service, and lack of resources.

Subd. 7. Universal and voluntary developmental and social-emotional screening and follow-up. (a) The commissioner shall establish a universal and voluntary developmental and social-emotional screening to identify young children at risk for developmental and behavioral concerns. Follow-up services shall be provided to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this subdivision and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

(b) The commissioner shall:

(1) increase the awareness of universal and voluntary developmental and social-emotional screening and follow-up in coordination with community and state partners;

(2) expand existing electronic screening systems to administer developmental and social-emotional screening of children from birth to kindergarten entrance;

(3) provide universal and voluntary periodic screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the child’s parent or guardian;

(5) support families in their role as caregivers by providing typical growth and development information, anticipatory guidance, and linkages to early childhood resources and programs;
(6) ensure that children and families are linked to appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

(7) establish performance measures and collect, analyze, and share program data regarding population-level outcomes of developmental and social-emotional screening, and make referrals to community-based services and follow-up activities.

Subd. 8. Grants authorized. The commissioner shall award grants to community health boards and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 9. Model jails practices for incarcerated parents. (a) The commissioner of health may make special grants to counties, groups of counties, or nonprofit organizations to implement model jails practices to benefit the children of incarcerated parents.

(b) "Model jail practices" means a set of practices that correctional administrators can implement to remove barriers that may prevent a child from cultivating or maintaining relationships with the child's incarcerated parent or parents during and immediately after incarceration without compromising the safety or security of the correctional facility.

Subd. 10. Grants authorized. (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) Grantee activities may include but are not limited to:

(1) parenting classes or groups;
(2) family-centered intake and assessment of inmate programs;
(3) family notification, information, and communication strategies;
(4) correctional staff training;
(5) policies and practices for family visits; and
(6) family-focused reentry planning.

(c) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.
Subd. 11. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 10, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

1. evidence-based training for incarcerated parents;
2. partnership building and community engagement;
3. evaluation of process and outcomes of model jail practices; and
4. expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

**Sec. 47.** [145.988] **MINNESOTA SCHOOL HEALTH INITIATIVE.**

Subdivision 1. **Purpose.** (a) The purpose of the Minnesota School Health Initiative is to implement evidence-based practices to strengthen and expand health promotion and health care delivery activities in schools to improve the holistic health of students. To better serve students, the Minnesota School Health Initiative shall unify the best practices of the school-based health center and Whole School, Whole Community, Whole Child models.

(b) The commissioner of health and the commissioner of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, by licensed and qualified health professionals in accordance with federal, state, and local law, when not located on school property, the school-based health center must have an established relationship with one or more schools in the community and operate primarily to serve those student groups.

(c) "Sponsoring organization" means any of the following that operate a school-based health center:

1. health care providers;
(2) community clinics;
(3) hospitals;
(4) federally qualified health centers and look-alikes as defined in section 145.9269;
(5) health care foundations or nonprofit organizations;
(6) higher education institutions; or
(7) local health departments.

Subd. 3. Expansion of Minnesota school-based health centers. (a) The commissioner of health shall administer a program to provide grants to school districts, school-based health centers, and sponsoring organizations to support existing school-based health centers and facilitate the growth of school-based health centers in Minnesota.
(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that: (1) operate in partnership with a school or district and with the permission of the school or district board; (2) provide health services through a sponsoring organization; and (3) provide health services to all students and youth within a school or district regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.
(c) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

Subd. 4. School-based health center services. Services provided by a school-based health center may include but are not limited to: (1) preventative health care; (2) chronic medical condition management, including diabetes and asthma care; (3) mental health care and crisis management; (4) acute care for illness and injury; (5) oral health care; (6) vision care; (7) nutritional counseling; (8) substance abuse counseling;
(9) referral to a specialist, medical home, or hospital for care;
(10) additional services that address social determinants of health; and
(11) emerging services such as mobile health and telehealth.

Subd. 5. Sponsoring organization. A sponsoring organization that agrees to operate a
school-based health center must enter into a memorandum of agreement with the school or
district. The memorandum of agreement must require the sponsoring organization to be
financially responsible for the operation of school-based health centers in the school or
district and must identify the costs that are the responsibility of the school or district, such
as Internet access, custodial services, utilities, and facility maintenance. To the greatest
extent possible, a sponsoring organization must bill private insurers, medical assistance,
and other public programs for services provided in the school-based health center in order
to maintain the financial sustainability of the school-based health center.

Subd. 6. Oral health in school settings. (a) The commissioner of health shall administer
a program to provide competitive grants to schools, oral health providers, and other
community groups to build capacity and infrastructure to establish, expand, link, or strengthen
oral health services in school settings.

(b) Grant funds distributed under this subdivision must be used to support new or existing
oral health services in schools that:
   (1) provide oral health risk assessment, screening, education, and anticipatory guidance;
   (2) provide oral health services, including fluoride varnish and dental sealants;
   (3) make referrals for restorative and other follow-up dental care as needed; and
   (4) provide free access to fluoridated drinking water to give students a healthy alternative
to sugar-sweetened beverages.

(c) Grant recipients must collect, monitor, and submit to the commissioner of health
baseline and annual data and provide information to improve the quality and impact of oral
health strategies.

Subd. 7. Whole School, Whole Community, Whole Child grants. (a) The commissioner
of health shall administer a program to provide competitive grants to local public health
organizations, schools, and community organizations using the evidence-based Whole
School, Whole Community, Whole Child (WSCC) model to increase alignment, integration,
and collaboration between public health and education sectors to improve each child’s
cognitive, physical, oral, social, and emotional development.

(b) Grant funds distributed under this subdivision must be used to support new or existing
programs that implement elements of the WSCC model in schools that:
(1) align health and learning strategies to improve health outcomes and academic achievement;

(2) improve the physical, nutritional, psychological, social, and emotional environments of schools;

(3) create collaborative approaches to engage schools, parents and guardians, and communities; and

(4) promote and establish lifelong healthy behaviors.

(c) Grant recipients shall report grant activities and progress to the commissioner in a time and format specified by the commissioner.

Subd. 8. Technical assistance and oversight. (a) The commissioner shall provide content expertise, technical expertise, and training to grant recipients under subdivisions 6 and 7.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) needs assessment;

(2) community engagement and capacity building;

(3) community asset building and risk behavior reduction;

(4) dental provider training in calibration;

(5) dental services related equipment, instruments, supplies;

(6) communications;

(7) community, school, health care, work site, and other site-specific strategies;

(8) health equity;

(9) data collection and analysis; and

(10) evaluation.

Sec. 48. Minnesota Statutes 2020, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. Funding formula for community health boards. (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health
services subsidy; state and federal maternal and child health special projects grants; family
home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and
available women, infants, and children grant funds in fiscal year 2003, prior to unallotment,
distributed based on the proportion of WIC participants served in fiscal year 2003 within
the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant
under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by
the percentage difference between the base, as calculated in paragraph (a), and the funding
available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership
base of up to $5,000 per year for each county or city in the case of a multicity community
health board included in the community health board.

(d) The State Community Health Services Advisory Committee may recommend a
formula to the commissioner to use in distributing funds to community health boards.
(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive
an increase equal to ten percent of the grant award to the community health board under
paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
the last six months of the year. For calendar years beginning on or after January 1, 2016,
the amount distributed under this paragraph shall be adjusted each year based on available
funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities shall be distributed based on
a formula determined by the commissioner in consultation with the State Community Health
Services Advisory Committee. Community health boards must use these funds as specified
in subdivision 5.

Sec. 49. Minnesota Statutes 2020, section 145A.131, subdivision 5, is amended to read:

Subd. 5. Use of funds. (a) Community health boards may use the base funding of their
local public health grant funds distributed according to subdivision 1, paragraphs (a) to (e),
to address the areas of public health responsibility and local priorities developed through
the community health assessment and community health improvement planning process.

(b) A community health board must use funding for foundational public health
responsibilities that is distributed according to subdivision 1, paragraph (f), to fulfill
foundational public health responsibilities as defined by the commissioner in consultation
with the State Community Health Services Advisory Committee.

(c) Notwithstanding paragraph (b), if a community health board can demonstrate that
foundational public health responsibilities are fulfilled, the community health board may
use funding for foundational public health responsibilities for local priorities developed.
through the community health assessment and community health improvement planning process.

(d) Notwithstanding paragraphs (a) to (c), by July 1, 2026, community health boards must use all local public health funds first to fulfill foundational public health responsibilities. Once a community health board can demonstrate foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 50. Minnesota Statutes 2020, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. Tribal governments; foundational public health responsibilities. The commissioner shall distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Sec. 51. Minnesota Statutes 2020, section 149A.01, subdivision 2, is amended to read:

Subd. 2. Scope. In Minnesota no person shall, without being licensed or registered by the commissioner of health:

1. take charge of or remove from the place of death a dead human body;
2. prepare a dead human body for final disposition, in any manner; or
3. arrange, direct, or supervise a funeral, memorial service, or graveside service.

Sec. 52. Minnesota Statutes 2020, section 149A.01, subdivision 3, is amended to read:

Subd. 3. Exceptions to licensure. (a) Except as otherwise provided in this chapter, nothing in this chapter shall in any way interfere with the duties of:
1. an anatomical bequest program located within an accredited school of medicine or an accredited college of mortuary science;
2. a person engaged in the performance of duties prescribed by law relating to the conditions under which unclaimed dead human bodies are held subject to anatomical study;
3. authorized personnel from a licensed ambulance service in the performance of their duties;
4. licensed medical personnel in the performance of their duties; or
5. the coroner or medical examiner in the performance of the duties of their offices.

(b) This chapter does not apply to or interfere with the recognized customs or rites of any culture or recognized religion in the ceremonial washing, dressing, casketing, and public transportation of their dead, to the extent that all other provisions of this chapter are complied with.
(c) Noncompensated persons with the right to control the dead human body, under section 149A.80, subdivision 2, may remove a body from the place of death; transport the body; prepare the body for disposition, except embalming; or arrange for final disposition of the body, provided that all actions are in compliance with this chapter.

(d) Persons serving internships pursuant to section 149A.20, subdivision 6, or students officially registered for a practicum or clinical through a program of mortuary science accredited by the American Board of Funeral Service Education, or transfer care specialists registered pursuant to section 149A.47 are not required to be licensed, provided that the persons or students are registered with the commissioner and act under the direct and exclusive supervision of a person holding a current license to practice mortuary science in Minnesota.

(e) Notwithstanding this subdivision, nothing in this section shall be construed to prohibit an institution or entity from establishing, implementing, or enforcing a policy that permits only persons licensed by the commissioner to remove or cause to be removed a dead body or body part from the institution or entity.

(f) An unlicensed person may arrange for and direct or supervise a memorial service if that person or that person's employer does not have charge of the dead human body. An unlicensed person may not take charge of the dead human body, unless that person has the right to control the dead human body under section 149A.80, subdivision 2, or is that person's noncompensated designee.

Sec. 53. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 12c. Dead human body or body. "Dead human body" or "body" includes an identifiable human body part that is detached from a human body.

Sec. 54. Minnesota Statutes 2020, section 149A.02, subdivision 13a, is amended to read:

Subd. 13a. Direct supervision. "Direct supervision" means overseeing the performance of an individual. For the purpose of a clinical, practicum, internship, or registration, direct supervision means that the supervisor is available to observe and correct, as needed, the performance of the trainee or registrant. The mortician supervisor is accountable for the actions of the clinical student, practicum student, intern, or registrant throughout the course of the training. The supervising mortician is accountable for any violations of law or rule, in the performance of their duties, by the clinical student, practicum student, intern, or registrant.

Sec. 55. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 37d. Registrant. "Registrant" means any person who is registered as a transfer care specialist under section 149A.47.
Sec. 56. Minnesota Statutes 2020, section 149A.02, is amended by adding a subdivision to read:

Subd. 37e. Transfer care specialist. "Transfer care specialist" means an individual who is registered with the commissioner in accordance with section 149A.47 and is authorized to perform the removal of a dead human body from the place of death under the direct supervision of a licensed mortician.

Sec. 57. Minnesota Statutes 2020, section 149A.03, is amended to read:

149A.03 DUTIES OF COMMISSIONER.

The commissioner shall:

(1) enforce all laws and adopt and enforce rules relating to the:

(i) removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies;

(ii) licensure, registration, and professional conduct of funeral directors, morticians, interns, transfer care specialists, practicum students, and clinical students;

(iii) licensing and operation of a funeral establishment;

(iv) licensing and operation of an alkaline hydrolysis facility; and

(v) licensing and operation of a crematory;

(2) provide copies of the requirements for licensure, registration, and permits to all applicants;

(3) administer examinations and issue licenses, registrations, and permits to qualified persons and other legal entities;

(4) maintain a record of the name and location of all current licensees, registrants, and interns;

(5) perform periodic compliance reviews and premise inspections of licensees;

(6) accept and investigate complaints relating to conduct governed by this chapter;

(7) maintain a record of all current preneed arrangement trust accounts;

(8) maintain a schedule of application, examination, permit, registration, and licensure fees, initial and renewal, sufficient to cover all necessary operating expenses;

(9) educate the public about the existence and content of the laws and rules for mortuary science licensing and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies to enable consumers to file complaints against licensees and others who may have violated those laws or rules;
(10) evaluate the laws, rules, and procedures regulating the practice of mortuary science
in order to refine the standards for licensing and to improve the regulatory and enforcement
methods used; and

(11) initiate proceedings to address and remedy deficiencies and inconsistencies in the
laws, rules, or procedures governing the practice of mortuary science and the removal,
preparation, transportation, arrangements for disposition, and final disposition of dead
human bodies.

Sec. 58. Minnesota Statutes 2020, section 149A.09, is amended to read:

149A.09 DENIAL; REFUSAL TO REISSUE; REVOCATION; SUSPENSION;
LIMITATION OF LICENSE, REGISTRATION, OR PERMIT.

Subdivision 1. Denial; refusal to renew; revocation; and suspension. The regulatory
agency may deny, refuse to renew, revoke, or suspend any license, registration, or permit
applied for or issued pursuant to this chapter when the person subject to regulation under
this chapter:

(1) does not meet or fails to maintain the minimum qualification for holding a license,
registration, or permit under this chapter;

(2) submits false or misleading material information to the regulatory agency in
connection with a license, registration, or permit issued by the regulatory agency or the
application for a license, registration, or permit;

(3) violates any law, rule, order, stipulation agreement, settlement, compliance agreement,
license, registration, or permit that regulates the removal, preparation, transportation,
arrangements for disposition, or final disposition of dead human bodies in Minnesota or
any other state in the United States;

(4) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt,
or a no contest plea in any court in Minnesota or any other jurisdiction in the United States.
"Conviction," as used in this subdivision, includes a conviction for an offense which, if
committed in this state, would be deemed a felony or gross misdemeanor without regard to
its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is
made or returned, but the adjudication of guilt is either withheld or not entered;

(5) is convicted of a crime, including a finding or verdict of guilt, an admission of guilt,
or a no contest plea in any court in Minnesota or any other jurisdiction in the United States
that the regulatory agency determines is reasonably related to the removal, preparation,
transportation, arrangements for disposition or final disposition of dead human bodies, or
the practice of mortuary science;

(6) is adjudicated as mentally incompetent, mentally ill, developmentally disabled, or
mentally ill and dangerous to the public;

(7) has a conservator or guardian appointed;
(8) fails to comply with an order issued by the regulatory agency or fails to pay an
administrative penalty imposed by the regulatory agency;
(9) owes uncontested delinquent taxes in the amount of $500 or more to the Minnesota
Department of Revenue, or any other governmental agency authorized to collect taxes
anywhere in the United States;
(10) is in arrears on any court ordered family or child support obligations; or
(11) engages in any conduct that, in the determination of the regulatory agency, is
unprofessional as prescribed in section 149A.70, subdivision 7, or renders the person unfit
to practice mortuary science or to operate a funeral establishment or crematory.

Subd. 2. Hearings related to refusal to renew, suspension, or revocation of license,
registration, or permit. If the regulatory agency proposes to deny renewal, suspend, or
revoke a license, registration, or permit issued under this chapter, the regulatory agency
must first notify, in writing, the person against whom the action is proposed to be taken and
provide an opportunity to request a hearing under the contested case provisions of sections
14.57 to 14.62. If the subject of the proposed action does not request a hearing by notifying
the regulatory agency, by mail, within 20 calendar days after the receipt of the notice of
proposed action, the regulatory agency may proceed with the action without a hearing and
the action will be the final order of the regulatory agency.

Subd. 3. Review of final order. A judicial review of the final order issued by the
regulatory agency may be requested in the manner prescribed in sections 14.63 to 14.69.
Failure to request a hearing pursuant to subdivision 2 shall constitute a waiver of the right
to further agency or judicial review of the final order.

Subd. 4. Limitations or qualifications placed on license, registration, or permit. The
regulatory agency may, where the facts support such action, place reasonable limitations
or qualifications on the right to practice mortuary science, to operate a funeral
establishment or crematory, or to conduct activities or actions permitted under this chapter.

Subd. 5. Restoring license, registration, or permit. The regulatory agency may, where
there is sufficient reason, restore a license, registration, or permit that has been revoked,
reduce a period of suspension, or remove limitations or qualifications.

Sec. 59. Minnesota Statutes 2020, section 149A.11, is amended to read:

149A.11 PUBLICATION OF DISCIPLINARY ACTIONS.

The regulatory agencies shall report all disciplinary measures or actions taken to the
commissioner. At least annually, the commissioner shall publish and make available to the
public a description of all disciplinary measures or actions taken by the regulatory agencies.
The publication shall include, for each disciplinary measure or action taken, the name and
business address of the licensee, registrant, or intern; the nature of the misconduct; and
the measure or action taken by the regulatory agency.
Sec. 60. [149A.47] TRANSFER CARE SPECIALIST.

Subdivision 1. General. A transfer care specialist may remove a dead human body from the place of death under the direct supervision of a licensed mortician if the transfer care specialist is registered with the commissioner in accordance with this section. A transfer care specialist is not licensed to engage in the practice of mortuary science and shall not engage in the practice of mortuary science except as provided in this section.

Subd. 2. Registration. To be eligible for registration as a transfer care specialist, an applicant must submit to the commissioner:

(1) a complete application on a form provided by the commissioner that includes at a minimum:

(i) the applicant's name, home address and telephone number, business name, and business address and telephone number; and

(ii) the name, license number, business name, and business address and telephone number of the supervising licensed mortician;

(2) proof of completion of a training program that meets the requirements specified in subdivision 4; and

(3) the appropriate fees specified in section 149A.65.

Subd. 3. Duties. A transfer care specialist registered under this section is authorized to perform the removal of a dead human body from the place of death in accordance with this chapter to a licensed funeral establishment. The transfer care specialist must work under the direct supervision of a licensed mortician. The supervising mortician is responsible for the work performed by the transfer care specialist. A licensed mortician may supervise up to six transfer care specialists at any one time.

Subd. 4. Training program. (a) Each transfer care specialist must complete a training program that has been approved by the commissioner. To be approved, a training program must be at least seven hours long and must cover, at a minimum, the following:

(1) ethical care and transportation procedures for a deceased person;

(2) health and safety concerns to the public and the individual performing the transfer of the deceased person; and

(3) all relevant state and federal laws and regulations related to the transfer and transportation of deceased persons.

(b) A transfer care specialist must complete a training program every five years.

Subd. 5. Registration renewal. (a) A registration issued under this section expires one year after the date of issuance and must be renewed to remain valid.
75.29 (b) To renew a registration, the transfer care specialist must submit a completed renewal
75.30 application as provided by the commissioner and the appropriate fees specified in section
75.31 149A.65. Every five years, the renewal application must include proof of completion of a
75.32 training program that meets the requirements in subdivision 4.

76.1 Sec. 61. Minnesota Statutes 2020, section 149A.60, is amended to read:
76.2 149A.60 PROHIBITED CONDUCT.
76.3 The regulatory agency may impose disciplinary measures or take disciplinary action
76.4 against a person whose conduct is subject to regulation under this chapter for failure to
76.5 comply with any provision of this chapter or laws, rules, stipulation agreements,
76.6 settlements, compliance agreements, licenses, registrations, and permits adopted, or issued
76.7 for the regulation of the removal, preparation, transportation, arrangements for disposition
76.8 or final disposition of dead human bodies, or for the regulation of the practice of mortuary
76.9 science.

76.10 Sec. 62. Minnesota Statutes 2020, section 149A.61, subdivision 4, is amended to read:
76.11 Subd. 4. Licensees, registrants, and interns. A licensee, registrant, or intern regulated
76.12 under this chapter may report to the commissioner any conduct that the licensee
76.13 or intern has personal knowledge of, and reasonably believes constitutes grounds for,
76.14 disciplinary action under this chapter.

76.15 Sec. 63. Minnesota Statutes 2020, section 149A.61, subdivision 5, is amended to read:
76.16 Subd. 5. Courts. The court administrator of district court or any court of competent
76.17 jurisdiction shall report to the commissioner any judgment or other determination of the
76.18 court that adjudges or includes a finding that a licensee, registrant, or intern is a person who
76.19 is mentally ill, mentally incompetent, guilty of a felony or gross misdemeanor, guilty of
76.20 violations of federal or state narcotics laws or controlled substances acts; appoints a guardian
76.21 or conservator for the licensee, registrant, or intern; or commits a licensee, registrant, or
76.22 intern.

76.23 Sec. 64. Minnesota Statutes 2020, section 149A.62, is amended to read:
76.24 149A.62 IMMUNITY; REPORTING.
76.25 Any person, private agency, organization, society, association, licensee, registrant, or
76.26 intern who, in good faith, submits information to a regulatory agency under section 149A.61
76.27 or otherwise reports violations or alleged violations of this chapter, is immune from civil
76.28 liability or criminal prosecution. This section does not prohibit disciplinary action taken by
76.29 the commissioner against any licensee, registrant, or intern pursuant to a self report of a
76.30 violation.
Sec. 65. Minnesota Statutes 2020, section 149A.63, is amended to read:

**149A.63 PROFESSIONAL COOPERATION.**

A licensee, clinical student, practicum student, registrant, intern, or applicant for licensure under this chapter that is the subject of or part of an inspection or investigation by the commissioner or the commissioner's designee shall cooperate fully with the inspection or investigation. Failure to cooperate constitutes grounds for disciplinary action under this chapter.

Sec. 66. Minnesota Statutes 2020, section 149A.65, subdivision 2, is amended to read:

Subd. 2. Mortuary science fees. Fees for mortuary science are:

1. $75 for the initial and renewal registration of a mortuary science intern;
2. $125 for the mortuary science examination;
3. $200 for issuance of initial and renewal mortuary science licenses;
4. $100 late fee charge for a license renewal; and
5. $250 for issuing a mortuary science license by endorsement; and
6. $687 for the initial and renewal registration of a transfer care specialist.

Sec. 67. Minnesota Statutes 2020, section 149A.70, subdivision 3, is amended to read:

Subd. 3. Advertising. No licensee, registrant, clinical student, practicum student, or intern shall publish or disseminate false, misleading, or deceptive advertising. False, misleading, or deceptive advertising includes, but is not limited to:

1. identifying, by using the names or pictures of, persons who are not licensed to practice mortuary science in a way that leads the public to believe that those persons will provide mortuary science services;
2. using any name other than the names under which the funeral establishment, alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;
3. using a surname not directly, actively, or presently associated with a licensed funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had been previously and continuously used by the licensed funeral establishment, alkaline hydrolysis facility, or crematory; and
4. using a founding or establishing date or total years of service not directly or continuously related to a name under which the funeral establishment, alkaline hydrolysis facility, or crematory is currently or was previously licensed.

Any advertising or other printed material that contains the names or pictures of persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state

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the position held by the persons and shall identify each person who is licensed or unlicensed
under this chapter.

Sec. 68. Minnesota Statutes 2020, section 149A.70, subdivision 4, is amended to read:

Subd. 4. Solicitation of business. No licensee shall directly or indirectly pay or cause
to be paid any sum of money or other valuable consideration for the securing of business
or for obtaining the authority to dispose of any dead human body.

For purposes of this subdivision, licensee includes a registered intern or transfer care
specialist or any agent, representative, employee, or person acting on behalf of the licensee.

Sec. 69. Minnesota Statutes 2020, section 149A.70, subdivision 5, is amended to read:

Subd. 5. Reimbursement prohibited. No licensee, clinical student, practicum student,
or intern, or transfer care specialist shall offer, solicit, or accept a commission, fee, bonus,
rebate, or other reimbursement in consideration for recommending or causing a dead human
body to be disposed of by a specific body donation program, funeral establishment, alkaline
hydrolysis facility, crematory, mausoleum, or cemetery.

Sec. 70. Minnesota Statutes 2020, section 149A.70, subdivision 7, is amended to read:

Subd. 7. Unprofessional conduct. No licensee, registrant, or intern shall engage in or
permit others under the licensee's, registrant's, or intern's supervision or employment to
engage in unprofessional conduct. Unprofessional conduct includes, but is not limited to:

1. harassing, abusing, or intimidating a customer, employee, or any other person
encountered while within the scope of practice, employment, or business;

2. using profane, indecent, or obscene language within the immediate hearing of the
family or relatives of the deceased;

3. failure to treat with dignity and respect the body of the deceased, any member of the
family or relatives of the deceased, any employee, or any other person encountered while
within the scope of practice, employment, or business;

4. the habitual overindulgence in the use of or dependence on intoxicating liquors,

5. revealing personally identifiable facts, data, or information about a decedent, customer,

6. the prior consent of the individual, except as authorized by law;

7. intentionally misleading or deceiving any customer in the sale of any goods or services
provided by the licensee;

8. knowingly making a false statement in the procuring, preparation, or filing of any
required permit or document; or

9. required permit or document; or
Sec. 71. Minnesota Statutes 2020, section 149A.90, subdivision 2, is amended to read:

Subd. 2. Removal from place of death. No person subject to regulation under this chapter shall remove or cause to be removed any dead human body from the place of death without being licensed or registered by the commissioner. Every dead human body shall be removed from the place of death by a licensed mortician or funeral director, except as provided in section 149A.01, subdivision 3 or 149A.47.

Sec. 72. Minnesota Statutes 2020, section 149A.90, subdivision 4, is amended to read:

Subd. 4. Certificate of removal. No dead human body shall be removed from the place of death by a mortician, funeral director, or transfer care specialist or by a noncompensated person with the right to control the dead human body without the completion of a certificate of removal and, where possible, presentation of a copy of that certificate to the person or a representative of the legal entity with physical or legal custody of the body at the death site. The certificate of removal shall be in the format provided by the commissioner that contains, at least, the following information:

(1) the name of the deceased, if known;

(2) the date and time of removal;

(3) a brief listing of the type and condition of any personal property removed with the body;

(4) the location to which the body is being taken;

(5) the name, business address, and license number of the individual making the removal; and

(6) the signatures of the individual making the removal and, where possible, the individual or representative of the legal entity with physical or legal custody of the body at the death site.

Sec. 73. Minnesota Statutes 2020, section 149A.90, subdivision 5, is amended to read:

Subd. 5. Retention of certificate of removal. A copy of the certificate of removal shall be given, where possible, to the person or representative of the legal entity having physical or legal custody of the body at the death site. The original certificate of removal shall be retained by the individual making the removal and shall be kept on file, at the funeral establishment to which the body was taken, for a period of three calendar years following the date of the removal. If the removal was performed by a transfer care specialist not employed by the funeral establishment to which the body was taken, the transfer care specialist shall retain a copy of the certificate on file at the transfer care specialist's business address as registered with the commissioner for a period of three calendar years following the date of removal. Following this period, and subject to any other laws requiring retention...
of records, the funeral establishment may then place the records in storage or reduce them
to microfilm, microfiche, laser disc, or any other method that can produce an accurate
reproduction of the original record, for retention for a period of ten calendar years from the
date of the removal of the body. At the end of this period and subject to any other laws
requiring retention of records, the funeral establishment may destroy the records by shredding,
incineration, or any other manner that protects the privacy of the individuals identified in
the records.

Sec. 74. Minnesota Statutes 2020, section 149A.94, subdivision 1, is amended to read:

Subdivision 1. Generally. (a) Every dead human body lying within the state, except
unclaimed bodies delivered for dissection by the medical examiner, those delivered for
anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
the state for the purpose of disposition elsewhere; and the remains of any dead human body
after dissection or anatomical study, shall be decently buried or entombed in a public or
private cemetery, alkaline hydrolyzed, or cremated within a reasonable time after death.
Where final disposition of a body will not be accomplished within 72 hours following death
or release of the body by a competent authority with jurisdiction over the body, the body
must be properly embalmed, refrigerated, or packed with dry ice. A body may not be kept
in refrigeration for a period exceeding six calendar days, or packed in dry ice for a period
that exceeds four calendar days, from the time of death or release of the body from the
coroner or medical examiner. A body may be kept in refrigeration for up to 30 calendar
days from the time of death or release of the body from the coroner or medical examiner,
provided the dignity of the body is maintained and the funeral establishment complies with
paragraph (b) if applicable. A body may be kept in refrigeration for more than 30 calendar
days from the time of death or release of the body from the coroner or medical examiner in
accordance with paragraphs (c) and (d).

(b) For a body to be kept in refrigeration for between 15 and 30 calendar days, no later
than the 14th day of keeping the body in refrigeration the funeral establishment must notify
the person with the right to control final disposition that the body will be kept in refrigeration
for more than 14 days and that the person with the right to control final disposition has the
right to seek other arrangements.

(c) For a body to be kept in refrigeration for more than 30 calendar days, the funeral
establishment must:

(1) report at least the following to the commissioner on a form and in a manner prescribed
by the commissioner: body identification details determined by the commissioner, the funeral
establishment's plan to achieve final disposition of the body within the permitted time frame,
and other information required by the commissioner; and

(2) store each refrigerated body in a manner that maintains the dignity of the body.
(d) Each report filed with the commissioner under paragraph (c) authorizes a funeral establishment to keep a body in refrigeration for an additional 30 calendar days.

(e) Failure to submit a report required by paragraph (c) subjects a funeral establishment to enforcement under this chapter.

Sec. 75. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 1a. Bona fide labor organization. "Bona fide labor organization" means a labor union that represents or is actively seeking to represent workers of a medical cannabis manufacturer.

Sec. 76. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5d. Indian lands. "Indian lands" means all lands within the limits of any Indian reservation within the boundaries of Minnesota and any lands within the boundaries of Minnesota title which are either held in trust by the United States or over which an Indian Tribe exercises governmental power.

Sec. 77. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 5e. Labor peace agreement. "Labor peace agreement" means an agreement between a medical cannabis manufacturer and a bona fide labor organization that protects the state's interests by, at a minimum, prohibiting the labor organization from engaging in picketing, work stoppages, or boycotts against the manufacturer. This type of agreement shall not mandate a particular method of election or certification of the bona fide labor organization.

Sec. 78. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 15. Tribal medical cannabis board. "Tribal medical cannabis board" means an agency established by each federally recognized Tribal government and duly authorized by each Tribe's governing body to perform regulatory oversight and monitor compliance with a Tribal medical cannabis program and applicable regulations.

Sec. 79. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 16. Tribal medical cannabis program. "Tribal medical cannabis program" means a program established by a federally recognized Tribal government within the boundaries of Minnesota regarding the commercial production, processing, sale or distribution, and possession of medical cannabis and medical cannabis products.
Sec. 80. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to read:

Subd. 17. Tribal medical cannabis program patient. "Tribal medical cannabis program patient" means a person who possesses a valid registration verification card or equivalent document that is issued under the laws or regulations of a Tribal Nation within the boundaries of Minnesota and that verifies that the person is enrolled in or authorized to participate in that Tribal Nation's Tribal medical cannabis program.

Sec. 81. Minnesota Statutes 2020, section 152.25, subdivision 1, is amended to read:

Subdivision 1. Medical cannabis manufacturer registration and renewal. (a) The commissioner shall register at least four and up to ten in-state manufacturers for the production of all medical cannabis within the state. The registration agreement between the commissioner and a manufacturer is valid for two years, unless revoked under subdivision 1a, and is nontransferable. The commissioner shall register new manufacturers or reregister the existing manufacturers by December 1 every two years, using the factors described in this subdivision. The commissioner shall accept applications after December 1, 2014, if one of the manufacturers registered before December 1, 2014, ceases to be registered as a manufacturer. The commissioner's determination that no manufacturer exists to fulfill the duties under sections 152.22 to 152.37 is subject to judicial review in Ramsey County District Court.

Once the commissioner has registered more than two manufacturers, registration renewal for at least one manufacturer must occur each year. The commissioner shall begin registering additional manufacturers by December 1, 2022. The commissioner shall renew a registration if the manufacturer meets the factors described in this subdivision and submits the registration renewal fee under section 152.35.

(b) An individual or entity seeking registration or registration renewal under this subdivision must apply to the commissioner in a form and manner established by the commissioner. As part of the application, the applicant must submit an attestation signed by a bona fide labor organization stating that the applicant has entered into a labor peace agreement. Before accepting applications for registration or registration renewal, the commissioner must publish on the Office of Medical Cannabis website the application scoring criteria established by the commissioner to determine whether the applicant meets requirements for registration or registration renewal. Data submitted during the application process are private data on individuals or nonpublic data as defined in section 13.02 until the manufacturer is registered under this section. Data on a manufacturer that is registered are public data, unless the data are trade secret or security information under section 13.37.

(c) As a condition for registration, a manufacturer must agree:

(1) begin supplying medical cannabis to patients by July 1, 2015; and
(1) a manufacturer must comply with all requirements under sections 152.22 to 152.37.

(2) if the manufacturer is a business entity, the manufacturer must be incorporated in the state or otherwise formed or organized under the laws of the state; and

(3) the manufacturer must fulfill commitments made in the application for registration or registration renewal, including but not limited to maintenance of a labor peace agreement.

The commissioner shall consider the following factors when determining which manufacturer to register or when determining whether to renew a registration:

(1) the technical expertise of the manufacturer in cultivating medical cannabis and converting the medical cannabis into an acceptable delivery method under section 152.22, subdivision 6;

(2) the qualifications of the manufacturer's employees;

(3) the long-term financial stability of the manufacturer;

(4) the ability to provide appropriate security measures on the premises of the manufacturer;

(5) whether the manufacturer has demonstrated an ability to meet the medical cannabis production needs required by sections 152.22 to 152.37;

(6) the manufacturer's projection and ongoing assessment of fees on patients with a qualifying medical condition;

(7) the manufacturer's inclusion of leadership or beneficial ownership, as defined in section 302A.011, subdivision 41, by:

(i) minority persons as defined in section 116M.14, subdivision 6;

(ii) women;

(iii) individuals with disabilities as defined in section 363A.03, subdivision 12; or

(iv) military veterans who satisfy the requirements of section 197.447;

(8) the extent to which registering the manufacturer or renewing the registration will expand service to a currently underserved market;

(9) the extent to which registering the manufacturer or renewing the registration will promote development in a low-income area as defined in section 116J.982, subdivision 1, paragraph (c);

(10) beneficial ownership as defined in section 302A.011, subdivision 41, of the manufacturer by Minnesota residents; and
(11) other factors the commissioner determines are necessary to protect patient health and ensure public safety.

(g) Commitments made by an applicant in the application for registration or registration renewal, including but not limited to maintenance of a labor peace agreement, shall be an ongoing material condition of maintaining a manufacturer registration.

(d) (f) If an officer, director, or controlling person of the manufacturer pleads or is found guilty of intentionally diverting medical cannabis to a person other than allowed by law under section 152.33, subdivision 1, the commissioner may decide not to renew the registration of the manufacturer, provided the violation occurred while the person was an officer, director, or controlling person of the manufacturer.

(e) The commissioner shall require each medical cannabis manufacturer to contract with an independent laboratory to test medical cannabis produced by the manufacturer. The commissioner shall approve the laboratory chosen by each manufacturer and require that the laboratory report testing results to the manufacturer in a manner determined by the commissioner.

Sec. 82. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to read:

Subd. 1d. Background study. (a) Before the commissioner registers a manufacturer or renews a registration, each officer, director, and controlling person of the manufacturer must consent to a background study and must submit to the commissioner a completed criminal history records check consent form, a full set of classifiable fingerprints, and the required fees. The commissioner must submit these materials to the Bureau of Criminal Apprehension. The bureau must conduct a Minnesota criminal history records check, and the superintendent is authorized to exchange fingerprints with the Federal Bureau of Investigation to obtain national criminal history record information. The bureau must return the results of the Minnesota and federal criminal history records checks to the commissioner.

(b) The commissioner must not register a manufacturer or renew a registration if an officer, director, or controlling person of the manufacturer has been convicted of, pled guilty to, or received a stay of adjudication for:

(1) a violation of state or federal law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct that is a felony under Minnesota law or would be a felony if committed in Minnesota; or

(2) a violation of state or federal law relating to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance that is a felony under Minnesota law or would be a felony if committed in Minnesota.

Sec. 83. Minnesota Statutes 2020, section 152.29, subdivision 4, is amended to read:

Subd. 4. Report. (a) Each manufacturer shall report to the commissioner on a monthly basis the following information on each individual patient for the month prior to the report:
(1) the amount and dosages of medical cannabis distributed;

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

(3) the tracking number assigned to any medical cannabis distributed.

(b) For transactions involving Tribal medical cannabis program patients, each
manufacturer shall report to the commissioner on a weekly basis the following information
on each individual Tribal medical cannabis program patient for the week prior to the report:

(1) the name of the Tribal medical cannabis program in which the Tribal medical cannabis
program patient is enrolled;

(2) the amount and dosages of medical cannabis distributed;

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

(4) the tracking number assigned to the medical cannabis distributed.

Sec. 84. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
read:

Subd. 5. Distribution to Tribal medical cannabis program patient.
(a) A manufacturer
may distribute medical cannabis in accordance with subdivisions 1 to 4 to a Tribal medical
cannabis program patient.

(b) Prior to distribution, the Tribal medical cannabis program patient must provide to
the manufacturer:

(1) a valid medical cannabis registration verification card or equivalent document issued
by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program
patient is authorized to use medical cannabis on Indian lands over which the Tribe has
jurisdiction; and

(2) a valid photographic identification card issued by the Tribal medical cannabis
program, valid driver’s license, or valid state identification card.

(c) A manufacturer shall distribute medical cannabis to a Tribal medical cannabis program
patient only in a form allowed under section 152.22, subdivision 6.

Sec. 85. [152.291] TRIBAL MEDICAL CANNABIS PROGRAM;
MANUFACTURERS.

Subdivision 1. Manufacturer. Notwithstanding the requirements and limitations in
section 152.29, subdivision 1, paragraph (a), a Tribal medical cannabis program operated
by a federally recognized Indian Tribe located in Minnesota shall be recognized as a medical
cannabis manufacturer.
Subd. 2. Manufacturer transportation. (a) A manufacturer registered with a Tribal medical cannabis program may transport medical cannabis to testing laboratories and to other Indian lands in the state.

(b) A manufacturer registered with a Tribal medical cannabis program must staff a motor vehicle used to transport medical cannabis with at least two employees of the manufacturer. Each employee in the transport vehicle must carry identification specifying that the employee is an employee of the manufacturer, and one employee in the transport vehicle must carry a detailed transportation manifest that includes the place and time of departure, the address of the destination, and a description and count of the medical cannabis being transported.

152.30 PATIENT DUTIES.

(a) A patient shall apply to the commissioner for enrollment in the registry program by submitting an application as required in section 152.27 and an annual registration fee as determined under section 152.35.

(b) As a condition of continued enrollment, patients shall agree to:

(1) continue to receive regularly scheduled treatment for their qualifying medical condition from their health care practitioner; and

(2) report changes in their qualifying medical condition to their health care practitioner.

(c) A patient shall only receive medical cannabis from a registered manufacturer or Tribal medical cannabis program but is not required to receive medical cannabis products from only a registered manufacturer or Tribal medical cannabis program.

Subdivision 1. Presumption.

(a) There is a presumption that a patient enrolled in the registry program under sections 152.22 to 152.37 or a Tribal medical cannabis program is engaged in the authorized use of medical cannabis.

(b) The presumption may be rebutted:

(1) by evidence that a patient's conduct related to use of medical cannabis was not for the purpose of treating or alleviating the patient's qualifying medical condition or symptoms associated with the patient's qualifying medical condition;

(2) by evidence that a Tribal medical cannabis program patient's use of medical cannabis was not for a purpose authorized by the Tribal medical cannabis program.
Subd. 2. Criminal and civil protections. (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, possession by a registered designated caregiver or the parent, legal guardian, or spouse of a patient if the parent, legal guardian, or spouse is listed on the registry verification; or use or possession of medical cannabis or medical cannabis products by a Tribal medical cannabis program patient;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, members of a Tribal medical cannabis board, the commissioner's or Tribal medical cannabis board's staff, the commissioner's or Tribal medical cannabis board's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37 or in a Tribal medical cannabis program. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient or a Tribal medical cannabis program patient under sections 152.22 to 152.37 may be
admitted as evidence in a criminal proceeding unless independently obtained or in connection
with a proceeding involving a violation of sections 152.22 to 152.37.

(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty
of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme
Court, a Tribal court, or the professional responsibility board for providing legal assistance
to prospective or registered manufacturers or others related to activity that is no longer
subject to criminal penalties under state law pursuant to sections 152.22 to 152.37, or for
providing legal assistance to a Tribal medical cannabis program.

(j) Possession of a registry verification or application for enrollment in the program by
a person entitled to possess or apply for enrollment in the registry program, or possession
of a verification or equivalent issued by a Tribal medical cannabis program by a person
entitled to possess such verification, does not constitute probable cause or reasonable
suspicion, nor shall it be used to support a search of the person or property of the person
possessing or applying for the registry verification or equivalent, or otherwise subject the
person or property of the person to inspection by any governmental agency.

Subd. 3. Discrimination prohibited.

(a) No school or landlord may refuse to enroll or
lease to and may not otherwise penalize a person solely for the person's status as a patient
enrolled in the registry program under sections 152.22 to 152.37 or for the person's status
as a Tribal medical cannabis program patient enrolled in a Tribal medical cannabis program,
unless failing to do so would violate federal law or regulations or cause the school or landlord
to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ transplants, a registry program
enrollee's use of medical cannabis under sections 152.22 to 152.37, or a Tribal medical
cannabis program patient's use of medical cannabis as authorized by the Tribal medical
cannabis program, is considered the equivalent of the authorized use of any other medication
used at the discretion of a physician or advanced practice registered nurse and does not
constitute the use of an illicit substance or otherwise disqualify a patient from needed medical
care.

(c) Unless a failure to do so would violate federal law or regulations or cause an employer
to lose a monetary or licensing-related benefit under federal law or regulations, an employer
may not discriminate against a person in hiring, termination, or any term or condition of
employment, or otherwise penalize a person, if the discrimination is based upon either any
of the following:

(1) the person's status as a patient enrolled in the registry program under sections 152.22
to 152.37; or

(2) the person's status as a Tribal medical cannabis program patient enrolled in a Tribal
medical cannabis program; or
(3) a patient’s positive drug test for cannabis components or metabolites, unless the
patient used, possessed, or was impaired by medical cannabis on the premises of the place
of employment or during the hours of employment.

(d) An employee who is required to undergo employer drug testing pursuant to section
181.953 may present verification of enrollment in the patient registry or of enrollment in a
Tribal medical cannabis program as part of the employee's explanation under section 181.953,
subdivision 6.

(e) A person shall not be denied custody of a minor child or visitation rights or parenting
time with a minor child solely based on the person's status as a patient enrolled in the registry
program under sections 152.22 to 152.37 or on the person's status as a Tribal medical
cannabis program patient enrolled in a Tribal medical cannabis program. There shall be no
presumption of neglect or child endangerment for conduct allowed under sections 152.22
to 152.37 or under a Tribal medical cannabis program, unless the person's behavior is such
that it creates an unreasonable danger to the safety of the minor as established by clear and
convincing evidence.

Sec. 88. Minnesota Statutes 2020, section 152.33, subdivision 1, is amended to read:

Subdivision 1. Intentional diversion; criminal penalty. In addition to any other
applicable penalty in law, a manufacturer or an agent of a manufacturer who intentionally
transfers medical cannabis to a person other than another registered manufacturer, a patient,
a registered designated caregiver, a Tribal medical cannabis program patient, or, if listed
on the registry verification, a parent, legal guardian, or spouse of a patient is guilty of a
felony punishable by imprisonment for not more than two years or by payment of a fine of
not more than $3,000, or both. A person convicted under this subdivision may not continue
to be affiliated with the manufacturer and is disqualified from further participation under
sections 152.22 to 152.37.

Sec. 89. Minnesota Statutes 2020, section 152.35, is amended to read:

152.35 FEES; DEPOSIT OF REVENUE.

(a) The commissioner shall collect an enrollment fee of $40 from patients enrolled
under this section 152.27. If the patient provides evidence of receiving Social Security
disability insurance (SSDI), Supplemental Security Income (SSI), veterans disability, or
railroad disability payments, or being enrolled in medical assistance or MinnesotaCare, then
the fee shall be $20. For purposes of this section:

(1) a patient is considered to receive SSDI if the patient was receiving SSDI at the time
the patient was transitioned to retirement benefits by the United States Social Security
Administration; and

(2) veterans disability payments include VA dependency and indemnity compensation.

Unless a patient provides evidence of receiving payments from or participating in one of
the programs specifically listed in this paragraph, the commissioner of health must collect
the $200 enrollment fee from a patient to enroll the patient in the registry program. The fees
shall be payable annually and are due on the anniversary date of the patient's enrollment.

The fee amount shall be deposited in the state treasury and credited to the state government
special revenue fund.

(b) The commissioner shall collect a nonrefundable registration application fee of
$10,000 from each entity submitting an application for registration as a medical
cannabis manufacturer. Revenue from the fee shall be deposited in the state treasury and
credited to the state government special revenue fund.

c) The commissioner shall establish and collect an annual registration renewal fee from
a medical cannabis manufacturer equal to the cost of regulating and inspecting the
manufacturer for the upcoming registration period. Revenue from the fee amount
shall be deposited in the state treasury and credited to the state government special revenue
fund.

d) A medical cannabis manufacturer may charge patients enrolled in the registry program
a reasonable fee for costs associated with the operations of the manufacturer. The
manufacturer may establish a sliding scale of patient fees based upon a patient's household
income and may accept private donations to reduce patient fees.

Sec. 17. Minnesota Statutes 2021 Supplement, section 245C.03, subdivision 5a, is amended
to read:

Subd. 5a. Facilities serving children or adults licensed or regulated by the
Department of Health. (a) Except as specified in paragraph (b), the commissioner shall
conduct background studies of:

(1) individuals providing services who have direct contact, as defined under section
245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and
home care agencies licensed under chapter 144A; assisted living facilities and assisted living
facilities with dementia care licensed under chapter 144G; and board and lodging
establishments that are registered to provide supportive or health supervision services under
section 157.17;

(2) individuals specified in subdivision 2 who provide direct contact services in a nursing
home or a home care agency licensed under chapter 144A; an assisted living facility or
assisted living facility with dementia care licensed under chapter 144G; or a boarding care
home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides
outside of Minnesota, the study must include a check for substantiated findings of
maltreatment of adults and children in the individual's state of residence when the state
makes the information available;
(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact with or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined by section 144A.70.

(6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under this chapter, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual.

(b) The commissioner of human services shall not conduct a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.

(c) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.

(d) The commissioner of health shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of health shall inform the requesting individual and the Department of Human Services of the commissioner of health's decision regarding the reconsideration. The commissioner of health's decision to grant or deny a reconsideration of a disqualification is a final administrative agency action.

EFFECTIVE DATE. This section is effective the day following final enactment.
commissioner making a decision regarding disqualification, the board shall make a determination whether to impose disciplinary or corrective action under chapter 214. The commissioner shall notify a health-related licensing board as defined in section 214.01 subdivision 2, if the commissioner determines that an individual who is licensed by the health-related licensing board and who is included on the board's roster list provided in accordance with subdivision 3a is responsible for substantiated maltreatment under section 626.557 or chapter 260E, in accordance with subdivision 2. Upon receiving notification, the health-related licensing board shall make a determination as to whether to impose disciplinary or corrective action under chapter 214.

(b) This section does not apply to a background study of an individual regulated by a health-related licensing board if the individual's study is related to child foster care, adult foster care, or family child care licensure.

EFFECTIVE DATE. This section is effective February 1, 2023.

Sec. 19. Minnesota Statutes 2020, section 245C.31, subdivision 2, is amended to read:

Subd. 2. Commissioner's notice to board. (a) The commissioner shall notify the health-related licensing board:

(1) upon completion of a background study that produces a record showing that the individual licensed by the board was determined to have been responsible for substantiated maltreatment;

(2) upon the commissioner's completion of an investigation that determined the individual licensed by the board was responsible for substantiated maltreatment; or

(3) upon receipt from another agency of a finding of substantiated maltreatment for which the individual licensed by the board was responsible.

(b) The commissioner's notice to the health-related licensing board shall indicate whether the commissioner would have disqualified the individual for the substantiated maltreatment if the individual were not regulated by the board.

(c) The commissioner shall concurrently send the notice under this subdivision to the individual who is the subject of the background study.

EFFECTIVE DATE. This section is effective February 1, 2023.

Sec. 20. Minnesota Statutes 2020, section 245C.31, is amended by adding a subdivision to read:

Subd. 3a. Agreements with health-related licensing boards. The commissioner and each health-related licensing board shall enter into an agreement in order for each board to provide the commissioner with a daily roster list of individuals who have a license issued by the board in active status. The list must include for each licensed individual the individual's
Sec. 90. Laws 2021, First Special Session chapter 7, article 3, section 44, is amended to read:

Sec. 44. MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM.

(a) The commissioner of health shall develop a grant program, in consultation with the relevant mental health licensing boards, to:

(1) provide for the continuing education necessary for social workers, marriage and family therapists, psychologists, and professional clinical counselors to become supervisors for individuals pursuing licensure in mental health professions;

(2) cover the costs when supervision is required for professionals becoming supervisors; and

(3) cover the supervisory costs for mental health practitioners pursuing licensure at the professional level.

(b) Social workers, marriage and family therapists, psychologists, and professional clinical counselors obtaining continuing education and mental health practitioners needing supervised hours to become licensed as professionals under this section must:

(1) be members of communities of color or underrepresented communities as defined in Minnesota Statutes, section 148E.010, subdivision 20, or practice in a mental health professional shortage area; and

(2) work for community mental health providers and agree to deliver at least 25 percent of their yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

Sec. 91. BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL.

Subdivision 1. Contract for analysis of proposal. The commissioner of health shall contract with the University of Minnesota School of Public Health and the Carlson School of Management to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system.

Subd. 2. Proposal. The commissioner of health, with input from the commissioners of human services and commerce, shall submit to the University of Minnesota for analysis a
legislative proposal known as the Minnesota Health Plan that would offer a universal health care plan designed to meet the following principles:

(1) ensure all Minnesotans are covered;
(2) cover all necessary care, including dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care; and
(3) allow patients to choose their doctors, hospitals, and other providers.

Subd. 3. Proposal analysis. (a) The analysis must measure the performance of both the Minnesota Health Plan and the current health care financing system over a ten-year period to contrast the impact on:

(1) the number of people covered versus the number of people who continue to lack access to health care because of financial or other barriers, if any;
(2) the completeness of the coverage and the number of people lacking coverage for dental, long-term care, medical equipment or supplies, vision and hearing, or other health services that are not covered, if any;
(3) the adequacy of the coverage, the level of underinsured in the state, and whether people with coverage can afford the care they need or whether cost prevents them from accessing care;
(4) the timeliness and appropriateness of the care received and whether people turn to inappropriate care such as emergency rooms because of a lack of proper care in accordance with clinical guidelines; and
(5) total public and private health care spending in Minnesota under the current system versus the legislative proposal, including all spending by individuals, businesses, and government. "Total public and private health care spending" means spending on all medical care including but not limited to dental, vision and hearing, mental health, chemical dependency treatment, prescription drugs, medical equipment and supplies, long-term care, and home care, whether paid through premiums, co-pays and deductibles, other out-of-pocket payments, or other funding from government, employers, or other sources. Total public and private health care spending also includes the costs associated with administering, delivering, and paying for the care. The costs of administering, delivering, and paying for the care includes all expenses by insurers, providers, employers, individuals, and government to select, negotiate, purchase, and administer insurance and care including but not limited to coverage for health care, dental, long-term care, prescription drugs, medical expense portions of workers compensation and automobile insurance, and the cost of administering and paying for all health care products and services that are not covered by insurance. The analysis of total health care spending shall examine whether there are savings or additional costs under the legislative proposal compared to the existing system due to:
(i) reduced insurance, billing, underwriting, marketing, evaluation, and other administrative functions including savings from global budgeting for hospitals and institutional care instead of billing for individual services provided;

(ii) reduced prices on medical services and products including pharmaceuticals due to price negotiations, if applicable under the proposal;

(iii) changes in utilization, better health outcomes, and reduced time away from work due to prevention, early intervention, health-promoting activities, and to the extent possible given available data and resources;

(iv) shortages or excess capacity of medical facilities and equipment under either the current system or the proposal;

(v) the impact on state, local, and federal government non-health-care expenditures such as reduced crime and out-of-home placement costs due to mental health or chemical dependency coverage; and

(vi) job losses or gains in health care delivery, health billing and insurance administration, and elsewhere in the economy under the proposal due to implementation of the reforms and the resulting reduction of insurance and administrative burdens on businesses.

(b) The analysts may consult with authors of the legislative proposal to gain understanding or clarification of the specifics of the proposal. The analysis shall assume that the provisions in the proposal are not preempted by federal law or that the federal government gives a waiver to the preemptions.

(c) The commissioner shall issue a final report by January 15, 2023, and may provide interim reports and status updates to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 92. NURSING WORKFORCE REPORT.

The commissioner of health shall provide a public report on the following topics:

(1) Minnesota's supply of active licensed registered nurses;

(2) trends in Minnesota regarding retention by hospitals of licensed registered nurses;

(3) reasons licensed registered nurses are leaving direct care positions at hospitals; and

(4) reasons licensed registered nurses are choosing not to renew their licenses and leaving the profession.

Sec. 93. EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.

Subdivision 1. Short title. This section shall be known as the Emmett Louis Till Victims Recovery Program.
Subd. 2. Program established; grants. (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of:

1. victims who experienced trauma, including historical trauma, resulting from events such as assault or another violent physical act, intimidation, false accusations, wrongful conviction, a hate crime, the violent death of a family member, or experiences of discrimination or oppression based on the victim's race, ethnicity, or national origin; and

2. the families and heirs of victims described in clause (1), who experienced trauma, including historical trauma, because of their proximity or connection to the victim.

(b) The commissioner, in consultation with victims, families, and heirs who experienced trauma and with community-based organizations that provide culturally appropriate services to victims experiencing trauma and their families and heirs, shall award competitive grants to applicants for projects to provide the following services to victims, families, and heirs described in paragraph (a):

1. health and wellness services, which may include services and support to address physical health, mental health, and cultural needs;

2. remembrance and legacy preservation activities;

3. cultural awareness services; and

4. community resources and services to promote healing for victims, families, and heirs described in paragraph (a).

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims, families, and heirs described in paragraph (a).

Subd. 3. Evaluation. Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. Report. By January 15, 2023, the commissioner must submit a status report on the operation and results of the grant program, to the extent possible. The report must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report must include information on grant program activities to date, services offered by grant recipients, and an assessment of the need to continue to offer services to victims, families, and heirs who experienced trauma.

Sec. 94. IDENTIFY STRATEGIES FOR REDUCTION OF ADMINISTRATIVE SPENDING AND LOW-VALUE CARE; REPORT.

(a) The commissioner of health shall develop recommendations for strategies to reduce the volume and growth of administrative spending by health care organizations and group
purchasers and the amount of low-value care delivered to Minnesota residents. In support
of the development of recommendations, the commissioner shall:

1. review the availability of data and identify gaps in the data infrastructure to estimate
aggregated and disaggregated administrative spending and low-value care;

2. based on available data, estimate the volume and change over time of administrative
spending and low-value care in Minnesota;

3. conduct an environmental scan and key informant interviews with experts in health
care finance, health economics, health care management or administration, or the
administration of health insurance benefits to identify drivers of spending growth for spending
on administrative services or the provision of low-value care; and

4. convene a clinical learning community and an employer task force to review the
evidence from clauses (1) to (3) and develop a set of actionable strategies to address
administrative spending volume and growth and the magnitude of the volume of low-value
care.

(b) By December 15, 2024, the commissioner shall report the recommendations to the
chairs and ranking members of the legislative committees with jurisdiction over health and
human services financing and policy.

Sec. 95. INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE
BEDSIDE ACT.

(a) By April 1, 2024, each hospital must establish and convene a hospital nurse staffing
committee as described under Minnesota Statutes, section 144.7053.

(b) By June 1, 2024, each hospital must implement core staffing plans developed by its
hospital nurse staffing committee and satisfy the plan posting requirements under Minnesota
Statutes, section 144.7056.

(c) By June 1, 2024, each hospital must submit to the commissioner of health core
staffing plans meeting the requirements of Minnesota Statutes, section 144.7055.

Sec. 96. LEAD SERVICE LINE INVENTORY GRANT PROGRAM.

Subdivision 1. Establishment. The commissioner of health must establish a grant
program to provide financial assistance to municipalities for producing an inventory of
publicly and privately owned lead service lines within their jurisdiction.

Subd. 2. Eligible uses. A municipality receiving a grant under this section may use the
grant funds to:

1. survey households to determine the material of which their water service line is
made;
(2) create publicly available databases or visualizations of lead service lines; and

(3) comply with the lead service line inventory requirements in the Environmental Protection Agency’s Lead and Copper Rule.

Sec. 97. PAYMENT MECHANISMS IN RURAL HEALTH CARE.

The commissioner of health shall develop a plan to assess readiness of rural communities and rural health care providers to adopt value-based, global budgeting, or alternative payment systems and recommend steps needed to implement. The commissioner may use the development of case studies and modeling of alternate payment systems to demonstrate value-based payment systems that ensure a baseline level of essential community or regional health services and address population health needs. The commissioner shall develop recommendations for pilot projects by January 1, 2025, with the aim of ensuring financial viability of rural health care systems in the context of spending growth targets. The commissioner shall share findings with the Health Care Affordability Board.

Sec. 98. PROGRAM TO DISTRIBUTE COVID-19 TESTS, MASKS, AND RESPIRATORS.

Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section.

(b) "Antigen test" means a lateral flow immunoassay intended for the qualitative detection of nucleocapsid protein antigens from the SARS-CoV-2 virus in nasal swabs, that has emergency use authorization from the United States Food and Drug Administration and that is authorized for nonprescription home use with self-collected nasal swabs.

(c) "COVID-19 test" means a test authorized by the United States Food and Drug Administration to detect the presence of genetic material of the SARS-CoV-2 virus either through a molecular method that detects the RNA or nucleic acid component of the virus, such as polymerase chain reaction or isothermal amplification, or through a rapid lateral flow immunoassay that detects the nucleocapsid protein antigens from the SARS-CoV-2 virus.

(d) "KN95 respirator" means a type of filtering facepiece respirator that is commonly made and used in China, is designed and tested to meet an international standard, and does not include an exhalation valve.

(e) "Mask" means a face covering intended to contain droplets and particles in a person's breath, cough, or sneeze.

(f) "Respirator" means a face covering that filters the air and fits closely on the face to filter out particles, including the SARS-CoV-2 virus.

Subd. 2. Program established. In order to help reduce the number of cases of COVID-19 in the state, the commissioner of health must administer a program to distribute to individuals in Minnesota, COVID-19 tests, including antigen tests; and masks and respirators, including KN95 respirators and similar respirators approved by the Centers for Disease Control and Prevention.
Prevention and authorized by the commissioner for distribution under this program. Masks and respirators distributed under this program may include child-sized masks and respirators, if such masks and respirators are available and the commissioner finds there is a need for them. COVID-19 tests, masks, and respirators must be distributed at no cost to the individuals receiving them and may be shipped directly to individuals, distributed through local health departments, COVID community coordinators, and other community-based organizations; and distributed through other means determined by the commissioner. The commissioner may prioritize distribution under this section to communities and populations who are disproportionately impacted by COVID-19 or who have difficulty accessing COVID-19 tests, masks, or respirators.

Subd. 3. Process to order COVID-19 tests, masks, and respirators. The commissioner may establish a process for individuals to order COVID-19 tests, masks, and respirators to be shipped directly to the individual.

Subd. 4. Notice. An entity distributing KN95 respirators or similar respirators under this section may include with the respirators a notice that individuals with a medical condition that may make it difficult to wear a KN95 respirator or similar respirator should consult with a health care provider before use.

Subd. 5. Coordination. The commissioner may coordinate this program with other state and federal programs that distribute COVID-19 tests, masks, or respirators to the public.

Sec. 99. REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.

Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section.

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

c) "Non-claims-based payments" means payments to health care providers designed to support and reward value of health care services over volume of health care services and includes alternative payment models or incentives, payments for infrastructure expenditures or investments, and payments for workforce expenditures or investments.

(d) "Nonpublic data" has the meaning given in Minnesota Statutes, section 13.02, subdivision 9.

(e) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

Subd. 2. Report. (a) To provide the legislature with information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature by February 15, 2023, on the volume and distribution of health care spending across payment
models used by health plan companies and third-party administrators, with a particular focus on value-based care models and primary care spending.

(b) The report must include specific health plan and third-party administrator estimates of health care spending for claims-based payments and non-claims-based payments for the most recent available year, reported separately for Minnesotans enrolled in state health care programs, Medicare Advantage, and commercial health insurance. The report must also include recommendations on changes needed to gather better data from health plan companies and third-party administrators on the use of value-based payments that pay for value of health care services provided over volume of services provided, promote the health of all Minnesotans, reduce health disparities, and support the provision of primary care services and preventive services.

(c) In preparing the report, the commissioner shall:

(1) describe the form, manner, and timeline for submission of data by health plan companies and third-party administrators to produce estimates as specified in paragraph (b);

(2) collect summary data that permits the computation of:

(i) the percentage of total payments that are non-claims-based payments; and

(ii) the percentage of payments in item (i) that are for primary care services;

(3) where data was not directly derived, specify the methods used to estimate data elements;

(4) notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, conduct analyses of the magnitude of primary care payments using data collected by the commissioner under Minnesota Statutes, section 62U.04; and

(5) conduct interviews with health plan companies and third-party administrators to better understand the types of non-claims-based payments and models in use, the purposes or goals of each, the criteria for health care providers to qualify for these payments, and the timing and structure of health plan companies or third-party administrators making these payments to health care provider organizations.

(d) Health plan companies and third-party administrators must comply with data requests from the commissioner under this section within 60 days after receiving the request.

(e) Data collected under this section are nonpublic data. Notwithstanding the definition of summary data in Minnesota Statutes, section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data maintained by the commissioner.
Sec. 100. SAFETY IMPROVEMENTS FOR STATE LICENSED LONG-TERM CARE FACILITIES.

Subdivision 1. Temporary grant program for long-term care safety improvements. The commissioner of health shall develop, implement, and manage a temporary, competitive grant process for state-licensed long-term care facilities to improve their ability to reduce the transmission of COVID-19 or other similar conditions.

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

(b) "Eligible facility" means:
(1) an assisted living facility licensed under chapter 144G;  
(2) a supervised living facility licensed under chapter 144;  
(3) a boarding care facility that is not federally certified and is licensed under chapter 144; and  
(4) a nursing home that is not federally certified and is licensed under chapter 144A.

(c) "Eligible project" means a modernization project to update, remodel, or replace outdated equipment, systems, technology, or physical spaces.

Subd. 3. Program. (a) The commissioner of health shall award improvement grants to an eligible facility. An improvement grant shall not exceed $1,250,000.

(b) Funds may be used to improve the safety, quality of care, and livability of aging infrastructure in a Department of Health licensed eligible facility with an emphasis on reducing the transmission risk of COVID-19 and other infections. Projects include but are not limited to:

(1) heating, ventilation, and air-conditioning systems improvements to reduce airborne exposures;  
(2) physical space changes for infection control; and  
(3) technology improvements to reduce social isolation and improve resident or client well-being.

(c) Notwithstanding any law to the contrary, funds awarded in a grant agreement do not lapse until expended by the grantee.

Subd. 4. Applications. An eligible facility seeking a grant shall apply to the commissioner. The application must include a description of the resident population demographics, the problem the proposed project will address, a description of the project including construction and remodeling drawings or specifications, sources of funds for the project, including any in-kind resources, uses of funds for the project, the results expected, and a plan to maintain or operate any facility or equipment included in the project. The
applicant must describe achievable objectives, a timetable, and roles and capabilities of
responsible individuals and organization. An applicant must submit to the commissioner
evidence that competitive bidding was used to select contractors for the project.

Subd. 5. Consideration of applications. The commissioner shall review each application
to determine if the application is complete and if the facility and the project are eligible for
a grant. In evaluating applications, the commissioner shall develop a standardized scoring
system that assesses: (1) the applicant's understanding of the problem, description of the
project and the likelihood of a successful outcome of the project; (2) the extent to which
the project will reduce the transmission of COVID-19; (3) the extent to which the applicant
has demonstrated that it has made adequate provisions to ensure proper and efficient operation
of the facility once the project is completed; (4) and other relevant factors as determined
by the commissioner. During application review, the commissioner may request additional
information about a proposed project, including information on project cost. Failure to
provide the information requested disqualifies an applicant.

Subd. 6. Program oversight. The commissioner shall determine the amount of a grant
to be given to an eligible facility based on the relative score of each eligible facility's
application, other relevant factors discussed during the review, and the funds available to
the commissioner. During the grant period and within one year after completion of the grant
period, the commissioner may collect from an eligible facility receiving a grant, any
information necessary to evaluate the program.

Subd. 7. Expiration. This section expires June 30, 2025.

Sec. 101. STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR
PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.

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

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

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
medical device, or medical intervention that maintains life by sustaining, restoring, or
supplanting a vital function. Life-sustaining treatment does not include routine care necessary
to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
preferences of a patient with an advanced serious illness who is nearing the end of life are
honored.

(e) "POLST form" means a portable medical form used to communicate a physician's
order to help ensure that a patient's medical treatment preferences are conveyed to emergency
medical service personnel and other health care providers.
Subd. 2. Study. (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall study the issues related to creating a statewide registry of POLST forms to ensure that a patient’s medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner, for the provision of care or services.

(b) As a part of the study, the commissioner shall develop recommendations on the following:

1. electronic capture, storage, and security of information in the registry;
2. procedures to protect the accuracy and confidentiality of information submitted to the registry;
3. limits as to who can access the registry;
4. where the registry should be housed;
5. ongoing funding models for the registry; and
6. any other action needed to ensure that patients’ rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, nursing homes, emergency medical service providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. Report. The commissioner shall submit a report on the results of the study, including recommendations on establishing a statewide registry of POLST forms, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2023.

Sec. 102. REVISOR INSTRUCTION.

(a) The revisor of statutes shall codify Laws 2021, First Special Session chapter 7, article 3, section 44, as Minnesota Statutes, section 144.1512. The revisor of statutes may make any necessary cross-reference changes.

(b) The revisor of statutes shall correct cross-references in Minnesota Statutes to conform with the relettering of paragraphs in Minnesota Statutes, section 144.1501, subdivision 1.

(c) In Minnesota Statutes, section 144.705, the revisor shall renumber paragraphs (b) to (e) alphabetically as individual subdivisions under Minnesota Statutes, section 144.7051. The revisor shall make any necessary changes to sentence structure for this renumbering while preserving the meaning of the text. The revisor shall also make necessary
cross-reference changes in Minnesota Statutes and Minnesota Rules consistent with the
renumbering.
(d) The revisor of statutes shall renumber Minnesota Statutes, sections 145A.145 and
145A.17, as new sections following Minnesota Statutes, section 145.871. The revisor shall
also make necessary cross-reference changes consistent with the renumbering.

337.13 Sec. 23. **REPEALER.**
337.14 Minnesota Statutes 2020, section 254A.21, is repealed effective July 1, 2023.