

236.26

ARTICLE 5**MEDICAL EDUCATION AND RESEARCH COSTS**

236.27 Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

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

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

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

237.8 (d) "Clinical medical education program" means the accredited clinical training of
237.9 physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy
237.10 students and residents), doctors of chiropractic, dentists (dental students and residents),
237.11 advanced practice registered nurses (clinical nurse specialists, certified registered nurse
237.12 anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental
237.13 therapists and advanced dental therapists, psychologists, clinical social workers, community
237.14 paramedics, and community health workers.

237.15 (e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota
237.16 that sponsors and maintains primary organizational and financial responsibility for a clinical
237.17 medical education program in Minnesota and which is accountable to the accrediting body.

237.18 (f) "Teaching institution" means a hospital, medical center, clinic, or other organization
237.19 that conducts a clinical medical education program in Minnesota.

237.20 (g) "Trainee" means a student or resident involved in a clinical medical education
237.21 program.

237.22 (h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
237.23 equivalent counts, that are at training sites located in Minnesota with currently active medical
237.24 assistance enrollment status and a National Provider Identification (NPI) number where
237.25 training occurs ~~in~~ as part of or under the scope of either an inpatient or ambulatory patient
237.26 care setting and where the training is funded, in part, by patient care revenues. Training that
237.27 occurs in nursing facility settings is not eligible for funding under this section.

237.28 Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

237.29 Subd. 3. **Application process.** (a) A clinical medical education program conducted in
237.30 Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
237.31 dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,

297.28

ARTICLE 4**MEDICAL EDUCATION AND RESEARCH COSTS**

297.29 Section 1. Minnesota Statutes 2022, section 62J.692, subdivision 1, is amended to read:

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

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

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

298.8 (d) "Clinical medical education program" means the accredited clinical training of
298.9 physicians (medical students and residents), doctor of pharmacy practitioners (pharmacy
298.10 students and residents), doctors of chiropractic, dentists (dental students and residents),
298.11 advanced practice registered nurses (clinical nurse specialists, certified registered nurse
298.12 anesthetists, nurse practitioners, and certified nurse midwives), physician assistants, dental
298.13 therapists and advanced dental therapists, psychologists, clinical social workers, community
298.14 paramedics, and community health workers.

298.15 (e) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota
298.16 that sponsors and maintains primary organizational and financial responsibility for a clinical
298.17 medical education program in Minnesota and which is accountable to the accrediting body.

298.18 (f) "Teaching institution" means a hospital, medical center, clinic, or other organization
298.19 that conducts a clinical medical education program in Minnesota.

298.20 (g) "Trainee" means a student or resident involved in a clinical medical education
298.21 program.

298.22 (h) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
298.23 equivalent counts, that are at training sites located in Minnesota with currently active medical
298.24 assistance enrollment status and a National Provider Identification (NPI) number where
298.25 training occurs ~~in~~ either an inpatient or ambulatory patient care setting and where the training
298.26 is funded, in part, by patient care revenues. Training that occurs in nursing facility settings
298.27 is not eligible for funding under this section.

298.28 Sec. 2. Minnesota Statutes 2022, section 62J.692, subdivision 3, is amended to read:

298.29 Subd. 3. **Application process.** (a) A clinical medical education program conducted in
298.30 Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
298.31 dentists, chiropractors, physician assistants, dental therapists and advanced dental therapists,

237.32 psychologists, clinical social workers, community paramedics, or community health workers
237.33 is eligible for funds under subdivision 4 if the program:

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

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

238.4 (3) includes training hours in settings outside of the hospital or clinic site, as applicable,
238.5 including but not limited to school, home, and community settings; and

238.6 ~~(3)~~ (4) emphasizes primary care or specialties that are in undersupply in Minnesota.

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

238.12 (c) Applications must be submitted to the commissioner by a sponsoring institution on
238.13 behalf of an eligible clinical medical education program ~~and must be received by October~~
238.14 ~~31 of each year for distribution in the following year on a timeline determined by the~~
238.15 ~~commissioner. An application for funds must contain the following information: information~~
238.16 ~~the commissioner deems necessary to determine program eligibility based on the criteria~~
238.17 ~~in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

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

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

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

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

238.32 (4) An application must include the information specified in clauses (1) to (3) for each
238.33 clinical medical education program on an annual basis for three consecutive years. After

298.32 psychologists, clinical social workers, community paramedics, or community health workers
298.33 is eligible for funds under subdivision 4 if the program:

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

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

299.4 ~~(3)~~ (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

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

299.10 (c) Applications must be submitted to the commissioner by a sponsoring institution on
299.11 behalf of an eligible clinical medical education program ~~and must be received by October~~
299.12 ~~31 of each year for distribution in the following year on a timeline determined by the~~
299.13 ~~commissioner. An application for funds must contain the following information: information~~
299.14 ~~the commissioner deems necessary to determine program eligibility based on the criteria~~
299.15 ~~in paragraphs (a) and (b) and to ensure the equitable distribution of funds.~~

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

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

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

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

299.30 (4) An application must include the information specified in clauses (1) to (3) for each
299.31 clinical medical education program on an annual basis for three consecutive years. After

239.1 that time, an application must include the information specified in clauses (1) to (3) when
 239.2 requested, at the discretion of the commissioner:

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

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

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

239.9 (e) (d) An applicant that does not provide information requested by the commissioner
 239.10 shall not be eligible for funds for the current applicable funding cycle.

239.11 Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

239.12 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
 239.13 available medical education funds revenue credited or money transferred to the medical
 239.14 education and research cost account under subdivision 8 and section 297F.10, subdivision
 239.15 1, clause (2), to all qualifying applicants based on a public program volume factor, which
 239.16 is determined by the total volume of public program revenue received by each training site
 239.17 as a percentage of all public program revenue received by all training sites in the fund pool.

239.18 Public program revenue for the distribution formula includes revenue from medical
 239.19 assistance and prepaid medical assistance. Training sites that receive no public program
 239.20 revenue are ineligible for funds available under this subdivision. For purposes of determining
 239.21 training site level grants to be distributed under this paragraph, total statewide average costs
 239.22 per trainee for medical residents is based on audited clinical training costs per trainee in
 239.23 primary care clinical medical education programs for medical residents. Total statewide
 239.24 average costs per trainee for dental residents is based on audited clinical training costs per
 239.25 trainee in clinical medical education programs for dental students. Total statewide average
 239.26 costs per trainee for pharmacy residents is based on audited clinical training costs per trainee
 239.27 in clinical medical education programs for pharmacy students.

239.28 Training sites whose training site level grant is less than \$5,000, based on the formula
 239.29 formulas described in this paragraph subdivision, or that train fewer than 0.1 FTE eligible
 239.30 trainees, are ineligible for funds available under this subdivision. No training sites shall
 239.31 receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across
 239.32 all eligible training sites; grants in excess of this amount will be redistributed to other eligible
 239.33 sites based on the formula formulas described in this paragraph subdivision.

240.1 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall
 240.2 include a supplemental public program volume factor, which is determined by providing a
 240.3 supplemental payment to training sites whose public program revenue accounted for at least
 240.4 0.98 percent of the total public program revenue received by all eligible training sites. The
 240.5 supplemental public program volume factor shall be equal to ten percent of each training

299.32 that time, an application must include the information specified in clauses (1) to (3) when
 299.33 requested, at the discretion of the commissioner:

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

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

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

300.7 (e) (d) An applicant that does not provide information requested by the commissioner
 300.8 shall not be eligible for funds for the current applicable funding cycle.

300.9 Sec. 3. Minnesota Statutes 2022, section 62J.692, subdivision 4, is amended to read:

300.10 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
 300.11 available medical education funds revenue credited or money transferred to the medical
 300.12 education and research costs account under subdivision 8 and section 297F.10, subdivision
 300.13 1, clause (2), to all qualifying applicants based on a public program volume factor, which
 300.14 is determined by the total volume of public program revenue received by each training site
 300.15 as a percentage of all public program revenue received by all training sites in the fund pool.

300.16 Public program revenue for the distribution formula includes revenue from medical
 300.17 assistance and prepaid medical assistance. Training sites that receive no public program
 300.18 revenue are ineligible for funds available under this subdivision. For purposes of determining
 300.19 training site level grants to be distributed under this paragraph, total statewide average costs
 300.20 per trainee for medical residents is based on audited clinical training costs per trainee in
 300.21 primary care clinical medical education programs for medical residents. Total statewide
 300.22 average costs per trainee for dental residents is based on audited clinical training costs per
 300.23 trainee in clinical medical education programs for dental students. Total statewide average
 300.24 costs per trainee for pharmacy residents is based on audited clinical training costs per trainee
 300.25 in clinical medical education programs for pharmacy students.

300.26 Training sites whose training site level grant is less than \$5,000, based on the formula
 300.27 formulas described in this paragraph subdivision, or that train fewer than 0.1 FTE eligible
 300.28 trainees, are ineligible for funds available under this subdivision. No training sites shall
 300.29 receive a grant per FTE trainee that is in excess of the 95th percentile grant per FTE across
 300.30 all eligible training sites; grants in excess of this amount will be redistributed to other eligible
 300.31 sites based on the formula formulas described in this paragraph subdivision.

300.32 (b) For funds distributed in fiscal years 2014 and 2015, the distribution formula shall
 300.33 include a supplemental public program volume factor, which is determined by providing a
 301.1 supplemental payment to training sites whose public program revenue accounted for at least
 301.2 0.98 percent of the total public program revenue received by all eligible training sites. The
 301.3 supplemental public program volume factor shall be equal to ten percent of each training

240.6 site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year
240.7 2015. Grants to training sites whose public program revenue accounted for less than 0.98
240.8 percent of the total public program revenue received by all eligible training sites shall be
240.9 reduced by an amount equal to the total value of the supplemental payment. For fiscal year
240.10 2016 and beyond, the distribution of funds shall be based solely on the public program
240.11 volume factor as described in paragraph (a). Money appropriated through the state general
240.12 fund, the health care access fund, and any additional fund for the purpose of funding medical
240.13 education and research costs and that does not require federal approval must be awarded
240.14 only to eligible training sites that do not qualify for a medical education and research cost
240.15 rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph
240.16 (b). The commissioner shall distribute the available medical education money appropriated
240.17 to eligible training sites that do not qualify for a medical education and research cost rate
240.18 factor based on a distribution formula determined by the commissioner. The distribution
240.19 formula under this paragraph must consider clinical training costs, public program revenues,
240.20 and other factors identified by the commissioner that address the objective of supporting
240.21 clinical training.

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

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

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

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

241.4 (e) Use of funds is limited to expenses related to eligible clinical training program costs
241.5 for eligible programs. The commissioner shall develop a methodology for determining
241.6 eligible costs.

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

301.4 site's grant for funds distributed in fiscal year 2014 and for funds distributed in fiscal year
301.5 2015. Grants to training sites whose public program revenue accounted for less than 0.98
301.6 percent of the total public program revenue received by all eligible training sites shall be
301.7 reduced by an amount equal to the total value of the supplemental payment. For fiscal year
301.8 2016 and beyond, the distribution of funds shall be based solely on the public program
301.9 volume factor as described in paragraph (a). Money appropriated through the state general
301.10 fund, the health care access fund, and any additional fund for the purpose of funding medical
301.11 education and research costs and that does not require federal approval must be awarded
301.12 only to eligible training sites that do not qualify for a medical education and research cost
301.13 rate factor under sections 256.969, subdivision 2b, paragraph (k), or 256B.75, paragraph
301.14 (b). The commissioner shall distribute the available medical education money appropriated
301.15 to eligible training sites that do not qualify for a medical education and research cost rate
301.16 factor based on a distribution formula determined by the commissioner. The distribution
301.17 formula under this paragraph must consider clinical training costs, public program revenues,
301.18 and other factors identified by the commissioner that address the objective of supporting
301.19 clinical training.

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

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

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

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

302.1 (e) Use of funds is limited to expenses related to eligible clinical training program costs
302.2 for eligible programs. The commissioner shall develop a methodology for determining
302.3 eligible costs.

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

241.11 When appropriate, the commissioner shall include the undistributed money in the subsequent
 241.12 distribution cycle using the applicable methodology described in this subdivision.

241.13 (g) A maximum of \$150,000 of the funds dedicated to the commissioner under section
 241.14 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative
 241.15 expenses associated with implementing this section.

241.16 Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

241.17 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must
 241.18 sign and submit a medical education grant verification report (GVR) to verify that the correct
 241.19 grant amount was forwarded to each eligible training site. If the sponsoring institution fails
 241.20 to submit the GVR by the stated deadline, or to request and meet the deadline for an
 241.21 extension, the sponsoring institution is required to return the full amount of funds received
 241.22 to the commissioner within 30 days of receiving notice from the commissioner. The
 241.23 commissioner shall distribute returned funds to the appropriate training sites in accordance
 241.24 with the commissioner's approval letter.

241.25 (b) The reports must provide verification of the distribution of the funds and must include:
 241.26 (1) the total number of eligible trainee FTEs in each clinical medical education program;
 241.27 (2) the name of each funded program and, for each program, the dollar amount distributed
 241.28 to each training site and a training site expenditure report;

241.29 (3) documentation of any discrepancies between the initial grant distribution notice
 241.30 included in the commissioner's approval letter and the actual distribution;

241.31 (4) a statement by the sponsoring institution stating that the completed grant
 241.32 verification report is valid and accurate; and

242.1 (5) other information the commissioner deems appropriate to evaluate the effectiveness
 242.2 of the use of funds for medical education.

242.3 (e) Each year, the commissioner shall provide an annual summary report to the legislature
 242.4 on the implementation of this section. This report is exempt from section 144.05, subdivision
 242.5 7.

242.6 Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

242.7 Subd. 8. **Federal financial participation.** The commissioner of human services shall
 242.8 seek to maximize federal financial participation in payments for the dedicated revenue for
 242.9 medical education and research costs provided under section 297F.10, subdivision 1, clause
 242.10 (2).

242.11 The commissioner shall use physician clinic rates where possible to maximize federal
 242.12 financial participation. Any additional funds that become available must be distributed under
 242.13 subdivision 4, paragraph (a).

302.8 When appropriate, the commissioner shall include the undistributed money in the subsequent
 302.9 distribution cycle using the applicable methodology described in this subdivision.

302.10 (g) A maximum of \$150,000 of the funds dedicated to the commissioner under section
 302.11 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative
 302.12 expenses associated with implementing this section.

302.13 Sec. 4. Minnesota Statutes 2022, section 62J.692, subdivision 5, is amended to read:

302.14 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must
 302.15 sign and submit a medical education grant verification report (GVR) to verify that the correct
 302.16 grant amount was forwarded to each eligible training site. If the sponsoring institution fails
 302.17 to submit the GVR by the stated deadline, or to request and meet the deadline for an
 302.18 extension, the sponsoring institution is required to return the full amount of funds received
 302.19 to the commissioner within 30 days of receiving notice from the commissioner. The
 302.20 commissioner shall distribute returned funds to the appropriate training sites in accordance
 302.21 with the commissioner's approval letter.

302.22 (b) The reports must provide verification of the distribution of the funds and must include:
 302.23 (1) the total number of eligible trainee FTEs in each clinical medical education program;
 302.24 (2) the name of each funded program and, for each program, the dollar amount distributed
 302.25 to each training site and a training site expenditure report;

302.26 (3) documentation of any discrepancies between the initial grant distribution notice
 302.27 included in the commissioner's approval letter and the actual distribution;

302.28 (4) a statement by the sponsoring institution stating that the completed grant
 302.29 verification report is valid and accurate; and

302.30 (5) other information the commissioner deems appropriate to evaluate the effectiveness
 302.31 of the use of funds for medical education.

303.1 (e) Each year, the commissioner shall provide an annual summary report to the legislature
 303.2 on the implementation of this section. This report is exempt from section 144.05, subdivision
 303.3 7.

303.4 Sec. 5. Minnesota Statutes 2022, section 62J.692, subdivision 8, is amended to read:

303.5 Subd. 8. **Federal financial participation.** The commissioner of human services shall
 303.6 seek to maximize federal financial participation in payments for the dedicated revenue for
 303.7 medical education and research costs provided under section 297F.10, subdivision 1, clause
 303.8 (2).

303.9 The commissioner shall use physician clinic rates where possible to maximize federal
 303.10 financial participation. Any additional funds that become available must be distributed under
 303.11 subdivision 4, paragraph (a).

242.14 Sec. 6. Minnesota Statutes 2022, section 144.1501, subdivision 2, is amended to read:

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

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

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

242.24 (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate
242.25 care facility for persons with developmental disability; in a hospital if the hospital owns
242.26 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked
242.27 by the nurse is in the nursing home; a housing with services establishment in an assisted
242.28 living facility as defined in section ~~144D.01~~ 144G.08, subdivision 4; or for a home care
242.29 provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit
242.30 hours, or 720 hours per year in the nursing field in a postsecondary program at the
242.31 undergraduate level or the equivalent at the graduate level;

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

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

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

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

THIS SECTION ALSO APPEARS IN THE HHS ARTICLE 3 COMPARISON
(S2995-3, ARTICLE 3, SECTION 2, AND UES2995-2, ARTICLE 3, SECTION
48)

243.18 Sec. 7. Minnesota Statutes 2022, section 144.1501, subdivision 3, is amended to read:

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

243.21 (1) be a medical or dental resident; be a licensed pharmacist; or be enrolled in a training
243.22 or education program or obtaining required supervision hours to become a dentist, dental
243.23 therapist, advanced dental therapist, mental health professional, alcohol and drug counselor,
243.24 pharmacist, public health nurse, midlevel practitioner, registered nurse, or a licensed practical
243.25 nurse. The commissioner may also consider applications submitted by graduates in eligible
243.26 professions who are licensed and in practice; and

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

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

244.1 Sec. 8. Minnesota Statutes 2022, section 144.1506, subdivision 4, is amended to read:

244.2 Subd. 4. **Consideration of expansion grant applications.** The commissioner shall
244.3 review each application to determine whether or not the residency program application is
244.4 complete and whether the proposed new residency program and any new residency slots
244.5 are eligible for a grant. The commissioner shall award grants to support up to six family
244.6 medicine, general internal medicine, or general pediatrics residents; four five psychiatry
244.7 residents; two geriatrics residents; and two general surgery residents. If insufficient
244.8 applications are received from any eligible specialty, funds may be redistributed to
244.9 applications from other eligible specialties.

244.10 Sec. 9. **[144.1507] PEDIATRIC PRIMARY CARE MENTAL HEALTH TRAINING
244.11 GRANT PROGRAM.**

244.12 Subdivision 1. **Establishment.** The commissioner of health shall award grants for the
244.13 development of child mental health training programs that are located in outpatient primary
244.14 care clinics. To be eligible for a grant, a training program must:

244.15 (1) focus on the training of pediatric primary care providers working with
244.16 multidisciplinary mental health teams;

244.17 (2) provide training on conducting comprehensive clinical mental health assessments
244.18 and potential pharmacological therapy;

THIS SECTION ALSO APPEARS IN THE HHS ARTICLE 3 COMPARISON
(S2995-3, ARTICLE 3, SECTION 3 AND UES2995-2, ARTICLE 3, SECTION
49)

244.19 (3) provide psychiatric consultation to pediatric primary care providers during their
244.20 outpatient pediatric primary care experiences;

244.21 (4) emphasize longitudinal care for patients with behavioral health needs; and

244.22 (5) develop partnerships with community resources.

244.23 Subd. 2. **Child mental health training grant program.** (a) Child mental health training
244.24 grants may be awarded to eligible primary care training programs to plan and implement
244.25 new programs or expand existing programs in child mental health training.

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

244.27 (1) planning related to implementing or expanding child mental health training in an
244.28 outpatient primary care clinic setting;

244.29 (2) training site improvements, fees, equipment, and supplies required for implementation
244.30 of the training programs; and

244.31 (3) supporting clinical training in the outpatient primary clinic sites.

245.1 Subd. 3. **Applications for child mental health training grants.** Eligible primary care
245.2 training programs seeking a grant shall apply to the commissioner. Applications must include
245.3 the location of the training; a description of the training program, including all costs
245.4 associated with the training program; all sources of money for the training program; detailed
245.5 uses of all money for the training program; the results expected; and a plan to maintain the
245.6 training program after the grant period. The applicant must describe achievable objectives
245.7 and a timetable for the training program.

245.8 Subd. 4. **Consideration of child mental health training grant applications.** The
245.9 commissioner shall review each application to determine whether the application meets the
245.10 stated goals of the grant and shall award grants to support up to four training program
245.11 proposals.

245.12 Subd. 5. **Program oversight.** During the grant period, the commissioner may require
245.13 and collect from grantees any information necessary to evaluate the training program.

245.14 Sec. 10. **[144.1511] MENTAL HEALTH CULTURAL COMMUNITY CONTINUING
245.15 EDUCATION GRANT PROGRAM.**

245.16 The mental health cultural community continuing education grant program is established
245.17 in the Department of Health to provide grants for the continuing education necessary for
245.18 social workers, marriage and family therapists, psychologists, and professional clinical
245.19 counselors to become supervisors for individuals pursuing licensure in mental health
245.20 professions. The commissioner must consult with the relevant mental health licensing boards
245.21 in creating the program. To be eligible for a grant under this section, a social worker, marriage
245.22 and family therapist, psychologist, or professional clinical counselor must:

245.23 (1) be a member of a community of color or an underrepresented community as defined
245.24 in section 148E.010, subdivision 20; and

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

245.30 Sec. 11. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

245.31 (a) The commissioner of health shall award clinical dental education innovation grants
245.32 to teaching institutions and clinical training sites for projects that increase dental access for
246.1 underserved populations and promote innovative clinical training of dental professionals.
246.2 In awarding the grants, the commissioner shall consider the following:

246.3 (1) potential to successfully increase access to dental services for an underserved
246.4 population;

246.5 (2) the long-term viability of the project to improve access to dental services beyond
246.6 the period of initial funding;

246.7 (3) evidence of collaboration between the applicant and local communities;

246.8 (4) efficiency in the use of grant money; and

246.9 (5) the priority level of the project in relation to state education, access, and workforce
246.10 goals.

246.11 (b) The commissioner shall periodically evaluate the priorities in awarding innovations
246.12 grants under this section to ensure that the priorities meet the changing workforce needs of
246.13 the state.

246.14 Sec. 12. **[144.88] MENTAL HEALTH AND SUBSTANCE USE DISORDER
246.15 EDUCATION CENTER.**

246.16 Subdivision 1. **Establishment.** The Mental Health and Substance Use Disorder Education
246.17 Center is established in the Department of Health. The purpose of the center is to increase
246.18 the number of professionals, practitioners, and peers working in mental health and substance
246.19 use disorder treatment; increase the diversity of professionals, practitioners, and peers
246.20 working in mental health and substance use disorder treatment; and facilitate a culturally
246.21 informed and responsive mental health and substance use disorder treatment workforce.

246.22 Subd. 2. **Activities.** The Mental Health and Substance Use Disorder Education Center
246.23 must:

303.12 Sec. 6. **[144.1913] CLINICAL DENTAL EDUCATION INNOVATION GRANTS.**

303.13 (a) The commissioner shall award clinical dental education innovation grants to teaching
303.14 institutions and clinical training sites for projects that increase dental access for underserved
303.15 populations and promote innovative clinical training of dental professionals. In awarding
303.16 the grants, the commissioner shall consider the following:

303.17 (1) the potential to successfully increase access to dental services for an underserved
303.18 population;

303.19 (2) the long-term viability of the project to improve access to dental services beyond
303.20 the period of initial funding;

303.21 (3) the evidence of collaboration between the applicant and local communities;

303.22 (4) the efficiency in the use of grant funding; and

303.23 (5) the priority level of the project in relation to state education, access, and workforce
303.24 goals.

303.25 (b) The commissioner shall periodically evaluate the priorities in awarding innovations
303.26 grants under this section to ensure that the priorities meet the changing workforce needs of
303.27 the state.

246.24 (1) analyze the geographic and demographic availability of licensed professionals in the
246.25 field, identify gaps, and prioritize the need for additional licensed professionals by type,
246.26 location, and demographics;

246.27 (2) create a program that exposes high school and college students to careers in the
246.28 mental health and substance use disorder treatment field;

246.29 (3) create a website for individuals considering becoming a mental health provider that
246.30 clearly labels the steps necessary to achieve licensure and certification in the various mental
246.31 health fields and lists resources and links for more information;

247.1 (4) create a job board for organizations seeking employees to provide mental health and
247.2 substance use disorder treatment, services, and supports;

247.3 (5) track the number of students at the college and graduate level who are graduating
247.4 from programs that could facilitate a career as a mental health or substance use disorder
247.5 treatment practitioner or professional and work with the colleges and universities to support
247.6 the students in obtaining licensure;

247.7 (6) identify barriers to licensure and make recommendations to address the barriers;

247.8 (7) establish learning collaborative partnerships with mental health and substance use
247.9 disorder treatment providers, schools, criminal justice agencies, and others;

247.10 (8) promote and expand loan forgiveness programs, funding for professionals to become
247.11 supervisors, funding to pay for supervision, and funding for pathways to licensure;

247.12 (9) identify barriers to using loan forgiveness programs and develop recommendations
247.13 to address the barriers;

247.14 (10) work to expand Medicaid graduate medical education to other mental health
247.15 professionals;

247.16 (11) identify current sites for internships and practicums and assess the need for additional
247.17 sites;

247.18 (12) develop training for other health care professionals to increase their knowledge
247.19 about mental health and substance use disorder treatment, including but not limited to
247.20 community health workers, pediatricians, primary care physicians, physician assistants, and
247.21 nurses; and

247.22 (13) support training for integrated mental health and primary care in rural areas.

247.23 Subd. 3. **Reports.** Beginning January 1, 2024, the commissioner of health shall submit
247.24 an annual report to the chairs and ranking minority members of the legislative committees
247.25 with jurisdiction over health finance and policy summarizing the center's activities and
247.26 progress in addressing the mental health and substance use disorder treatment workforce
247.27 shortage.

247.28 Sec. 13. **[145.9272] FEDERALLY QUALIFIED HEALTH CENTERS**247.29 **APPRENTICESHIP PROGRAM.**247.30 Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

248.1 (b) "Federally qualified health center" has the meaning given in section 145.9269,

248.2 subdivision 1.

248.3 (c) "Nonprofit organization of community health centers" means a nonprofit organization

248.4 the membership of which consists of federally qualified health centers operating service

248.5 delivery sites in Minnesota and that provides services to federally qualified health centers

248.6 in Minnesota to promote the delivery of affordable, quality primary care services in the

248.7 state.

248.8 Subd. 2. **Apprenticeship program.** The commissioner of health shall distribute a grant

248.9 to a nonprofit organization of community health centers for an apprenticeship program in

248.10 federally qualified health centers operating in Minnesota. Grant money must be used to

248.11 establish and fund ongoing costs for apprenticeship programs for medical assistants and

248.12 dental assistants at federally qualified health center service delivery sites in Minnesota. An

248.13 apprenticeship program funded under this section must be a 12-month program led by

248.14 certified medical assistants and licensed dental assistants. Trainees for an apprenticeship

248.15 program must be recruited from federally qualified health center staff and from the population

248.16 in the geographic area served by the federally qualified health center.

248.17 Sec. 14. Minnesota Statutes 2022, section 245.4663, subdivision 4, is amended to read:

248.18 Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds
248.19 received under this section for one or more of the following:248.20 (1) to pay for direct supervision hours for interns and clinical trainees, in an amount up
248.21 to \$7,500 per intern or clinical trainee;

248.22 (2) to establish a program to provide supervision to multiple interns or clinical trainees;

248.23 ~~or~~

248.24 (3) to pay licensing application and examination fees for clinical trainees; or

248.25 (4) to provide a weekend training program for workers to become supervisors.

THE FOLLOWING SECTION WAS MOVED IN FROM UES2995-2, ARTICLE
7, SECTION 2, TO MATCH S2995-2, ARTICLE 5, SECTION 14

362.15 Sec. 2. Minnesota Statutes 2022, section 245.4663, subdivision 4, is amended to read:

362.16 Subd. 4. **Allowable uses of grant funds.** A mental health provider must use grant funds
362.17 received under this section for one or more of the following:362.18 (1) to pay for direct supervision hours ~~or preceptorships~~ for ~~students, interns,~~ and clinical
362.19 trainees, in an amount up to \$7,500 per ~~student, intern,~~ or clinical trainee;362.20 (2) to establish a program to provide supervision to multiple ~~students, interns,~~ or clinical
362.21 trainees; ~~or~~

362.22 (3) to pay licensing application and examination fees for clinical trainees; or

362.23 (4) to provide a weekend training program for workers to become supervisors.

248.26 Sec. 15. **[245.4664] MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT**
248.27 **PROGRAM.**

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

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

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

249.3 Subd. 2. **Grant program established.** The mental health professional scholarship
249.4 program is established in the Department of Human Services to assist mental health providers
249.5 in funding employee scholarships for master's degree-level education programs in order to
249.6 create a pathway to becoming a mental health professional.

249.7 Subd. 3. **Provision of grants.** The commissioner of human services shall award grants
249.8 to licensed or certified mental health providers who meet the criteria in subdivision 4 to
249.9 provide tuition reimbursement for master's degree-level programs and certain related costs
249.10 for individuals who have worked for the mental health provider for at least the past two
249.11 years in one or more of the following roles:

249.12 (1) a mental health behavioral aide who meets a qualification in section 245I.04,
249.13 subdivision 16;

249.14 (2) a mental health certified family peer specialist who meets the qualifications in section
249.15 245I.04, subdivision 12;

249.16 (3) a mental health certified peer specialist who meets the qualifications in section
249.17 245I.04, subdivision 10;

249.18 (4) a mental health practitioner who meets a qualification in section 245I.04, subdivision
249.19 4;

249.20 (5) a mental health rehabilitation worker who meets the qualifications in section 245I.04,
249.21 subdivision 14;

249.22 (6) an individual employed in a role in which the individual provides face-to-face client
249.23 services at a mental health center or certified community behavioral health center; or

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

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

249.28 (1) primarily provide at least 25 percent of the provider's yearly patient encounters to
249.29 state public program enrollees or patients receiving sliding fee schedule discounts through

249.30 a formal sliding fee schedule meeting the standards established by the United States
249.31 Department of Health and Human Services under Code of Federal Regulations, title 42,
249.32 section 51c.303; or

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

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

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

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

250.23 Subd. 8. **Grant agreements.** Notwithstanding any law or rule to the contrary, grant
250.24 money awarded to a grant recipient in a grant agreement does not lapse until the grant
250.25 agreement expires.

250.26 Subd. 9. **Allowable uses of grant money.** A mental health provider receiving a grant
250.27 under this section must use the grant money for one or more of the following:

250.28 (1) to provide employees with tuition reimbursement for a master's degree-level program
250.29 in a discipline that will allow the employee to qualify as a mental health professional; or

250.30 (2) for resources and supports, such as child care and transportation, that allow an
250.31 employee to attend a master's degree-level program specified in clause (1).

250.32 Subd. 10. **Reporting requirements.** A mental health provider receiving a grant under
250.33 this section must submit an invoice for reimbursement and a report to the commissioner on
251.1 a schedule determined by the commissioner and using a form supplied by the commissioner.
251.2 The report must include the amount spent on scholarships; the number of employees who

251.3 received scholarships; and, for each scholarship recipient, the recipient's name, current
251.4 position, amount awarded, educational institution attended, name of the educational program,
251.5 and expected or actual program completion date.

251.6 Sec. 16. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

251.7 **Subd. 2b. Hospital payment rates.** (a) For discharges occurring on or after November
251.8 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
251.9 to the following:

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

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

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

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

251.18 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
251.19 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
251.20 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
251.21 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
251.22 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
251.23 years are updated, a Minnesota long-term hospital's base year shall remain within the same
251.24 period as other hospitals.

251.25 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
251.26 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
251.27 area, except for the hospitals paid under the methodologies described in paragraph (a),
251.28 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
251.29 manner similar to Medicare. The base year or years for the rates effective November 1,
251.30 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
251.31 ensuring that the total aggregate payments under the rebased system are equal to the total
251.32 aggregate payments that were made for the same number and types of services in the base
251.33 year. Separate budget neutrality calculations shall be determined for payments made to
251.34 critical access hospitals and payments made to hospitals paid under the DRG system. Only
251.35 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
251.36 rebased during the entire base period shall be incorporated into the budget neutrality
251.37 calculation.

252.5 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
252.6 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
252.7 (a), clause (4), shall include adjustments to the projected rates that result in no greater than

304.1 Sec. 7. Minnesota Statutes 2022, section 256.969, subdivision 2b, is amended to read:

304.2 **Subd. 2b. Hospital payment rates.** (a) For discharges occurring on or after November
304.3 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
304.4 to the following:

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

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

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

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

304.13 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
304.14 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
304.15 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
304.16 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
304.17 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
304.18 years are updated, a Minnesota long-term hospital's base year shall remain within the same
304.19 period as other hospitals.

304.20 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
304.21 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
304.22 area, except for the hospitals paid under the methodologies described in paragraph (a),
304.23 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
304.24 manner similar to Medicare. The base year or years for the rates effective November 1,
304.25 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
304.26 ensuring that the total aggregate payments under the rebased system are equal to the total
304.27 aggregate payments that were made for the same number and types of services in the base
304.28 year. Separate budget neutrality calculations shall be determined for payments made to
304.29 critical access hospitals and payments made to hospitals paid under the DRG system. Only
304.30 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
304.31 rebased during the entire base period shall be incorporated into the budget neutrality
304.32 calculation.

305.1 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
305.2 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
305.3 (a), clause (4), shall include adjustments to the projected rates that result in no greater than

252.8 a five percent increase or decrease from the base year payments for any hospital. Any
252.9 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
252.10 shall maintain budget neutrality as described in paragraph (c).

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

252.15 (1) pediatric services;
252.16 (2) behavioral health services;
252.17 (3) trauma services as defined by the National Uniform Billing Committee;
252.18 (4) transplant services;
252.19 (5) obstetric services, newborn services, and behavioral health services provided by
252.20 hospitals outside the seven-county metropolitan area;
252.21 (6) outlier admissions;
252.22 (7) low-volume providers; and
252.23 (8) services provided by small rural hospitals that are not critical access hospitals.

252.24 (f) Hospital payment rates established under paragraph (c) must incorporate the following:
252.25 (1) for hospitals paid under the DRG methodology, the base year payment rate per
252.26 admission is standardized by the applicable Medicare wage index and adjusted by the
252.27 hospital's disproportionate population adjustment;

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

253.1 (3) the cost and charge data used to establish hospital payment rates must only reflect
253.2 inpatient services covered by medical assistance; and
253.3 (4) in determining hospital payment rates for discharges occurring on or after the rate
253.4 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
253.5 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
253.6 program in effect during the base year or years. In determining hospital payment rates for
253.7 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
253.8 methods and allowable costs of the Medicare program in effect during the base year or
253.9 years.

253.10 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
253.11 the rates established under paragraph (c), and any adjustments made to the rates under
253.12 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

305.4 a five percent increase or decrease from the base year payments for any hospital. Any
305.5 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
305.6 shall maintain budget neutrality as described in paragraph (c).

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

305.11 (1) pediatric services;
305.12 (2) behavioral health services;
305.13 (3) trauma services as defined by the National Uniform Billing Committee;
305.14 (4) transplant services;
305.15 (5) obstetric services, newborn services, and behavioral health services provided by
305.16 hospitals outside the seven-county metropolitan area;
305.17 (6) outlier admissions;
305.18 (7) low-volume providers; and
305.19 (8) services provided by small rural hospitals that are not critical access hospitals.

305.20 (f) Hospital payment rates established under paragraph (c) must incorporate the following:
305.21 (1) for hospitals paid under the DRG methodology, the base year payment rate per
305.22 admission is standardized by the applicable Medicare wage index and adjusted by the
305.23 hospital's disproportionate population adjustment;

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

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

305.29 (4) in determining hospital payment rates for discharges occurring on or after the rate
305.30 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
305.31 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
306.1 program in effect during the base year or years. In determining hospital payment rates for
306.2 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
306.3 methods and allowable costs of the Medicare program in effect during the base year or
306.4 years.

306.5 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
306.6 the rates established under paragraph (c), and any adjustments made to the rates under
306.7 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

253.13 total aggregate payments for the same number and types of services under the rebased rates
253.14 are equal to the total aggregate payments made during calendar year 2013.

253.15 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
253.16 thereafter, payment rates under this section shall be rebased to reflect only those changes
253.17 in hospital costs between the existing base year or years and the next base year or years. In
253.18 any year that inpatient claims volume falls below the threshold required to ensure a
253.19 statistically valid sample of claims, the commissioner may combine claims data from two
253.20 consecutive years to serve as the base year. Years in which inpatient claims volume is
253.21 reduced or altered due to a pandemic or other public health emergency shall not be used as
253.22 a base year or part of a base year if the base year includes more than one year. Changes in
253.23 costs between base years shall be measured using the lower of the hospital cost index defined
253.24 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
253.25 claim. The commissioner shall establish the base year for each rebasing period considering
253.26 the most recent year or years for which filed Medicare cost reports are available. The
253.27 estimated change in the average payment per hospital discharge resulting from a scheduled
253.28 rebasing must be calculated and made available to the legislature by January 15 of each
253.29 year in which rebasing is scheduled to occur, and must include by hospital the differential
253.30 in payment rates compared to the individual hospital's costs.

253.31 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
253.32 for critical access hospitals located in Minnesota or the local trade area shall be determined
253.33 using a new cost-based methodology. The commissioner shall establish within the
253.34 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
253.35 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
254.1 the total cost for critical access hospitals as reflected in base year cost reports. Until the
254.2 next rebasing that occurs, the new methodology shall result in no greater than a five percent
254.3 decrease from the base year payments for any hospital, except a hospital that had payments
254.4 that were greater than 100 percent of the hospital's costs in the base year shall have their
254.5 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
254.6 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
254.7 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
254.8 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
254.9 following criteria:

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

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

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

306.8 total aggregate payments for the same number and types of services under the rebased rates
306.9 are equal to the total aggregate payments made during calendar year 2013.

306.10 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
306.11 thereafter, payment rates under this section shall be rebased to reflect only those changes
306.12 in hospital costs between the existing base year or years and the next base year or years. In
306.13 any year that inpatient claims volume falls below the threshold required to ensure a
306.14 statistically valid sample of claims, the commissioner may combine claims data from two
306.15 consecutive years to serve as the base year. Years in which inpatient claims volume is
306.16 reduced or altered due to a pandemic or other public health emergency shall not be used as
306.17 a base year or part of a base year if the base year includes more than one year. Changes in
306.18 costs between base years shall be measured using the lower of the hospital cost index defined
306.19 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
306.20 claim. The commissioner shall establish the base year for each rebasing period considering
306.21 the most recent year or years for which filed Medicare cost reports are available. The
306.22 estimated change in the average payment per hospital discharge resulting from a scheduled
306.23 rebasing must be calculated and made available to the legislature by January 15 of each
306.24 year in which rebasing is scheduled to occur, and must include by hospital the differential
306.25 in payment rates compared to the individual hospital's costs.

306.26 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
306.27 for critical access hospitals located in Minnesota or the local trade area shall be determined
306.28 using a new cost-based methodology. The commissioner shall establish within the
306.29 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
306.30 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
306.31 the total cost for critical access hospitals as reflected in base year cost reports. Until the
306.32 next rebasing that occurs, the new methodology shall result in no greater than a five percent
306.33 decrease from the base year payments for any hospital, except a hospital that had payments
306.34 that were greater than 100 percent of the hospital's costs in the base year shall have their
306.35 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
307.1 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
307.2 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
307.3 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
307.4 following criteria:

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

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

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

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

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

254.22 (2) the ratio between the hospital's costs for treating medical assistance patients and the
254.23 hospital's payments received from the medical assistance program for the care of medical
254.24 assistance patients;

254.25 (3) the ratio between the hospital's charges to the medical assistance program and the
254.26 hospital's payments received from the medical assistance program for the care of medical
254.27 assistance patients;

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

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

254.31 (6) geographic location.

255.1 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to
255.2 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific
255.3 to each hospital that qualifies for a medical education and research cost distribution under
255.4 section 62J.692 subdivision 4, paragraph (a).

255.5 Sec. 17. Minnesota Statutes 2022, section 256B.75, is amended to read:

255.6 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

255.7 (a) For outpatient hospital facility fee payments for services rendered on or after October
255.8 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
255.9 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
255.10 which there is a federal maximum allowable payment. Effective for services rendered on
255.11 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
255.12 emergency room facility fees shall be increased by eight percent over the rates in effect on
255.13 December 31, 1999, except for those services for which there is a federal maximum allowable
255.14 payment. Services for which there is a federal maximum allowable payment shall be paid
255.15 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
255.16 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
255.17 upper limit. If it is determined that a provision of this section conflicts with existing or
255.18 future requirements of the United States government with respect to federal financial
255.19 participation in medical assistance, the federal requirements prevail. The commissioner
255.20 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
255.21 participation resulting from rates that are in excess of the Medicare upper limitations.

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

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

307.17 (2) the ratio between the hospital's costs for treating medical assistance patients and the
307.18 hospital's payments received from the medical assistance program for the care of medical
307.19 assistance patients;

307.20 (3) the ratio between the hospital's charges to the medical assistance program and the
307.21 hospital's payments received from the medical assistance program for the care of medical
307.22 assistance patients;

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

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

307.26 (6) geographic location.

307.27 (k) Effective for discharges occurring on or after January 1, 2024, the rates paid to
307.28 hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific
307.29 to each hospital that qualifies for a medical education and research cost distribution under
307.30 section 62J.692 subdivision 4, paragraph (a).

308.1 Sec. 8. Minnesota Statutes 2022, section 256B.75, is amended to read:

308.2 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

308.3 (a) For outpatient hospital facility fee payments for services rendered on or after October
308.4 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
308.5 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
308.6 which there is a federal maximum allowable payment. Effective for services rendered on
308.7 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
308.8 emergency room facility fees shall be increased by eight percent over the rates in effect on
308.9 December 31, 1999, except for those services for which there is a federal maximum allowable
308.10 payment. Services for which there is a federal maximum allowable payment shall be paid
308.11 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
308.12 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
308.13 upper limit. If it is determined that a provision of this section conflicts with existing or
308.14 future requirements of the United States government with respect to federal financial
308.15 participation in medical assistance, the federal requirements prevail. The commissioner
308.16 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
308.17 participation resulting from rates that are in excess of the Medicare upper limitations.

255.22 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
255.23 surgery hospital facility fee services for critical access hospitals designated under section
255.24 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
255.25 cost-finding methods and allowable costs of the Medicare program. Effective for services
255.26 provided on or after July 1, 2015, rates established for critical access hospitals under this
255.27 paragraph for the applicable payment year shall be the final payment and shall not be settled
255.28 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
255.29 year ending in 2017, the rate for outpatient hospital services shall be computed using
255.30 information from each hospital's Medicare cost report as filed with Medicare for the year
255.31 that is two years before the year that the rate is being computed. Rates shall be computed
255.32 using information from Worksheet C series until the department finalizes the medical
255.33 assistance cost reporting process for critical access hospitals. After the cost reporting process
255.34 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
256.1 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
256.2 related to rural health clinics and federally qualified health clinics, divided by ancillary
256.3 charges plus outpatient charges, excluding charges related to rural health clinics and federally
256.4 qualified health clinics. Effective for services delivered on or after January 1, 2024, the
256.5 rates paid to critical access hospitals under this section must be adjusted to include the
256.6 amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were
256.7 not included in the rate adjustment described under section 256.969, subdivision 2b,
256.8 paragraph (k).

256.9 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
256.10 Medicare outpatient prospective payment system shall be replaced by a budget neutral
256.11 prospective payment system that is derived using medical assistance data. The commissioner
256.12 shall provide a proposal to the 2003 legislature to define and implement this provision.
256.13 When implementing prospective payment methodologies, the commissioner shall use general
256.14 methods and rate calculation parameters similar to the applicable Medicare prospective
256.15 payment systems for services delivered in outpatient hospital and ambulatory surgical center
256.16 settings unless other payment methodologies for these services are specified in this chapter.

256.17 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
256.18 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
256.19 services is reduced by .5 percent from the current statutory rate.

256.20 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
256.21 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility
256.22 services before third-party liability and spenddown, is reduced five percent from the current
256.23 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
256.24 this paragraph.

256.25 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
256.26 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
256.27 hospital facility services before third-party liability and spenddown, is reduced three percent

308.18 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
308.19 surgery hospital facility fee services for critical access hospitals designated under section
308.20 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
308.21 cost-finding methods and allowable costs of the Medicare program. Effective for services
308.22 provided on or after July 1, 2015, rates established for critical access hospitals under this
308.23 paragraph for the applicable payment year shall be the final payment and shall not be settled
308.24 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
308.25 year ending in 2017, the rate for outpatient hospital services shall be computed using
308.26 information from each hospital's Medicare cost report as filed with Medicare for the year
308.27 that is two years before the year that the rate is being computed. Rates shall be computed
308.28 using information from Worksheet C series until the department finalizes the medical
308.29 assistance cost reporting process for critical access hospitals. After the cost reporting process
308.30 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
308.31 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
308.32 related to rural health clinics and federally qualified health clinics, divided by ancillary
308.33 charges plus outpatient charges, excluding charges related to rural health clinics and federally
308.34 qualified health clinics. Effective for services delivered on or after January 1, 2024, the
308.35 rates paid to critical access hospitals under this section must be adjusted to include the
309.1 amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were
309.2 not included in the rate adjustment described under section 256.969, subdivision 2b,
309.3 paragraph (k).

309.4 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
309.5 Medicare outpatient prospective payment system shall be replaced by a budget neutral
309.6 prospective payment system that is derived using medical assistance data. The commissioner
309.7 shall provide a proposal to the 2003 legislature to define and implement this provision.
309.8 When implementing prospective payment methodologies, the commissioner shall use general
309.9 methods and rate calculation parameters similar to the applicable Medicare prospective
309.10 payment systems for services delivered in outpatient hospital and ambulatory surgical center
309.11 settings unless other payment methodologies for these services are specified in this chapter.

309.12 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
309.13 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
309.14 services is reduced by .5 percent from the current statutory rate.

309.15 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
309.16 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility
309.17 services before third-party liability and spenddown, is reduced five percent from the current
309.18 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
309.19 this paragraph.

309.20 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
309.21 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
309.22 hospital facility services before third-party liability and spenddown, is reduced three percent

256.28 from the current statutory rates. Mental health services and facilities defined under section
256.29 256.969, subdivision 16, are excluded from this paragraph.

256.30 Sec. 18. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

256.31 Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes,
256.32 as well as related penalties, interest, license fees, and miscellaneous sources of revenue
256.33 shall be deposited by the commissioner in the state treasury and credited as follows:

257.1 (1) \$22,250,000 each year must be credited to the Academic Health Center special
257.2 revenue fund hereby created and is annually appropriated to the Board of Regents at the
257.3 University of Minnesota for Academic Health Center funding at the University of Minnesota;
257.4 and

257.5 (2) ~~\$3,937,000~~ \$3,788,000 each year must be credited to the medical education and
257.6 research costs account hereby created in the special revenue fund and is annually appropriated
257.7 to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph
257.8 (a); and

257.9 (3) the balance of the revenues derived from taxes, penalties, and interest (under this
257.10 chapter) and from license fees and miscellaneous sources of revenue shall be credited to
257.11 the general fund.

257.12 Sec. 19. **REPEALER.**

257.13 Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision
257.14 1; and 256B.69, subdivision 5c, are repealed.

309.23 from the current statutory rates. Mental health services and facilities defined under section
309.24 256.969, subdivision 16, are excluded from this paragraph.

309.25 Sec. 9. Minnesota Statutes 2022, section 297F.10, subdivision 1, is amended to read:

309.26 Subdivision 1. **Tax and use tax on cigarettes.** Revenue received from cigarette taxes,
309.27 as well as related penalties, interest, license fees, and miscellaneous sources of revenue
309.28 shall be deposited by the commissioner in the state treasury and credited as follows:

309.29 (1) \$22,250,000 each year must be credited to the Academic Health Center special
309.30 revenue fund hereby created and is annually appropriated to the Board of Regents at the
309.31 University of Minnesota for Academic Health Center funding at the University of Minnesota;
309.32 and

310.1 (2) ~~\$3,937,000~~ \$3,788,000 each year must be credited to the medical education and
310.2 research costs account hereby created in the special revenue fund and is annually appropriated
310.3 to the commissioner of health for distribution under section 62J.692, subdivision 4, paragraph
310.4 (a); and

310.5 (3) the balance of the revenues derived from taxes, penalties, and interest (under this
310.6 chapter) and from license fees and miscellaneous sources of revenue shall be credited to
310.7 the general fund.

310.8 Sec. 10. **REPEALER.**

310.9 Minnesota Statutes 2022, sections 62J.692, subdivisions 4a, 7, and 7a; 137.38, subdivision
310.10 1; and 256B.69, subdivision 5c, are repealed.