

151.1

ARTICLE 4

151.2

DEPARTMENT OF HEALTH151.3 Section 1. **Minnesota Statutes 2022, section 13.10, subdivision 5, is amended to read:**151.4 Subd. 5. **Adoption records.** Notwithstanding any provision of this or any other chapter,
151.5 adoption records shall be treated as provided in sections 259.53, 259.61, 259.79, and 259.83
151.6 to 259.89 259.88.151.7 **EFFECTIVE DATE.** This section is effective July 1, 2024.

92.23

ARTICLE 3

92.24

DEPARTMENT OF HEALTH92.25 Section 1. **Minnesota Statutes 2022, section 12A.08, subdivision 3, is amended to read:**92.26 Subd. 3. **Implementation.** To implement the requirements of this section, the
92.27 commissioner may cooperate with private health care providers and facilities, Tribal nations,
92.28 and community health boards as defined in section 145A.02; provide grants to assist
92.29 community health boards, and Tribal nations; use volunteer services of individuals qualified
92.30 to provide public health services; and enter into cooperative or mutual aid agreements to
92.31 provide public health services.93.1 Sec. 2. **Minnesota Statutes 2022, section 13.3805, subdivision 1, is amended to read:**93.2 Subdivision 1. **Health data generally.** (a) **Definitions.** As used in this subdivision:
93.3 (1) "Commissioner" means the commissioner of health.93.4 (2) "Health data" are data on individuals created, collected, received, or maintained by
93.5 the Department of Health, political subdivisions, or statewide systems relating to the
93.6 identification, description, prevention, and control of disease or as part of an epidemiologic
93.7 investigation the commissioner designates as necessary to analyze, describe, or protect the
93.8 public health.93.9 (b) **Data on individuals.** (1) Health data are private data on individuals. Notwithstanding
93.10 section 13.05, subdivision 9, health data may not be disclosed except as provided in this
93.11 subdivision and section 13.04.93.12 (2) The commissioner or a community health board as defined in section 145A.02,
93.13 subdivision 5, may disclose health data to the data subject's physician as necessary to locate
93.14 or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to
93.15 identify persons at risk of illness, or to conduct an epidemiologic investigation.93.16 (3) With the approval of the commissioner, health data may be disclosed to the extent
93.17 necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to
93.18 alert persons who may be threatened by illness as evidenced by epidemiologic data, to
93.19 control or prevent the spread of serious disease, or to diminish an imminent threat to the
93.20 public health.

151.8 Sec. 2. Minnesota Statutes 2022, section 13.465, subdivision 8, is amended to read:

151.9 Subd. 8. **Adoption records.** Various adoption records are classified under section 259.53,
151.10 subdivision 1. Access to the original birth record of a person who has been adopted is
151.11 governed by section 259.89 144.2252.

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

151.13 Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

151.14 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
151.15 injured persons or entities, this section does not prohibit distribution of money to the specific
151.16 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
151.17 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
151.18 to those persons or entities because they cannot readily be located or identified or because
151.19 the cost of distributing the money would outweigh the benefit to the persons or entities, the
151.20 money must be paid into the general fund.

151.21 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
151.22 may be deposited in that fund.

151.23 (c) This section does not prohibit a state official from distributing money to a person or
151.24 entity other than the state in litigation or potential litigation in which the state is a defendant
151.25 or potential defendant.

151.26 (d) State agencies may accept funds as directed by a federal court for any restitution or
151.27 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States
151.28 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue
151.29 account and are appropriated to the commissioner of the agency for the purpose as directed
151.30 by the federal court.

152.1 (e) Tobacco settlement revenues as defined in section 16A.98, subdivision 1, paragraph
152.2 (t), may be deposited as provided in section 16A.98, subdivision 12.

152.3 (f) Any money received by the state resulting from a settlement agreement or an assurance
152.4 of discontinuance entered into by the attorney general of the state, or a court order in litigation
152.5 brought by the attorney general of the state, on behalf of the state or a state agency, related
152.6 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids
152.7 in this state or other alleged illegal actions that contributed to the excessive use of opioids,
152.8 must be deposited in the settlement account established in the opiate epidemic response
152.9 fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees
152.10 and costs awarded to the state or the Attorney General's Office, to contract attorneys hired
152.11 by the state or Attorney General's Office, or to other state agency attorneys.

93.21 (e) **Health summary data.** Summary data derived from data collected under section

93.22 145.413 may be provided under section 13.05, subdivision 7.

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

93.24 Sec. 3. Minnesota Statutes 2022, section 16A.151, subdivision 2, is amended to read:

93.25 Subd. 2. **Exceptions.** (a) If a state official litigates or settles a matter on behalf of specific
93.26 injured persons or entities, this section does not prohibit distribution of money to the specific
93.27 injured persons or entities on whose behalf the litigation or settlement efforts were initiated.
93.28 If money recovered on behalf of injured persons or entities cannot reasonably be distributed
93.29 to those persons or entities because they cannot readily be located or identified or because
93.30 the cost of distributing the money would outweigh the benefit to the persons or entities, the
93.31 money must be paid into the general fund.

94.1 (b) Money recovered on behalf of a fund in the state treasury other than the general fund
94.2 may be deposited in that fund.

94.3 (c) This section does not prohibit a state official from distributing money to a person or
94.4 entity other than the state in litigation or potential litigation in which the state is a defendant
94.5 or potential defendant.

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94.7 monetary penalty under United States Code, title 18, section 3663(a)(3), or United States
94.8 Code, title 18, section 3663A(a)(3). Funds received must be deposited in a special revenue
94.9 account and are appropriated to the commissioner of the agency for the purpose as directed
94.10 by the federal court.

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94.14 of discontinuance entered into by the attorney general of the state, or a court order in litigation
94.15 brought by the attorney general of the state, on behalf of the state or a state agency, related
94.16 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids
94.17 in this state or other alleged illegal actions that contributed to the excessive use of opioids,
94.18 must be deposited in the settlement account established in the opiate epidemic response
94.19 fund under section 256.043, subdivision 1. This paragraph does not apply to attorney fees
94.20 and costs awarded to the state or the Attorney General's Office, to contract attorneys hired
94.21 by the state or Attorney General's Office, or to other state agency attorneys.

152.12 (g) Notwithstanding paragraph (f), if money is received from a settlement agreement or
 152.13 an assurance of discontinuance entered into by the attorney general of the state or a court
 152.14 order in litigation brought by the attorney general of the state on behalf of the state or a state
 152.15 agency against a consulting firm working for an opioid manufacturer or opioid wholesale
 152.16 drug distributor, the commissioner shall deposit any money received into the settlement
 152.17 account established within the opiate epidemic response fund under section 256.042,
 152.18 subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount
 152.19 deposited into the settlement account in accordance with this paragraph shall be appropriated
 152.20 to the commissioner of human services to award as grants as specified by the opiate epidemic
 152.21 response advisory council in accordance with section 256.043, subdivision 3a, paragraph
 152.22 (d).

152.23 (h) Any money received by the state resulting from a settlement agreement or an assurance
 152.24 of discontinuance entered into by the attorney general of the state, or a court order in litigation
 152.25 brought by the attorney general of the state on behalf of the state or a state agency related
 152.26 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of
 152.27 electronic nicotine delivery systems in this state or other alleged illegal actions that
 152.28 contributed to the exacerbation of youth nicotine use, must be deposited in the tobacco use
 152.29 prevention account under section 144.398. This paragraph does not apply to: (1) attorney
 152.30 fees and costs awarded or paid to the state or the Attorney General's Office; (2) contract
 152.31 attorneys hired by the state or Attorney General's Office; or (3) other state agency attorneys.

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

153.1 Sec. 4. Minnesota Statutes 2022, section 103I.005, subdivision 17a, is amended to read:
 153.2 Subd. 17a. **Temporary boring Submerged closed-loop heat exchanger.** "Temporary
 153.3 boring" "Submerged closed-loop heat exchanger" means an excavation that is 15 feet or

94.22 (g) Notwithstanding paragraph (f), if money is received from a settlement agreement or
 94.23 an assurance of discontinuance entered into by the attorney general of the state or a court
 94.24 order in litigation brought by the attorney general of the state on behalf of the state or a state
 94.25 agency against a consulting firm working for an opioid manufacturer or opioid wholesale
 94.26 drug distributor, the commissioner shall deposit any money received into the settlement
 94.27 account established within the opiate epidemic response fund under section 256.042,
 94.28 subdivision 1. Notwithstanding section 256.043, subdivision 3a, paragraph (a), any amount
 94.29 deposited into the settlement account in accordance with this paragraph shall be appropriated
 94.30 to the commissioner of human services to award as grants as specified by the opiate epidemic
 94.31 response advisory council in accordance with section 256.043, subdivision 3a, paragraph
 94.32 (d).

94.33 (h) Any money received by the state resulting from a settlement agreement or an assurance
 94.34 of discontinuance entered into by the attorney general of the state, or a court order in litigation
 95.1 brought by the attorney general of the state on behalf of the state or a state agency related
 95.2 to alleged violations of consumer fraud laws in the marketing, sale, or distribution of
 95.3 electronic nicotine delivery systems in this state or other alleged illegal actions that
 95.4 contributed to the exacerbation of youth nicotine use, must be deposited in the tobacco use
 95.5 prevention account under section 144.398. This paragraph does not apply to: (1) attorney
 95.6 fees and costs awarded or paid to the state or the Attorney General's Office; (2) contract
 95.7 attorneys hired by the state or Attorney General's Office; or (3) other state agency attorneys.

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

95.9 Sec. 4. Minnesota Statutes 2022, section 62J.17, subdivision 5a, is amended to read:

95.10 Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review
 95.11 each major spending commitment and notify the provider of the results of the review. The
 95.12 commissioner shall determine whether the major spending commitment was appropriate.
 95.13 In making the determination, the commissioner may consider the following criteria: the
 95.14 major spending commitment's impact on the cost, access, and quality of health care; the
 95.15 clinical effectiveness and cost-effectiveness of the major spending commitment; and the
 95.16 alternatives available to the provider. If the major expenditure is determined not to be
 95.17 appropriate, the commissioner shall notify the provider.

95.18 (b) The commissioner may not prevent or prohibit a major spending commitment subject
 95.19 to retrospective review. However, if the provider fails the retrospective review, any major
 95.20 spending commitments by that provider for the five-year period following the commissioner's
 95.21 decision are subject to prospective review under subdivision 6a.

FOR SECTIONS 5 TO 33, SEE ARTICLE 2, HEALTH INSURANCE

153.4 ~~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 a heating and cooling system that:~~

153.6 ~~(1) conduct physical, chemical, or biological testing of groundwater, including groundwater quality monitoring is installed in a water supply well;~~

153.8 ~~(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;~~

153.12 ~~(3) measure groundwater levels, including use of a piezometer contains potable water as the heat transfer fluid; and~~

153.14 ~~(4) determine groundwater flow direction or velocity is operated using nonconsumptive recirculation.~~

153.16 ~~A submerged closed-loop heat exchanger also includes submersible pumps, a heat exchanger device, piping, and other necessary appurtenances.~~

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

153.19 Sec. 5. Minnesota Statutes 2022, section 103I.005, is amended by adding a subdivision to read:

153.21 ~~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:~~

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

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

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

153.30 ~~(4) determine groundwater flow direction or velocity.~~

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

154.1 Sec. 6. Minnesota Statutes 2022, section 103I.005, subdivision 20a, is amended to read:

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

154.4 ~~(1) for potable water supply;~~

154.5 ~~(2) for irrigation;~~

154.6 (3) for agricultural, commercial, or industrial water supply;
154.7 (4) for heating or cooling; **and**
154.8 (5) for containing a submerged closed-loop heat exchanger; and
154.9 (6) for testing water yield for irrigation, commercial or industrial uses, residential supply,
154.10 or public water supply.

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

154.12 Sec. 7. Minnesota Statutes 2022, section 103I.208, subdivision 2, is amended to read:

154.13 Subd. 2. **Permit fee.** The permit fee to be paid by a property owner is:

154.14 (1) for a water supply well that is not in use under a maintenance permit, \$175 annually;
154.15 (2) for an environmental well that is unsealed under a maintenance permit, \$175 annually
154.16 except no fee is required for an environmental well owned by a federal agency, state agency,
154.17 or local unit of government that is unsealed under a maintenance permit. "Local unit of
154.18 government" means a statutory or home rule charter city, town, county, or soil and water
154.19 conservation district, watershed district, an organization formed for the joint exercise of
154.20 powers under section 471.59, a community health board, or other special purpose district
154.21 or authority with local jurisdiction in water and related land resources management;

154.22 (3) for environmental wells that are unsealed under a maintenance permit, \$175 annually
154.23 per site regardless of the number of environmental wells located on site;

154.24 (4) for a groundwater thermal exchange device, in addition to the notification fee for
154.25 water supply wells, \$275, which includes the state core function fee;

154.26 (5) for a bored geothermal heat exchanger with less than ten tons of heating/cooling
154.27 capacity, \$275;

154.28 (6) for a bored geothermal heat exchanger with ten to 50 tons of heating/cooling capacity,
154.29 \$515;

155.1 (7) for a bored geothermal heat exchanger with greater than 50 tons of heating/cooling
155.2 capacity, \$740;

155.3 (8) for a dewatering well that is unsealed under a maintenance permit, \$175 annually
155.4 for each dewatering well, except a dewatering project comprising more than five dewatering
155.5 wells shall be issued a single permit for \$875 annually for dewatering wells recorded on
155.6 the permit; **and**

155.7 (9) for an elevator boring, \$275 for each boring; and

155.8 (10) for a submerged closed loop heat exchanger, in addition to the notification fee for
155.9 water supply wells, \$275, which includes the state core function fee.

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

155.11 Sec. 8. **[103I.209] SUBMERGED CLOSED LOOP HEAT EXCHANGER SYSTEM; REQUIREMENTS.**

155.13 Subdivision 1. **Permit required.** After the effective date of this act, a person must not
155.14 install a submerged closed loop heat exchanger in a water supply well without a permit
155.15 granted by the commissioner as provided in section 103I.210. A submerged closed loop
155.16 heat exchanger system approved by a variance granted by the commissioner prior to the
155.17 effective date of this act may continue to operate without obtaining a permit under this
155.18 section or section 103I.210.

155.19 Subd. 2. **Setbacks.** A water supply well containing a submerged closed-loop heat
155.20 exchanger that is used for the sole purpose of heating and cooling and does not remove
155.21 water from an aquifer is exempt from the isolation distance requirements of Minnesota
155.22 Rules, part 4725.4450, or a successor rule on the same topic, and in no instance will the
155.23 setback distance be greater than ten feet. A water supply well that does not comply with the
155.24 isolation distance requirements of Minnesota Rules, part 4725.4450, must not be used for
155.25 any other water supply well purpose.

155.26 Subd. 3. **Construction.** (a) A water supply well constructed to house a submerged closed
155.27 loop heat exchanger must be constructed by a licensed well contractor, and the submerged
155.28 closed loop heat exchanger must be installed by a licensed well contractor.

155.29 (b) The screened interval of a water supply well constructed to contain a submerged
155.30 closed loop heat exchanger completed within a single aquifer may be designed and
155.31 constructed using any combination of screen, casing, leader, riser, sump, or other piping
155.32 combinations, so long as the screen configuration does not interconnect aquifers.

156.1 (c) A water supply well used for a submerged closed loop heat exchanger must comply
156.2 with the requirements of chapter 103I and Minnesota Rules, chapter 4725.

156.3 Subd. 4. **Heat transfer fluid.** Water used as heat transfer fluid must be sourced from a
156.4 potable supply. The heat transfer fluid may be amended with additives to inhibit corrosion
156.5 or microbial activity. Any additive used must be ANSI/NSF-60 certified.

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

156.7 Sec. 9. **[103I.210] SUBMERGED CLOSED LOOP HEAT EXCHANGER SYSTEM; PERMITS.**

156.9 Subdivision 1. **Definition.** For purposes of this section, "permit holder" means persons
156.10 who receive a permit under this section and includes the property owner and licensed well
156.11 contractor.

156.12 Subd. 2. **Permit; limitations.** (a) The commissioner must issue a permit for the
156.13 installation of a submerged closed loop heat exchanger system as provided in this section.
156.14 The property owner or the property owner's agent must submit to the commissioner a permit

156.15 application on a form provided by the commissioner, or in a format approved by the
156.16 commissioner. The application must be legible and must contain:

156.17 (1) the name, license number, and signature of the well contractor installing the closed

156.18 loop heat exchangers;

156.19 (2) the name, address, and signature of the owner of the property on which the device

156.20 will be installed;

156.21 (3) the township number, range number, section, and one quartile, and the property street

156.22 address if assigned, of the proposed device location;

156.23 (4) a description of existing wells to be utilized or any wells proposed to be constructed

156.24 including, the unique well numbers, locations, well depth, diameters of bore holes and

156.25 casing, depth of casing, grouting methods and materials, and dates of construction;

156.26 (5) the specifications for piping including the materials to be used for piping, the closed

156.27 loop water treatment protocol, and the provisions for pressure testing the system; and

156.28 (6) a diagram of the proposed system.

156.29 (b) The fees collected under this subdivision must be deposited in the state government

156.30 special revenue fund.

157.1 (c) Permit holders must allow for the inspection of the submerged closed loop heat
157.2 exchanger system by the commissioner during working hours.

157.3 (d) If a permit application contains all of the information required in paragraph (a) and
157.4 for which the technical specifications are consistent with the requirements of paragraph (a),

157.5 the commissioner may only deny the permit if the commissioner determines that the proposed

157.6 submerged closed loop heat exchanger system creates a new material risk to human health

157.7 and the environment by adversely affecting the migration of an existing groundwater

157.8 contamination plume.

157.9 (e) Within 30 days of submission of a complete permit application, the commissioner
157.10 must either issue the permit or notify the applicant that the commissioner has determined

157.11 that the proposed submerged closed loop heat exchanger system may create a material risk

157.12 to human health and the environment by adversely affecting the migration of an existing

157.13 groundwater plume. If the commissioner determines the system may create a material risk,

157.14 the commissioner must make a final determination as to whether the proposed system poses

157.15 such material risk within 30 days after initial notice is provided to the applicant. The

157.16 commissioner may extend this 30-day period with the consent of the applicant. An application

157.17 is deemed to have been granted if the commissioner fails to notify the applicant that the

157.18 commissioner has determined that the proposed submerged closed loop heat exchanger

157.19 system may create a material risk to human health and the environment by adversely affecting

157.20 the migration of an existing groundwater within 30 days of submission of a complete

157.21 application or if the commissioner fails to make a final determination regarding such potential
157.22 material risks within 30 days after notifying the applicant.

157.23 (f) The commissioner must not limit the number of permits available or the size of
157.24 systems. A project may consist of more than one submerged closed loop heat exchanger.
157.25 Installing a submerged closed loop heat exchanger must not be subject to additional review
157.26 or requirements with regards to the construction of a water supply well, beyond the
157.27 requirements promulgated in chapter 103I, and Minnesota Rules, chapter 4725. A variance
157.28 is not required to install or operate a submerged closed loop heat exchanger.

157.29 (g) Permit holders must comply with this chapter, and Minnesota Rules, chapter 4725.

157.30 (h) A permit holder must inform the Minnesota duty officer of the failure or leak of a
157.31 submerged closed loop heat exchanger.

157.32 Subd. 3. **Permit conditions.** Permit holders must construct, install, operate, maintain,
157.33 and report on the submerged closed loop heat exchanger system to comply with permit
157.34 conditions identified by the commissioner, which will address:

158.1 (1) notification to the commissioner at intervals specified in the permit conditions;

158.2 (2) material and design specifications and standards;

158.3 (3) heat exchange fluid requirements;

158.4 (4) signage requirements;

158.5 (5) backflow prevention requirements;

158.6 (6) pressure tests of the system;

158.7 (7) documentation of the system construction;

158.8 (8) requirements for maintenance and repair of the system;

158.9 (9) removal of the system upon termination of use or failure;

158.10 (10) disclosure of the system at the time of property transfer; and

158.11 (11) requirement to obtain approval from the commissioner prior to deviation of the
158.12 approved plans and conditions of the permit.

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

123.1 Sec. 34. **[115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND
123.2 WASTEWATER TREATMENT FACILITIES.**

123.3 Subdivision 1. **Purpose; membership.** The Advisory Council on Water Supply Systems
123.4 and Wastewater Treatment Facilities shall advise the commissioners of health and the

123.5 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:

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

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

123.15 (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;

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

123.20 (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

123.23 (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.

123.28 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.

123.32 Subd. 3. **Terms; compensation.** The terms of the appointed members and the compensation and removal of all members are governed by section 15.059.

124.1 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.

124.4 Sec. 35. Minnesota Statutes 2022, section 121A.335, is amended to read:

124.5 **121A.335 LEAD IN SCHOOL DRINKING WATER.**

124.6 Subdivision 1. **Model plan.** The commissioners of health and education shall jointly develop a model plan to require school districts to accurately and efficiently test for the

124.8 presence of lead in water in public school buildings serving students in kindergarten through
124.9 grade 12. To the extent possible, the commissioners shall base the plan on the standards
124.10 established by the United States Environmental Protection Agency. The plan may be based
124.11 on the technical guidance in the Department of Health's document, "Reducing Lead in
124.12 Drinking Water: A Technical Guidance for Minnesota's School and Child Care Facilities."
124.13 The plan must include recommendations for remediation efforts when testing reveals the
124.14 presence of lead at or above five parts per billion.

124.15 Subd. 2. **School plans.** (a) By July 1, 2018, the board of each school district or charter
124.16 school must adopt the commissioners' model plan or develop and adopt an alternative plan
124.17 to accurately and efficiently test for the presence of lead in water in school buildings serving
124.18 prekindergarten students and students in kindergarten through grade 12.

124.19 (b) By July 1, 2024, a school district or charter school must revise its plan to include its
124.20 policies and procedures for ensuring consistent water quality throughout the district's or
124.21 charter school's facilities. The plan must document the routine water management strategies
124.22 and procedures used in each building or facility to maintain water quality and reduce exposure
124.23 to lead. A district or charter school must base the plan on the United States Environmental
124.24 Protection Agency's "Ensuring Drinking Water Quality in Schools During and After Extended
124.25 Closures" fact sheet and the United States Environmental Protection Agency's "3Ts Toolkit
124.26 for Reducing Lead in Drinking Water in Schools and Child Care Facilities" manual. A
124.27 district or charter school's plan must be publicly available upon request.

158.14 Sec. 10. Minnesota Statutes 2022, section 121A.335, subdivision 3, is amended to read:

158.15 Subd. 3. **Frequency of testing.** (a) The plan under subdivision 2 must include a testing
158.16 schedule for every building serving prekindergarten through grade 12 students. The schedule
158.17 must require that each building be tested at least once every five years. A school district or
158.18 charter school must begin testing school buildings by July 1, 2018, and complete testing of
158.19 all buildings that serve students within five years.

158.20 (b) A school district or charter school that finds lead at a specific location providing
158.21 cooking or drinking water within a facility must formulate, make publicly available, and
158.22 implement a plan that is consistent with established guidelines and recommendations to
158.23 ensure that student exposure to lead is minimized. This includes, when a school district or
158.24 charter school finds the presence of lead at a level where action should be taken as set by
158.25 the guidance in any water source that can provide cooking or drinking water, immediately
158.26 shutting off the water source or making it unavailable until the hazard has been minimized.

124.28 Subd. 3. **Frequency of testing.** (a) The plan under subdivision 2 must include a testing
124.29 schedule for every building serving prekindergarten through grade 12 students. The schedule
124.30 must require that each building be tested at least once every five years. A school district or
124.31 charter school must begin testing school buildings by July 1, 2018, and complete testing of
124.32 all buildings that serve students within five years.

125.1 (b) A school district or charter school that finds lead at a specific location providing
125.2 cooking or drinking water within a facility must formulate, make publicly available, and
125.3 implement a plan that is consistent with established guidelines and recommendations to
125.4 ensure that student exposure to lead is minimized reduced to below five parts per billion as
125.5 verified by a retest. This includes, when a school district or charter school finds the presence
125.6 of lead at a level where action should be taken as set by the guidance at or above five parts
125.7 per billion in any water source fixture that can provide cooking or drinking water,
125.8 immediately shutting off the water source fixture or making it unavailable until the hazard
125.9 has been minimized remediated as verified by a retest.

125.10 (c) A school district or charter school must test for the presence of lead after completing
125.11 remediation activities required under this section to confirm that the water contains lead at
125.12 a level below five parts per billion.

158.27 Sec. 11. Minnesota Statutes 2022, section 121A.335, subdivision 5, is amended to read:

158.28 Subd. 5. **Reporting.** (a) A school district or charter school that has tested its buildings
 158.29 for the presence of lead shall make the results of the testing available to the public for review
 158.30 and must directly notify parents annually of the availability of the information. School
 159.1 districts and charter schools must follow the actions outlined in guidance from the
 159.2 commissioners of health and education. If a test conducted under subdivision 3, paragraph
 159.3 (a), reveals the presence of lead above a level where action should be taken as set by the
 159.4 guidance, the school district or charter school must, within 30 days of receiving the test
 159.5 result, either remediate the presence of lead to below the level set in guidance, verified by
 159.6 retest, or directly notify parents of the test result. The school district or charter school must
 159.7 make the water source unavailable until the hazard has been minimized.

159.8 (b) Results of testing, and any planned remediation steps, shall be made available within
 159.9 30 days of receiving results.

159.10 (c) A school district or charter school that has tested for lead in drinking water shall
 159.11 report the results of testing, and any planned remediation steps to the school board at the
 159.12 next available school board meeting or within 30 days of receiving results, whichever is
 159.13 sooner.

159.14 (d) The school district or charter school shall maintain records of lead testing in drinking
 159.15 water records electronically or by paper copy for at least 15 years.

159.16 (e) Beginning July 1, 2024, school districts and charter schools must report their test
 159.17 results and remediation activities to the commissioner of health annually on or before July
 159.18 1 of each year.

159.19 Sec. 12. Minnesota Statutes 2022, section 121A.335, is amended by adding a subdivision
 159.20 to read:

159.21 Subd. 6. **Remediation.** (a) A school district or charter school that finds lead above five
 159.22 parts per billion at a specific location providing cooking or drinking water within a facility

125.13 Subd. 4. **Ten-year facilities plan.** A school district may include lead testing and
 125.14 remediation as a part of its ten-year facilities plan under section 123B.595.

125.15 Subd. 5. **Reporting.** (a) A school district or charter school that has tested its buildings
 125.16 for the presence of lead shall make the results of the testing available to the public for review
 125.17 and must notify parents of the availability of the information. School districts and charter
 125.18 schools must follow the actions outlined in guidance from the commissioners of health and
 125.19 education, must send parents an annual notice that includes the district's or charter school's
 125.20 annual testing and remediation plan, information about how to find test results, and a
 125.21 description of remediation efforts on the district website. The district or charter school must
 125.22 update the lead testing and remediation information on its website at least annually. In
 125.23 addition to the annual notice, the district or charter school must include in an official school
 125.24 handbook or official school policy guide information on how parents may find the test
 125.25 results and a description of remediation efforts on the district or charter school website and
 125.26 how often this information is updated.

125.27 (b) If a test conducted under subdivision 3, paragraph (a), reveals the presence of lead
 125.28 at or above a level where action should be taken as set by the guidance five parts per billion,
 125.29 the school district or charter school must, within 30 days of receiving the test result, either
 125.30 remediate the presence of lead to below the level set in guidance five parts per billion,
 125.31 verified by retest, or directly notify parents of the test result. The school district or charter
 125.32 school must make the water source unavailable until the hazard has been minimized.

126.4 (d) A district or charter school must maintain a record of lead testing results and
 126.5 remediation activities for at least 15 years.

125.33 (e) Starting July 1, 2024, school districts and charter schools must report their test results
 125.34 and remediation activities to the commissioner of health in the form and manner determined
 126.1 by the commissioner in consultation with school districts and charter schools, by July 1 of
 126.2 each year. The commissioner of health must post and annually update the test results and
 126.3 remediation efforts on the department website by school site.

126.6 Subd. 6. **Public water systems.** (a) A district or charter school is not financially
 126.7 responsible for remediation of documented elevated lead levels in drinking water caused

159.23 must formulate, make publicly available, and implement a plan to remediate the lead in
 159.24 drinking water. The plan must be consistent with established guidelines and recommendations
 159.25 to ensure exposure to lead is remediated.

159.26 (b) When lead is found above five parts per billion the water fixture shall immediately
 159.27 be shut off or made unavailable for consumption until the hazard has been minimized as
 159.28 verified by a test.

159.29 (c) If the school district or charter school receives water from a public water supply that
 159.30 has an action level exceedance of the federal Lead and Copper Rule, it may delay remediation
 159.31 activities until the public water system meets state and federal requirements for the Lead
 159.32 and Copper Rule. If the school district or charter school receives water from a lead service
 159.33 line or other lead infrastructure owned by the public water supply, the school district may
 160.1 delay remediation of fixtures until the lead service line is fully replaced. The school must
 160.2 ensure that any fixture testing above five parts per billion is not used for consumption until
 160.3 remediation activities are complete.

160.4 Sec. 13. Minnesota Statutes 2022, section 144.05, is amended by adding a subdivision to
 160.5 read:

160.6 Subd. 8. Grant program reporting. The commissioner must submit a report to the
 160.7 chairs and ranking minority members of the legislative committees with jurisdiction over
 160.8 health by December 31, 2023, and by each December 31 thereafter on the following
 160.9 information:

160.10 (1) the number of grant programs administered by the commissioner that required a
 160.11 full-time equivalent staff appropriation or administrative appropriation in order to implement;
 160.12 (2) the total amount of funds appropriated to the commissioner for full-time equivalent
 160.13 staff or administration for all the grant programs; and
 160.14 (3) for each grant program administered by the commissioner:
 160.15 (i) the amount of funds appropriated to the commissioner for full-time equivalent staff
 160.16 or administration to administer that particular grant program;

126.8 by the presence of lead infrastructure owned by a public water supply utility providing water
 126.9 to the school facility, such as lead service lines, meters, galvanized service lines downstream
 126.10 of lead, or lead connectors. The district or charter school must communicate with the public
 126.11 water system regarding its documented significant contribution to lead contamination in
 126.12 school drinking water and request from the public water system a plan for reducing the lead
 126.13 contamination.

126.14 (b) If the infrastructure is jointly owned by a district or charter school and a public water
 126.15 supply utility, the district or charter school must attempt to coordinate any needed
 126.16 replacements of lead service lines with the public water supply utility.

126.17 (c) A district or charter school may defer its remediation activities under this section
 126.18 until after the elevated lead level in the public water system's infrastructure is remediated
 126.19 and postremediation testing does not detect an elevated lead level in the drinking water that
 126.20 passes through that infrastructure. A district or charter school may also defer its remediation
 126.21 activities if the public water supply exceeds the federal Safe Drinking Water Act lead action
 126.22 level or is in violation of the Safe Drinking Water Act Lead and Copper Rule.

126.23 Subd. 7. Commissioner recommendations. By January 1, 2026, and every five years
 126.24 thereafter, the commissioner of health must report to the legislative committees having
 126.25 jurisdiction over health and kindergarten through grade 12 education any recommended
 126.26 changes to this section. The recommendations must be based on currently available scientific
 126.27 evidence regarding the effects of lead in drinking water.

160.17 (ii) the actual amount of funds that were spent on full-time equivalent staff or
160.18 administration to administer that particular grant program; and

160.19 (iii) if there were funds appropriated that were not spent on full-time equivalent staff or
160.20 administration to administer that particular grant program, what the funds were actually
160.21 spent on.

160.22 Sec. 14. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL
160.23 STEWARDSHIP COLLABORATIVE.**

160.24 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota
160.25 One Health Antimicrobial Stewardship Collaborative. The director shall serve in the
160.26 unclassified service. The commissioner shall appoint a director to execute operations,
160.27 conduct health education, and provide technical assistance.

160.28 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
160.29 to:

160.30 (1) maintain the position of director of One Health Antimicrobial Stewardship to lead
160.31 state antimicrobial stewardship initiatives across human, animal, and environmental health;

161.1 (2) communicate to professionals and the public the interconnectedness of human, animal,
161.2 and environmental health, especially related to preserving the efficacy of antibiotic
161.3 medications, which are a shared resource;

161.4 (3) leverage new and existing partnerships. The commissioner of health shall consult
161.5 and collaborate with organizations and agencies in fields including but not limited to health
161.6 care, veterinary medicine, animal agriculture, academic institutions, and industry and
161.7 community organizations to inform strategies for education, practice improvement, and
161.8 research in all settings where antimicrobials are used;

161.9 (4) ensure that veterinary settings have education and strategies needed to practice
161.10 appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs,
161.11 and prevent transmission of antimicrobial-resistant microbes; and

161.12 (5) support collaborative research and programmatic initiatives to improve the
161.13 understanding of the impact of antimicrobial use and resistance in the natural environment.

161.14 Subd. 3. **Annual report.** The commissioner of health shall report annually by January
161.15 15 to the chairs and ranking minority members of the legislative committees with primary
161.16 jurisdiction over health policy and finance on the work accomplished by the commissioner
161.17 and the collaborative research in the previous year and describe goals for the following year.

126.28 Sec. 36. **[144.0526] MINNESOTA ONE HEALTH ANTIMICROBIAL
126.29 STEWARDSHIP COLLABORATIVE.**

126.30 Subdivision 1. **Establishment.** The commissioner of health shall establish the Minnesota
126.31 One Health Antimicrobial Stewardship Collaborative. The commissioner shall appoint a
126.32 director to execute operations, conduct health education, and provide technical assistance.

127.1 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
127.2 to:

127.3 (1) maintain the position of director of One Health Antimicrobial Stewardship to lead
127.4 state antimicrobial stewardship initiatives across human, animal, and environmental health;

127.5 (2) communicate to professionals and the public the interconnectedness of human, animal,
127.6 and environmental health, especially related to preserving the efficacy of antibiotic
127.7 medications, which are a shared resource;

127.8 (3) leverage new and existing partnerships. The commissioner of health shall consult
127.9 and collaborate with academic institutions, industry and community organizations, and
127.10 organizations and agencies in fields including but not limited to health care, veterinary
127.11 medicine, and animal agriculture to inform strategies for education, practice improvement,
127.12 and research in all settings where antimicrobial products are used;

127.13 (4) ensure that veterinary settings have education and strategies needed to practice
127.14 appropriate antibiotic prescribing, implement clinical antimicrobial stewardship programs,
127.15 and prevent transmission of antimicrobial-resistant microbes; and

127.16 (5) support collaborative research and programmatic initiatives to improve the
127.17 understanding of the impact of antimicrobial use and resistance in the natural environment.

127.18 Sec. 37. **[144.0528] COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY**
127.19 **PREVENTION ACT.**

127.20 Subdivision 1. **Definition.** For the purpose of this section, "drug overdose and morbidity" means health problems that people experience after inhaling, ingesting, or injecting medicines in quantities that exceed prescription status; medicines taken that are prescribed to a different person; medicines that have been adulterated or adjusted by contaminants intentionally or unintentionally; or nonprescription drugs in amounts that result in morbidity or mortality.

127.25 Subd. 2. **Establishment.** The commissioner of health shall establish a comprehensive drug overdose and morbidity program to conduct comprehensive drug overdose and morbidity prevention activities, epidemiologic investigations and surveillance, and evaluation to monitor, address, and prevent drug overdoses statewide through integrated strategies that include the following:

127.30 (1) advance access to evidence-based nonnarcotic pain management services;
127.31 (2) implement culturally specific interventions and prevention programs with population
127.32 and community groups in greatest need, including those who are pregnant and their infants;

128.1 (3) enhance overdose prevention and supportive services for people experiencing
128.2 homelessness. This strategy includes funding for emergency and short-term housing subsidies
128.3 through the homeless overdose prevention hub and expanding support for syringe services
128.4 programs serving people experiencing homelessness statewide;

128.5 (4) equip employers to promote health and well-being of employees by addressing
128.6 substance misuse and drug overdose;

128.7 (5) improve outbreak detection and identification of substances involved in overdoses
128.8 through the expansion of the Minnesota Drug Overdose and Substance Use Surveillance
128.9 Activity (MNDOSA);

128.10 (6) implement Tackling Overdose With Networks (TOWN) community prevention
128.11 programs;

128.12 (7) identify, address, and respond to drug overdose and morbidity in those who are
128.13 pregnant or have just given birth through multitiered approaches that may:

128.14 (i) promote medication-assisted treatment options;

128.15 (ii) support programs that provide services in accord with evidence-based care models
128.16 for mental health and substance abuse disorder;

128.17 (iii) collaborate with interdisciplinary and professional organizations that focus on quality
128.18 improvement initiatives related to substance use disorder; and

128.19 (iv) implement substance use disorder-related recommendations from the maternal
128.20 mortality review committee, as appropriate; and

128.21 (8) design a system to assess, address, and prevent the impacts of drug overdose and
128.22 morbidity on those who are pregnant, their infants, and children. Specifically, the
128.23 commissioner of health may:
128.24 (i) inform health care providers and the public of the prevalence, risks, conditions, and
128.25 treatments associated with substance use disorders involving or affecting pregnancies,
128.26 infants, and children; and
128.27 (ii) identify communities, families, infants, and children affected by substance use
128.28 disorder in order to recommend focused interventions, prevention, and services.
128.29 Subd. 3. **Partnerships.** The commissioner of health may consult with sovereign Tribal
128.30 nations, the Minnesota Departments of Human Services, Corrections, Public Safety, and
128.31 Education, local public health agencies, care providers and insurers, community organizations
128.32 that focus on substance abuse risks and recovery, individuals affected by substance use
129.1 disorders, and any other individuals, entities, and organizations as necessary to carry out
129.2 the goals of this section.
129.3 Subd. 4. **Grants authorized.** (a) The commissioner of health may award grants, as
129.4 funding allows, to entities and organizations focused on addressing and preventing the
129.5 negative impacts of drug overdose and morbidity. Examples of activities the commissioner
129.6 may consider for these grant awards include:
129.7 (1) developing, implementing, or promoting drug overdose and morbidity prevention
129.8 programs and activities;
129.9 (2) community outreach and other efforts addressing the root causes of drug overdose
129.10 and morbidity;
129.11 (3) identifying risk and protective factors relating to drug overdose and morbidity that
129.12 contribute to identification, development, or improvement of prevention strategies and
129.13 community outreach;
129.14 (4) developing or providing trauma-informed drug overdose and morbidity prevention
129.15 and services;
129.16 (5) developing or providing culturally and linguistically appropriate drug overdose and
129.17 morbidity prevention and services, and programs that target and serve historically underserved
129.18 communities;
129.19 (6) working collaboratively with educational institutions, including school districts, to
129.20 implement drug overdose and morbidity prevention strategies for students, teachers, and
129.21 administrators;
129.22 (7) working collaboratively with sovereign Tribal nations, care providers, nonprofit
129.23 organizations, for-profit organizations, government entities, community-based organizations,

129.24 and other entities to implement substance misuse and drug overdose prevention strategies
129.25 within their communities; and

129.26 (8) creating or implementing quality improvement initiatives to improve drug overdose
129.27 and morbidity treatment and outcomes.

129.28 (b) Any organization or government entity receiving grant money under this section
129.29 must collect and make available to the commissioner of health aggregate data related to the
129.30 activity funded by the program under this section. The commissioner of health shall use the
129.31 information and data from the program evaluation to inform the administration of existing
129.32 Department of Health programming and the development of Department of Health policies,
129.33 programs, and procedures.

130.1 Subd. 5. **Promotion; administration.** In fiscal years 2026 and beyond, the commissioner
130.2 may spend up to 25 percent of the total funding appropriated to the comprehensive drug
130.3 overdose and morbidity program in each fiscal year to promote, administer, support, and
130.4 evaluate the programs authorized under this section and to provide technical assistance to
130.5 program grantees.

130.6 Subd. 6. **External contributions.** The commissioner may accept contributions from
130.7 governmental and nongovernmental sources and may apply for grants to supplement state
130.8 appropriations for the programs authorized under this section. Contributions and grants
130.9 received from the sources identified in this subdivision to advance the purpose of this section
130.10 are appropriated to the commissioner for the comprehensive drug overdose and morbidity
130.11 program.

130.12 Subd. 7. **Program evaluation.** Beginning February 28, 2024, the commissioner of health
130.13 shall report every even-numbered year to the legislative committees with jurisdiction over
130.14 health detailing the expenditures of funds authorized under this section. The commissioner
130.15 shall use the data to evaluate the effectiveness of the program. The commissioner must
130.16 include in the report:

130.17 (1) the number of organizations receiving grant money under this section;
130.18 (2) the number of individuals served by the grant programs;
130.19 (3) a description and analysis of the practices implemented by program grantees; and

130.20 (4) best practices recommendations to prevent drug overdose and morbidity, including
130.21 culturally relevant best practices and recommendations focused on historically underserved
130.22 communities.

130.23 Subd. 8. **Measurement.** Notwithstanding any law to the contrary, the commissioner of
130.24 health shall assess and evaluate grants and contracts awarded using available data sources,
130.25 including but not limited to the Minnesota All Payer Claims Database (MN APCD), the
130.26 Minnesota Behavioral Risk Factor Surveillance System (BRFSS), the Minnesota Student

130.27 Survey, vital records, hospitalization data, syndromic surveillance, and the Minnesota
130.28 Electronic Health Record Consortium.

161.18 Sec. 15. **[144.0701] SPECIAL GUERILLA UNIT VETERANS GRANT PROGRAM.**

161.19 Subdivision 1. **Establishment.** The commissioner of health must establish a grant
161.20 program to offer culturally specific and specialized assistance to support the health and
161.21 well-being of special guerilla unit veterans.

161.22 Subd. 2. **Eligible applicants.** To be eligible for a grant under this section, applicants
161.23 must be a nonprofit organization or a nongovernmental organization that offers culturally
161.24 specific and specialized assistance to support the health and well-being of special guerilla
161.25 unit veterans.

161.26 Subd. 3. **Application.** An organization seeking a grant under this section must apply to
161.27 the commissioner at a time and in a manner specified by the commissioner.

161.28 Subd. 4. **Grant activities.** Grant funds must be used to offer programming and culturally
161.29 specific and specialized assistance to support the health and well-being of special guerilla
161.30 unit veterans.

162.1 Sec. 16. **[144.0752] CULTURAL COMMUNICATIONS.**

162.2 Subdivision 1. **Establishment.** The commissioner of health shall establish:

162.3 (1) a cultural communications program that advances culturally and linguistically
162.4 appropriate communication services for communities most impacted by health disparities
162.5 which includes limited English proficient (LEP) populations, African American, LGBTQ+,
162.6 and people with disabilities; and

162.7 (2) a position that works with department leadership and division to ensure that the
162.8 department follows the National Standards for Culturally and Linguistically Appropriate
162.9 Services (CLAS) Standards.

162.10 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
162.11 to:

162.12 (1) align the department services, policies, procedures, and governance with the National
162.13 CLAS Standards and establish culturally and linguistically appropriate goals, policies, and
162.14 management accountability and apply them throughout the organization's planning and
162.15 operations;

162.16 (2) ensure the department services respond to the cultural and linguistic diversity of
162.17 Minnesotans and that the department partners with the community to design, implement,
162.18 and evaluate policies, practices, and services that are aligned with the national cultural and
162.19 linguistic appropriateness standard; and

130.29 Sec. 38. **[144.0752] CULTURAL COMMUNICATIONS.**

130.30 Subdivision 1. **Establishment.** The commissioner of health shall establish:

130.31 (1) a cultural communications program that advances culturally and linguistically
130.32 appropriate communication services for communities most impacted by health disparities
131.1 which includes limited English proficient (LEP) populations, African American populations,
131.2 LGBTQ+ populations, and people with disabilities; and

131.3 (2) a position that works with department and division leadership to ensure that the
131.4 department follows the National Standards for Culturally and Linguistically Appropriate
131.5 Services (CLAS) Standards.

131.6 Subd. 2. **Commissioner's duties.** The commissioner of health shall oversee a program
131.7 to:

131.8 (1) align the department services, policies, procedures, and governance with the National
131.9 CLAS Standards, establish culturally and linguistically appropriate goals, policies, and
131.10 management accountability, and apply them throughout the organization's planning and
131.11 operations;

131.12 (2) ensure the department services respond to the cultural and linguistic diversity of
131.13 Minnesotans and that the department partners with the community to design, implement,
131.14 and evaluate policies, practices, and services that are aligned with the national cultural and
131.15 linguistic appropriateness standard; and

162.20 (3) ensure the department leadership, workforce, and partners embed culturally and
162.21 linguistically appropriate policies and practices into leadership and public health program
162.22 planning, intervention, evaluation, and dissemination.

162.23 Subd. 3. **Eligible contractors.** Organizations eligible to receive contract funding under
162.24 this section include:

162.25 (1) master contractors that are selected through the state to provide language and
162.26 communication services; and

162.27 (2) organizations that are able to provide services for languages that master contractors
162.28 are unable to cover.

162.29 Sec. 17. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

162.30 (a) The commissioner shall establish the Office of African American Health to address
162.31 the unique public health needs of African American Minnesotans. The office must work to
162.32 develop solutions and systems to address identified health disparities of African American
163.1 Minnesotans arising from a context of cumulative and historical discrimination and
163.2 disadvantages in multiple systems, including but not limited to housing, education,
163.3 employment, gun violence, incarceration, environmental factors, and health care
163.4 discrimination. The office shall:

163.5 (1) convene the African American Health State Advisory Council under section 144.0755
163.6 to advise the commissioner on issues and to develop specific, targeted policy solutions to
163.7 improve the health of African American Minnesotans, with a focus on United States-born
163.8 African Americans;

163.9 (2) based upon input from and collaboration with the **African American Health State**
163.10 **Advisory Council**, health indicators, and identified disparities, conduct analysis and develop
163.11 policy and program recommendations and solutions targeted at improving African American
163.12 health outcomes;

163.13 (3) coordinate and conduct community engagement across multiple systems, sectors,
163.14 and communities to address racial disparities in labor force participation, educational
163.15 achievement, and involvement with the criminal justice system that impact African American
163.16 health and well-being;

163.17 (4) conduct data analysis and research to support policy goals and solutions;

163.18 (5) award and administer African American health special emphasis grants to health and
163.19 community-based organizations to plan and develop programs targeted at improving African
163.20 American health outcomes, based upon needs identified by the council, health indicators,
163.21 and identified disparities and addressing historical trauma and systems of United States
163.22 born African American Minnesotans; and

131.16 (3) ensure the department leadership, workforce, and partners embed culturally and
131.17 linguistically appropriate policies and practices into leadership and public health program
131.18 planning, intervention, evaluation, and dissemination.

131.19 Subd. 3. **Eligible contractors.** The commissioner may enter into contracts to implement
131.20 this section. Organizations eligible to receive contract funding under this section include:

131.21 (1) master contractors that are selected through the state to provide language and
131.22 communication services; and

131.23 (2) organizations that are able to provide services for languages that master contractors
131.24 are unable to cover.

131.25 Sec. 39. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

131.26 Subdivision 1. **Establishment.** The commissioner shall establish the Office of African
131.27 American Health to address the unique public health needs of African American Minnesotans
131.28 and work to develop solutions and systems to address identified health disparities of African
131.29 American Minnesotans arising from a context of cumulative and historical discrimination
131.30 and disadvantages in multiple systems, including but not limited to housing, education,
131.31 employment, gun violence, incarceration, environmental factors, and health care
131.32 discrimination.

132.1 Subd. 2. **Duties of the office.** The office shall:

132.2 (1) convene the African American Health State Advisory Council (AAHSAC) under
132.3 section 144.0755 to advise the commissioner on issues and to develop specific, targeted
132.4 policy solutions to improve the health of African American Minnesotans, with a focus on
132.5 United States-born African Americans;

132.6 (2) based upon input from and collaboration with the **AAHSAC**, health indicators, and
132.7 identified disparities, conduct analysis and develop policy and program recommendations
132.8 and solutions targeted at improving African American health outcomes;

132.9 (3) coordinate and conduct community engagement across multiple systems, sectors,
132.10 and communities to address racial disparities in labor force participation, educational
132.11 achievement, and involvement with the criminal justice system that impact African American
132.12 health and well-being;

132.13 (4) conduct data analysis and research to support policy goals and solutions;

132.14 (5) award and administer African American health special emphasis grants to health and
132.15 community-based organizations to plan and develop programs targeted at improving African
132.16 American health outcomes, based upon needs identified by the council, health indicators,
132.17 and identified disparities and addressing historical trauma and systems of United States-born
132.18 African American Minnesotans; and

163.23 (6) develop and administer Department of Health immersion experiences for students
 163.24 in secondary education and community colleges to improve diversity of the public health
 163.25 workforce and introduce career pathways that contribute to reducing health disparities.

163.26 (b) The commissioner of health shall report annually by January 15 to the chairs and
 163.27 ranking minority members of the legislative committees with primary jurisdiction over
 163.28 health policy and finance on the work accomplished by the Office of African American
 163.29 Health during the previous year and describe goals for the following year.

163.30 Sec. 18. **[144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY**
 163.31 **COUNCIL.**

163.32 Subdivision 1. **Members.** (a) The African American Health State Advisory Council
 163.33 shall include no fewer than 12 or more than 20 members from any of the following groups:

164.1 (1) representatives of community-based organizations serving or advocating for African
 164.2 American citizens;
 164.3 (2) at-large community leaders or elders, as nominated by other council members;
 164.4 (3) African American individuals who provide and receive health care services;
 164.5 (4) African American secondary or college students;
 164.6 (5) health or human service professionals serving African American communities or
 164.7 clients;
 164.8 (6) representatives with research or academic expertise in racial equity; and
 164.9 (7) other members that the commissioner deems appropriate to facilitate the goals and
 164.10 duties of the council.

164.11 (b) The commissioner shall make recommendations for council membership and, after
 164.12 considering recommendations from the council, shall appoint a chair or chairs of the council.
 164.13 Council members shall be appointed by the governor.

164.14 Subd. 2. **Terms.** A term shall be for two years and appointees may be reappointed to
 164.15 serve two additional terms. The commissioner shall recommend appointments to replace
 164.16 members vacating their positions in a timely manner, no more than three months after the
 164.17 council reviews panel recommendations.

164.18 Subd. 3. **Duties of commissioner.** The commissioner or commissioner's designee shall:
 164.19 (1) maintain and actively engage with the council established in this section;

132.19 (6) develop and administer Department of Health immersion experiences for students
 132.20 in secondary education and community colleges to improve diversity of the public health
 132.21 workforce and introduce career pathways that contribute to reducing health disparities.

132.22 Sec. 40. **[144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY**
 132.23 **COUNCIL.**

132.24 Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish
 132.25 and administer the African American Health State Advisory Council to advise the
 132.26 commissioner on implementing specific strategies to reduce health inequities and disparities
 132.27 that particularly affect African Americans in Minnesota.

132.28 Subd. 2. **Members.** (a) The council shall include no fewer than 12 or more than 20
 132.29 members from any of the following groups:

132.30 (1) representatives of community-based organizations serving or advocating for African
 132.31 American citizens;
 132.32 (2) at-large community leaders or elders, as nominated by other council members;
 133.1 (3) African American individuals who provide and receive health care services;
 133.2 (4) African American secondary or college students;
 133.3 (5) health or human service professionals serving African American communities or
 133.4 clients;
 133.5 (6) representatives with research or academic expertise in racial equity; and
 133.6 (7) other members that the commissioner deems appropriate to facilitate the goals and
 133.7 duties of the council.

133.8 (b) The commissioner shall make recommendations for council membership and, after
 133.9 considering recommendations from the council, shall appoint a chair or chairs of the council.
 133.10 Council members shall be appointed by the governor.

133.11 Subd. 3. **Terms.** A term shall be for two years and appointees may be reappointed to
 133.12 serve two additional terms. The commissioner shall recommend appointments to replace
 133.13 members vacating their positions in a timely manner, no more than three months after the
 133.14 council reviews panel recommendations.

133.15 Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:
 133.16 (1) maintain and actively engage with the council established in this section;

164.20 (2) based on recommendations of the council, review identified department or other
 164.21 related policies or practices that maintain health inequities and disparities that particularly
 164.22 affect African Americans in Minnesota;

164.23 (3) in partnership with the council, recommend or implement action plans and resources
 164.24 necessary to address identified disparities and advance African American health equity;

164.25 (4) support interagency collaboration to advance African American health equity; and

164.26 (5) support member participation in the council, including participation in educational
 164.27 and community engagement events across Minnesota that specifically address African
 164.28 American health equity.

164.29 **Subd. 4. Duties of council.** The council shall:

164.30 (1) identify health disparities found in African American communities and contributing
 164.31 factors;

165.1 (2) recommend to the commissioner for review any statutes, rules, or administrative
 165.2 policies or practices that would address African American health disparities;

165.3 (3) recommend policies and strategies to the commissioner of health to address disparities
 165.4 specifically affecting African American health;

165.5 (4) form work groups of council members who are persons who provide and receive
 165.6 services and representatives of advocacy groups;

165.7 (5) provide the work groups with clear guidelines, standardized parameters, and tasks
 165.8 for the work groups to accomplish; and

165.9 (6) annually submit to the commissioner and to the chairs and ranking minority members
 165.10 of the legislative committees with primary jurisdiction over health policy and finance a
 165.11 report that summarizes the activities of the council, identifies disparities specially affecting
 165.12 the health of African American Minnesotans, and makes recommendations to address
 165.13 identified disparities.

165.14 **Subd. 5. Duties of council members.** The members of the council shall:

165.15 (1) attend scheduled meetings with no more than three absences per year, participate in
 165.16 scheduled meetings, and prepare for meetings by reviewing meeting notes;

165.17 (2) maintain open communication channels with respective constituencies;

165.18 (3) identify and communicate issues and risks that may impact the timely completion
 165.19 of tasks;

165.20 (4) participate in any activities the council or commissioner deems appropriate and
 165.21 necessary to facilitate the goals and duties of the council; and

133.17 (2) based on recommendations of the council, review identified department or other
 133.18 related policies or practices that maintain health inequities and disparities that particularly
 133.19 affect African Americans in Minnesota;

133.20 (3) in partnership with the council, recommend or implement action plans and resources
 133.21 necessary to address identified disparities and advance African American health equity;

133.22 (4) support interagency collaboration to advance African American health equity; and

133.23 (5) support member participation in the council, including participation in educational
 133.24 and community engagement events across Minnesota that specifically address African
 133.25 American health equity.

133.26 **Subd. 5. Duties of council.** The council shall:

133.27 (1) identify health disparities found in African American communities and contributing
 133.28 factors;

133.29 (2) recommend to the commissioner for review any statutes, rules, or administrative
 133.30 policies or practices that would address African American health disparities;

134.1 (3) recommend policies and strategies to the commissioner of health to address disparities
 134.2 specifically affecting African American health;

134.3 (4) form work groups of council members who are persons who provide and receive
 134.4 services and representatives of advocacy groups;

134.5 (5) provide the work groups with clear guidelines, standardized parameters, and tasks
 134.6 for the work groups to accomplish; and

134.7 (6) annually submit to the commissioner a report that summarizes the activities of the
 134.8 council, identifies disparities specially affecting the health of African American Minnesotans,
 134.9 and makes recommendations to address identified disparities.

134.10 **Subd. 6. Duties of council members.** The members of the council shall:

134.11 (1) attend scheduled meetings with no more than three absences per year, participate in
 134.12 scheduled meetings, and prepare for meetings by reviewing meeting notes;

134.13 (2) maintain open communication channels with respective constituencies;

134.14 (3) identify and communicate issues and risks that may impact the timely completion
 134.15 of tasks;

134.16 (4) participate in any activities the council or commissioner deems appropriate and
 134.17 necessary to facilitate the goals and duties of the council; and

165.22 (5) participate in work groups to carry out council duties.

165.23 Subd. 6. **Staffing; office space; equipment.** The commissioner shall provide the advisory

165.24 council with staff support, office space, and access to office equipment and services.

165.25 Subd. 7. **Reimbursement.** Compensation or reimbursement for travel and expenses, or

165.26 both, incurred for council activities is governed in accordance with section 15.059,

165.27 subdivision 3.

166.1 Sec. 19. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT**

166.2 **PROGRAM.**

166.3 Subdivision 1. **Establishment.** The commissioner of health shall establish the African

166.4 American health special emphasis grant program administered by the Office of African

166.5 American Health. The purposes of the program are to:

166.6 (1) identify disparities impacting African American health arising from cumulative and

166.7 historical discrimination and disadvantages in multiple systems, including but not limited

166.8 to housing, education, employment, gun violence, incarceration, environmental factors, and

166.9 health care discrimination; and

166.10 (2) develop community-based solutions that incorporate a multisector approach to

166.11 addressing identified disparities impacting African American health.

166.12 Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the

166.13 commissioner of health, the Office of African American Health shall:

166.14 (1) develop a request for proposals for an African American health special emphasis

166.15 grant program in consultation with community stakeholders;

166.16 (2) provide outreach, technical assistance, and program development guidance to potential

166.17 qualifying organizations or entities;

166.18 (3) review responses to requests for proposals in consultation with community

166.19 stakeholders and award grants under this section;

166.20 (4) establish a transparent and objective accountability process in consultation with

166.21 community stakeholders, focused on outcomes that grantees agree to achieve;

166.22 (5) provide grantees with access to summary and other public data to assist grantees in

166.23 establishing and implementing effective community-led solutions; and

166.24 (6) collect and maintain data on outcomes reported by grantees.

166.25 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this

166.26 section include nonprofit organizations or entities that work with African American

166.27 communities or are focused on addressing disparities impacting the health of African

166.28 American communities.

134.18 (5) participate in work groups to carry out council duties.

134.19 Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory

134.20 council with staff support, office space, and access to office equipment and services.

134.21 Subd. 8. **Reimbursement.** Compensation and reimbursement for travel and expenses

134.22 incurred for council activities are governed by section 15.059, subdivision 3.

134.23 Sec. 41. **[144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT**

134.24 **PROGRAM.**

134.25 Subdivision 1. **Establishment.** The commissioner of health shall establish the African

134.26 American health special emphasis grant program administered by the Office of African

134.27 American Health. The purposes of the program are to:

134.28 (1) identify disparities impacting African American health arising from cumulative and

134.29 historical discrimination and disadvantages in multiple systems, including but not limited

134.30 to housing, education, employment, gun violence, incarceration, environmental factors, and

134.31 health care discrimination; and

135.1 (2) develop community-based solutions that incorporate a multisector approach to

135.2 addressing identified disparities impacting African American health.

135.3 Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the

135.4 commissioner of health, the Office of African American Health shall:

135.5 (1) develop a request for proposals for an African American health special emphasis

135.6 grant program in consultation with community stakeholders;

135.7 (2) provide outreach, technical assistance, and program development guidance to potential

135.8 qualifying organizations or entities;

135.9 (3) review responses to requests for proposals in consultation with community

135.10 stakeholders and award grants under this section;

135.11 (4) establish a transparent and objective accountability process in consultation with

135.12 community stakeholders, focused on outcomes that grantees agree to achieve;

135.13 (5) provide grantees with access to summary and other public data to assist grantees in

135.14 establishing and implementing effective community-led solutions; and

135.15 (6) collect and maintain data on outcomes reported by grantees.

135.16 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this

135.17 section include nonprofit organizations or entities that work with African American

135.18 communities or are focused on addressing disparities impacting the health of African

135.19 American communities.

166.29 **Subd. 4. Strategic consideration and priority of proposals; grant awards.** In
 166.30 developing the requests for proposals and awarding the grants, the commissioner and the
 166.31 Office of African American Health shall consider building upon the existing capacity of
 166.32 communities and on developing capacity where it is lacking. Proposals shall focus on
 167.1 addressing health equity issues specific to United States born African American communities;
 167.2 addressing the health impact of historical trauma; and reducing health disparities experienced
 167.3 by United States born African American communities; and incorporating a multisector
 167.4 approach to addressing identified disparities.

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

167.7 **Sec. 20. [144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

167.8 **Subdivision 1. Duties.** The Office of American Indian Health is established to address
 167.9 unique public health needs of American Indian Tribal communities in Minnesota. The office
 167.10 shall:

167.11 (1) coordinate with Minnesota's Tribal Nations and urban American Indian
 167.12 community-based organizations to identify underlying causes of health disparities, address
 167.13 unique health needs of Minnesota's Tribal communities, and develop public health approaches
 167.14 to achieve health equity;

167.15 (2) strengthen capacity of American Indian and community-based organizations and
 167.16 Tribal Nations to address identified health disparities and needs;

167.17 (3) administer state and federal grant funding opportunities targeted to improve the
 167.18 health of American Indians;

167.19 (4) provide overall leadership for targeted development of holistic health and wellness
 167.20 strategies to improve health and to support Tribal and urban American Indian public health
 167.21 leadership and self-sufficiency;

167.22 (5) provide technical assistance to Tribal and American Indian urban community leaders
 167.23 to develop culturally appropriate activities to address public health emergencies;

167.24 (6) develop and administer the department immersion experiences for American Indian
 167.25 students in secondary education and community colleges to improve diversity of the public
 167.26 health workforce and introduce career pathways that contribute to reducing health disparities;
 167.27 and

167.28 (7) identify and promote workforce development strategies for Department of Health
 167.29 staff to work with the American Indian population and Tribal Nations more effectively in
 167.30 Minnesota.

167.31 **Subd. 2. Grants and contracts.** To carry out these duties, the office may contract with
 167.32 or provide grants to qualifying entities.

135.20 **Subd. 4. Strategic consideration and priority of proposals; grant awards.** In
 135.21 developing the requests for proposals and awarding the grants, the commissioner and the
 135.22 Office of African American Health shall consider building upon the existing capacity of
 135.23 communities and on developing capacity where it is lacking. Proposals shall focus on
 135.24 addressing health equity issues specific to United States-born African American communities;
 135.25 addressing the health impact of historical trauma; reducing health disparities experienced
 135.26 by United States-born African American communities; and incorporating a multisector
 135.27 approach to addressing identified disparities.

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

135.30 **Sec. 42. [144.0757] OFFICE OF AMERICAN INDIAN HEALTH.**

135.31 **Subdivision 1. Duties.** The Office of American Indian Health is established to address
 135.32 unique public health needs of American Indian Tribal communities in Minnesota, and shall:

136.1 (1) coordinate with Minnesota's Tribal Nations and urban American Indian
 136.2 community-based organizations to identify underlying causes of health disparities, address
 136.3 unique health needs of Minnesota's Tribal communities, and develop public health approaches
 136.4 to achieve health equity;

136.5 (2) strengthen capacity of American Indian and community-based organizations and
 136.6 Tribal Nations to address identified health disparities and needs;

136.7 (3) administer state and federal grant funding opportunities targeted to improve the
 136.8 health of American Indians;

136.9 (4) provide overall leadership for targeted development of holistic health and wellness
 136.10 strategies to improve health and to support Tribal and urban American Indian public health
 136.11 leadership and self-sufficiency;

136.12 (5) provide technical assistance to Tribal and American Indian urban community leaders
 136.13 to develop culturally appropriate activities to address public health emergencies;

136.14 (6) develop and administer the department immersion experiences for American Indian
 136.15 students in secondary education and community colleges to improve diversity of the public
 136.16 health workforce and introduce career pathways that contribute to reducing health disparities;
 136.17 and

136.18 (7) identify and promote workforce development strategies for Department of Health
 136.19 staff to work with the American Indian population and Tribal Nations more effectively in
 136.20 Minnesota.

136.21 **Subd. 2. Grants and contracts.** To carry out these duties, the office may contract with
 136.22 or provide grants to qualifying entities.

168.1 Subd. 3. **Reporting.** The person appointed to head the Office of American Indian Health
 168.2 must report annually by January 15 to the chairs and ranking minority members of the
 168.3 legislative committees with primary jurisdiction over health policy and finance on the work
 168.4 of the office during the previous year and the goals for the office for the following year.

168.5 Sec. 21. **[144.0758] AMERICAN INDIAN SPECIAL EMPHASIS GRANTS.**

168.6 Subdivision 1. **Establishment.** The commissioner of health shall establish the American
 168.7 Indian health special emphasis grant program. The purposes of the program are to:

168.8 (1) plan and develop programs targeted to address continuing and persistent health
 168.9 disparities of Minnesota's American Indian population and improve American Indian health
 168.10 outcomes based upon needs identified by health indicators and identified disparities;

168.11 (2) identify disparities in American Indian health arising from cumulative and historical
 168.12 discrimination; and

168.13 (3) plan and develop community-based solutions with a multisector approach to
 168.14 addressing identified disparities in American Indian health.

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

168.16 (1) develop a request for proposals for an American Indian special emphasis grant
 168.17 program in consultation with Minnesota's Tribal Nations and urban American Indian
 168.18 community-based organizations based upon needs identified by the community, health
 168.19 indicators, and identified disparities;

168.20 (2) provide outreach, technical assistance, and program development guidance to potential
 168.21 qualifying organizations or entities;

168.22 (3) review responses to requests for proposals in consultation with community
 168.23 stakeholders and award grants under this section;

168.24 (4) establish a transparent and objective accountability process in consultation with
 168.25 community stakeholders focused on outcomes that grantees agree to achieve;

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

168.28 (6) collect and maintain data on outcomes reported by grantees.

168.29 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
 168.30 section are Minnesota's Tribal Nations and urban American Indian community-based
 168.31 organizations.

169.1 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In
 169.2 developing the proposals and awarding the grants, the commissioner shall consider building
 169.3 upon the existing capacity of Minnesota's Tribal Nations and urban American Indian
 169.4 community-based organizations and on developing capacity where it is lacking. Proposals

136.23 Sec. 43. **[144.0758] AMERICAN INDIAN HEALTH SPECIAL EMPHASIS GRANTS.**

136.24 Subdivision 1. **Establishment.** The commissioner of health shall establish the American
 136.25 Indian health special emphasis grant program. The purposes of the program are to:

136.26 (1) plan and develop programs targeted to address continuing and persistent health
 136.27 disparities of Minnesota's American Indian population and improve American Indian health
 136.28 outcomes based upon needs identified by health indicators and identified disparities;

136.29 (2) identify disparities in American Indian health arising from cumulative and historical
 136.30 discrimination; and

136.31 (3) plan and develop community-based solutions with a multisector approach to
 136.32 addressing identified disparities in American Indian health.

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

137.2 (1) develop a request for proposals for an American Indian health special emphasis grant
 137.3 program in consultation with Minnesota's Tribal Nations and urban American Indian
 137.4 community-based organizations based upon needs identified by the community, health
 137.5 indicators, and identified disparities;

137.6 (2) provide outreach, technical assistance, and program development guidance to potential
 137.7 qualifying organizations or entities;

137.8 (3) review responses to requests for proposals in consultation with community
 137.9 stakeholders and award grants under this section;

137.10 (4) establish a transparent and objective accountability process in consultation with
 137.11 community stakeholders focused on outcomes that grantees agree to achieve;

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

137.14 (6) collect and maintain data on outcomes reported by grantees.

137.15 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
 137.16 section are Minnesota's Tribal Nations and urban American Indian community-based
 137.17 organizations.

137.18 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In
 137.19 developing the proposals and awarding the grants, the commissioner shall consider building
 137.20 upon the existing capacity of Minnesota's Tribal Nations and urban American Indian
 137.21 community-based organizations and on developing capacity where it is lacking. Proposals

169.5 should focus on addressing health equity issues specific to Tribal and urban American Indian
169.6 communities; addressing the health impact of historical trauma; reducing health disparities
169.7 experienced by American Indian communities; and incorporating a multisector approach
169.8 to addressing identified disparities.

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

169.11 **Sec. 22. [144.0759] PUBLIC HEALTH AMERICORPS.**

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

169.16 Sec. 23. Minnesota Statutes 2022, section 144.122, is amended to read:

169.17 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

169.18 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
169.19 filing with the commissioner as prescribed by statute and for the issuance of original and
169.20 renewal permits, licenses, registrations, and certifications issued under authority of the
169.21 commissioner. The expiration dates of the various licenses, permits, registrations, and
169.22 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
169.23 application and examination fees and a penalty fee for renewal applications submitted after
169.24 the expiration date of the previously issued permit, license, registration, and certification.
169.25 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
169.26 registrations, and certifications when the application therefor is submitted during the last
169.27 three months of the permit, license, registration, or certification period. Fees proposed to
169.28 be prescribed in the rules shall be first approved by the Department of Management and
169.29 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
169.30 in an amount so that the total fees collected by the commissioner will, where practical,
169.31 approximate the cost to the commissioner in administering the program. All fees collected
169.32 shall be deposited in the state treasury and credited to the state government special revenue
169.33 fund unless otherwise specifically appropriated by law for specific purposes.

170.1 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
170.2 and environmental laboratories, and for environmental and medical laboratory services
170.3 provided by the department, without complying with paragraph (a) or chapter 14. Fees
170.4 charged for environment and medical laboratory services provided by the department must
170.5 be approximately equal to the costs of providing the services.

170.6 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
170.7 conducted at clinics held by the services for children with disabilities program. All receipts
170.8 generated by the program are annually appropriated to the commissioner for use in the
170.9 maternal and child health program.

137.22 may focus on addressing health equity issues specific to Tribal and urban American Indian
137.23 communities; addressing the health impact of historical trauma; reducing health disparities
137.24 experienced by American Indian communities; and incorporating a multisector approach
137.25 to addressing identified disparities.

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

137.28 **Sec. 44. [144.0759] PUBLIC HEALTH AMERICORPS.**

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

138.1 Sec. 45. Minnesota Statutes 2022, section 144.122, is amended to read:

138.2 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

138.3 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
138.4 filing with the commissioner as prescribed by statute and for the issuance of original and
138.5 renewal permits, licenses, registrations, and certifications issued under authority of the
138.6 commissioner. The expiration dates of the various licenses, permits, registrations, and
138.7 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
138.8 application and examination fees and a penalty fee for renewal applications submitted after
138.9 the expiration date of the previously issued permit, license, registration, and certification.
138.10 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
138.11 registrations, and certifications when the application therefor is submitted during the last
138.12 three months of the permit, license, registration, or certification period. Fees proposed to
138.13 be prescribed in the rules shall be first approved by the Department of Management and
138.14 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
138.15 in an amount so that the total fees collected by the commissioner will, where practical,
138.16 approximate the cost to the commissioner in administering the program. All fees collected
138.17 shall be deposited in the state treasury and credited to the state government special revenue
138.18 fund unless otherwise specifically appropriated by law for specific purposes.

138.19 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
138.20 and environmental laboratories, and for environmental and medical laboratory services
138.21 provided by the department, without complying with paragraph (a) or chapter 14. Fees
138.22 charged for environment and medical laboratory services provided by the department must
138.23 be approximately equal to the costs of providing the services.

138.24 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
138.25 conducted at clinics held by the services for children with disabilities program. All receipts
138.26 generated by the program are annually appropriated to the commissioner for use in the
138.27 maternal and child health program.

170.10	(d) The commissioner shall set license fees for hospitals and nursing homes that are not	138.28	(d) The commissioner shall set license fees for hospitals and nursing homes that are not
170.11	boarding care homes at the following levels:	138.29	boarding care homes at the following levels:
170.12	Joint Commission on Accreditation of	138.30	Joint Commission on Accreditation of
170.13	Healthcare Organizations (JCAHO) and	138.31	Healthcare Organizations (JCAHO) and
170.14	American Osteopathic Association (AOA)	138.32	American Osteopathic Association (AOA)
170.15	hospitals	138.33	hospitals
170.16	Non-JCAHO and non-AOA hospitals	138.34	Non-JCAHO and non-AOA hospitals
	\$5,280 plus \$250 per bed		\$5,280 plus \$250 per bed
170.17	Nursing home	138.35	Nursing home
	\$183 plus \$91 per bed until June 30, 2018.		\$183 plus \$91 per bed until June 30, 2018.
170.18		138.36	
170.19	\$183 plus \$100 per bed between July 1, 2018,	139.1	\$183 plus \$100 per bed between July 1, 2018,
170.20	and June 30, 2020. \$183 plus \$105 per bed	139.2	and June 30, 2020. \$183 plus \$105 per bed
	beginning July 1, 2020.		beginning July 1, 2020.
170.21	The commissioner shall set license fees for outpatient surgical centers, boarding care	139.3	The commissioner shall set license fees for outpatient surgical centers, boarding care
170.22	homes, supervised living facilities, assisted living facilities, and assisted living facilities	139.4	homes, supervised living facilities, assisted living facilities, and assisted living facilities
170.23	with dementia care at the following levels:	139.5	with dementia care at the following levels:
170.24	Outpatient surgical centers	139.6	Outpatient surgical centers
	\$3,712		\$3,712
170.25	Boarding care homes	139.7	Boarding care homes
	\$183 plus \$91 per bed		\$183 plus \$91 per bed
170.26	Supervised living facilities	139.8	Supervised living facilities
	\$183 plus \$91 per bed.		\$183 plus \$91 per bed.
170.27	Assisted living facilities with dementia care	139.9	Assisted living facilities with dementia care
	\$3,000 plus \$100 per resident.		\$3,000 plus \$100 per resident.
170.28	Assisted living facilities	139.10	Assisted living facilities
	\$2,000 plus \$75 per resident.		\$2,000 plus \$75 per resident.
170.29	Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if	139.11	Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
170.30	received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,	139.12	received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
170.31	or later.	139.13	or later.
170.32	(e) Unless prohibited by federal law, the commissioner of health shall charge applicants	139.14	(e) Unless prohibited by federal law, the commissioner of health shall charge applicants
170.33	the following fees to cover the cost of any initial certification surveys required to determine	139.15	the following fees to cover the cost of any initial certification surveys required to determine
170.34	a provider's eligibility to participate in the Medicare or Medicaid program:	139.16	a provider's eligibility to participate in the Medicare or Medicaid program:
170.35	Prospective payment surveys for hospitals	139.17	Prospective payment surveys for hospitals
	\$ 900		\$ 900
170.36	Swing bed surveys for nursing homes	139.18	Swing bed surveys for nursing homes
	\$ 1,200		\$ 1,200
171.1	Psychiatric hospitals	139.19	Psychiatric hospitals
	\$ 1,400		\$ 1,400
171.2	Rural health facilities	139.20	Rural health facilities
	\$ 1,100		\$ 1,100
171.3	Portable x-ray providers	139.21	Portable x-ray providers
	\$ 500		\$ 500

171.4	Home health agencies	\$ 1,800	139.22	Home health agencies	\$ 1,800
171.5	Outpatient therapy agencies	\$ 800	139.23	Outpatient therapy agencies	\$ 800
171.6	End stage renal dialysis providers	\$ 2,100	139.24	End stage renal dialysis providers	\$ 2,100
171.7	Independent therapists	\$ 800	139.25	Independent therapists	\$ 800
171.8	Comprehensive rehabilitation outpatient facilities	\$ 1,200	139.26	Comprehensive rehabilitation outpatient facilities	\$ 1,200
171.9	Hospice providers	\$ 1,700	139.27	Hospice providers	\$ 1,700
171.10	Ambulatory surgical providers	\$ 1,800	139.28	Ambulatory surgical providers	\$ 1,800
171.11	Hospitals	\$ 4,200	139.29	Hospitals	\$ 4,200
171.12	Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.	139.30	Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.
171.13			139.31		
171.14			139.32		
171.15	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.		139.33	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.	
171.16			139.34		
171.17			139.35		
171.18			139.36		
171.19	(f) 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:		140.1	(f) 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:	
171.20			140.2		
171.21			140.3		
171.22	(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		140.4	(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	
171.23			140.5		
171.24			140.6		
171.25			140.7		
171.26			140.8		
171.27	(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.		140.9	(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.	
171.28			140.10		
171.29			140.11		
171.30			140.12		
171.31			140.13		
171.32	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.		140.14	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.	
171.33			140.15		
171.34			140.16		
171.35			140.17		
171.36			140.18		

172.1 (g) The commissioner shall charge hospitals an annual licensing base fee of \$1,826 per
 172.2 hospital, plus an additional \$23 per licensed bed or bassinet fee. Revenue shall be deposited
 172.3 to the state government special revenue fund and credited toward trauma hospital designations
 172.4 under sections 144.605 and 144.6071.

172.5 Sec. 24. **[144.1462] COMMUNITY HEALTH WORKERS; GRANTS AUTHORIZED.**

172.6 Subdivision 1. **Establishment.** The commissioner of health shall support collaboration
 172.7 and coordination between state and community partners to develop, refine, and expand the
 172.8 community health workers profession in Minnesota; equip community health workers to
 172.9 address health needs; and to improve health outcomes. This work must address the social
 172.10 conditions that impact community health and well-being in public safety, social services,
 172.11 youth and family services, schools, and neighborhood associations.

172.12 Subd. 2. **Grants and contracts authorized; eligibility.** The commissioner of health
 172.13 shall award grants or enter into contracts to expand and strengthen the community health
 172.14 worker workforce across Minnesota. The grant recipients or contractor shall include at least
 172.15 one not-for-profit community organization serving, convening, and supporting community
 172.16 health workers statewide.

172.17 Subd. 3. **Evaluation.** The commissioner of health shall design, conduct, and evaluate
 172.18 the community health worker initiative using measures such as workforce capacity,
 172.19 employment opportunity, reach of services, and return on investment, as well as descriptive
 172.20 measures of the existing community health worker models as they compare with the national
 172.21 community health workers' landscape. These initial measures point to longer-term change
 172.22 in social determinants of health and rates of death and injury by suicide, overdose, firearms,
 172.23 alcohol, and chronic disease.

172.24 Subd. 4. **Report.** Grant recipients and contractors must report program outcomes to the
 172.25 department annually and by the guidelines established by the commissioner.

140.19 (g) The commissioner shall charge hospitals an annual licensing base fee of \$1,826 per
 140.20 hospital, plus an additional \$23 per licensed bed or bassinet fee. Revenue shall be deposited
 140.21 to the state government special revenue fund and credited toward trauma hospital designations
 140.22 under sections 144.605 and 144.6071.

140.23 Sec. 46. Minnesota Statutes 2022, section 144.1481, subdivision 1, is amended to read:

140.24 Subdivision 1. **Establishment; membership.** The commissioner of health shall establish
 140.25 a **16 member** Rural Health Advisory Committee. The committee shall consist of the following
 140.26 **22** members, all of whom must reside outside the seven-county metropolitan area, as defined
 140.27 in section 473.121, subdivision 2:

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

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

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

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

141.2 (5) a representative of a nursing home located outside the seven-county metropolitan

141.3 area;

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

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

141.6 (8) an allied dental personnel as defined in Minnesota Rules, part 3100.0100, subpart

141.7 5;

141.8 (8) a midlevel practitioner;

141.9 (9) an advanced practice professional;

141.10 (9) (10) a registered nurse or licensed practical nurse;

141.11 (10) (11) a licensed health care professional from an occupation not otherwise represented

141.12 on the committee;

141.13 (11) (12) a representative of an institution of higher education located outside the

141.14 seven-county metropolitan area that provides training for rural health care providers; and

141.15 (13) a member of a Tribal Nation;

141.16 (14) a representative of a local public health agency or community health board;

141.17 (15) a health professional or advocate with experience working with people with mental

141.18 illness;

141.19 (16) a representative of a community organization that works with individuals

141.20 experiencing health disparities;

141.21 (17) an individual with expertise in economic development, or an employer working

141.22 outside the seven-county metropolitan area;

141.23 (12) three (18) two consumers, at least one of whom must be an advocate for persons

141.24 who are mentally ill or developmentally disabled, from a community experiencing health

141.25 disparities; and

141.26 (19) one consumer who is an advocate for persons who are developmentally disabled.

141.27 The commissioner will make recommendations for committee membership. Committee

141.28 members will be appointed by the governor. In making appointments, the governor shall

141.29 ensure that appointments provide geographic balance among those areas of the state outside

141.30 the seven-county metropolitan area. The chair of the committee shall be elected by the

142.1 members. The advisory committee is governed by section 15.059, except that the members

142.2 do not receive per diem compensation.

147.18 Sec. 52. Minnesota Statutes 2022, section 144.1505, is amended to read:

147.19 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**
147.20 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**
147.21 **PROGRAMS.**

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

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

147.28 (2) "eligible dental therapy program" means a dental therapy education program or
147.29 advanced dental therapy education program that is located in Minnesota and is either:

147.30 (i) approved by the Board of Dentistry; or

147.31 (ii) currently accredited by the Commission on Dental Accreditation;

148.1 (3) "eligible mental health professional program" means a program that is located in
148.2 Minnesota and is listed as a mental health professional program by the appropriate accrediting
148.3 body for clinical social work, psychology, marriage and family therapy, or licensed
148.4 professional clinical counseling, or is a candidate for accreditation;

148.5 (4) "eligible pharmacy program" means a program that is located in Minnesota and is
148.6 currently accredited as a doctor of pharmacy program by the Accreditation Council on
148.7 Pharmacy Education;

148.8 (5) "eligible physician assistant program" means a program that is located in Minnesota
148.9 and is currently accredited as a physician assistant program by the Accreditation Review
148.10 Commission on Education for the Physician Assistant, or is a candidate for accreditation;

148.11 (6) "mental health professional" means an individual providing clinical services in the
148.12 treatment of mental illness who meets one of the qualifications under section 245.462,
148.13 subdivision 18; and

148.14 (7) "eligible physician training program" means a physician residency training program
148.15 located in Minnesota and that is currently accredited by the accrediting body or has presented
148.16 a credible plan as a candidate for accreditation;

148.17 (8) "eligible dental program" means a dental education program or a dental residency
148.18 training program located in Minnesota and that is currently accredited by the accrediting
148.19 body or has presented a credible plan as a candidate for accreditation; and

148.20 (7) (9) "project" means a project to establish or expand clinical training for physician
148.21 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced
148.22 dental therapists, or mental health professionals in Minnesota.

148.23 Subd. 2. **Program Programs.** (a) For advanced practice provider clinical training
148.24 expansion grants, the commissioner of health shall award health professional training site
148.25 grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental
148.26 therapy, and mental health professional programs to plan and implement expanded clinical
148.27 training. A planning grant shall not exceed \$75,000, and a training grant shall not exceed
148.28 \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for the third year per
148.29 program.

148.30 (b) For health professional rural and underserved clinical rotations grants, the
148.31 commissioner of health shall award health professional training site grants to eligible
148.32 physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry,
148.33 dental therapy, and mental health professional programs to augment existing clinical training
149.1 programs to add rural and underserved rotations or clinical training experiences, such as
149.2 credential or certificate rural tracks or other specialized training. For physician and dentist
149.3 training, the expanded training must include rotations in primary care settings such as
149.4 community clinics, hospitals, health maintenance organizations, or practices in rural
149.5 communities.

149.6 (b) (c) Funds may be used for:

149.7 (1) establishing or expanding rotations and clinical training for physician assistants,
149.8 advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists,
149.9 and mental health professionals in Minnesota;
149.10 (2) recruitment, training, and retention of students and faculty;
149.11 (3) connecting students with appropriate clinical training sites, internships, practicums,
149.12 or externship activities;
149.13 (4) travel and lodging for students;
149.14 (5) faculty, student, and preceptor salaries, incentives, or other financial support;
149.15 (6) development and implementation of cultural competency training;
149.16 (7) evaluations;
149.17 (8) training site improvements, fees, equipment, and supplies required to establish,
149.18 maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy,
149.19 dental therapy, or mental health professional training program; and
149.20 (9) supporting clinical education in which trainees are part of a primary care team model.
149.21 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,
149.22 pharmacy, dental therapy, dental, physician, and mental health professional programs seeking
149.23 a grant shall apply to the commissioner. Applications must include a description of the
149.24 number of additional students who will be trained using grant funds; attestation that funding
149.25 will be used to support an increase in the number of clinical training slots; a description of

149.26 the problem that the proposed project will address; a description of the project, including
149.27 all costs associated with the project, sources of funds for the project, detailed uses of all
149.28 funds for the project, and the results expected; and a plan to maintain or operate any
149.29 component included in the project after the grant period. The applicant must describe
149.30 achievable objectives, a timetable, and roles and capabilities of responsible individuals in
149.31 the organization. Applicants applying under subdivision 2, paragraph (b), must include
150.1 information about length of training and training site settings, geographic location of rural
150.2 sites, and rural populations expected to be served.

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

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

150.21 Sec. 53. **[144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT
PROGRAM.**

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

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

150.26 (1) is located in Minnesota;

150.27 (2) trains medical residents in the specialties of family medicine, general internal
150.28 medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency
150.29 training programs or in community-based ambulatory care centers that primarily serve the
150.30 underserved; and

150.31 (3) is accredited by the Accreditation Council for Graduate Medical Education or presents
150.32 a credible plan to obtain accreditation.

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

151.5 (d) "Community-based ambulatory care centers" means federally qualified health centers,
151.6 community mental health centers, rural health clinics, health centers operated by the Indian
151.7 Health Service, an Indian Tribe or Tribal organization, or an urban American Indian
151.8 organization or an entity receiving funds under Title X of the Public Health Service Act.

151.9 (e) "Eligible project" means a project to establish and maintain a rural residency training
151.10 program.

151.11 Subd. 2. **Rural residency training program.** (a) The commissioner of health shall
151.12 award rural residency training program grants to eligible programs to plan, implement, and
151.13 sustain rural residency training programs. A rural residency training program grant shall
151.14 not exceed \$250,000 per year for up to three years for planning and development, and
151.15 \$225,000 per resident per year for each year thereafter to sustain the program.

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

151.17 (1) planning related to establishing accredited rural residency training programs;

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

151.20 (3) establishing new rural residency training programs;

151.21 (4) recruitment, training, and retention of new residents and faculty related to the new
151.22 rural residency training program;

151.23 (5) travel and lodging for new residents;

151.24 (6) faculty, new resident, and preceptor salaries related to new rural residency training
151.25 programs;

151.26 (7) training site improvements, fees, equipment, and supplies required for new rural
151.27 residency training programs; and

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

151.29 Subd. 3. **Applications for rural residency training program grants.** Eligible programs
151.30 seeking a grant shall apply to the commissioner. Applications must include the number of
151.31 new primary care rural residency training program slots planned, under development or
151.32 under contract; a description of the training program, including location of the established
152.1 residency program and rural training sites; a description of the project, including all costs
152.2 associated with the project; all sources of funds for the project; detailed uses of all funds
152.3 for the project; the results expected; proof of eligibility for federal graduate medical education
152.4 funding, if applicable; and a plan to seek the funding. The applicant must describe achievable

152.5 objectives, a timetable, and the roles and capabilities of responsible individuals in the
152.6 organization.

152.7 Subd. 4. Consideration of grant applications. The commissioner shall review each
152.8 application to determine if the residency program application is complete, if the proposed
152.9 rural residency program and residency slots are eligible for a grant, and if the program is
152.10 eligible for federal graduate medical education funding, and when the funding is available.
152.11 If eligible programs are not eligible for federal graduate medical education funding, the
152.12 commissioner may award continuation funding to the eligible program beyond the initial
152.13 grant period. The commissioner shall award grants to support training programs in family
152.14 medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general
152.15 surgery, and other primary care focus areas.

152.16 Subd. 5. Program oversight. During the grant period, the commissioner may require
152.17 and collect from grantees any information necessary to evaluate the program. Notwithstanding
152.18 section 16A.28, subdivision 6, encumbrances for grants under this section issued by June
152.19 30 of each year may be certified for a period of up to three years beyond the year in which
152.20 the funds were originally appropriated.

152.21 Sec. 54. [144.1508] CLINICAL HEALTH CARE TRAINING.

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

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

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

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

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

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

153.14 (g) "Teaching institution" means a hospital, medical center, clinic, or other organization
153.15 that conducts a clinical medical education program in Minnesota that is accountable to the
153.16 accrediting body.

153.17 (h) "Trainee" means a student, resident, fellow, or other postgraduate involved in a
153.18 clinical medical education program from an accredited Minnesota teaching program and
153.19 institution.

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

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

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

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

153.29 (b) An entity hosting a clinical medical education program for advanced practice nursing
153.30 is eligible for funds under subdivision 3, if the program meets the eligibility requirements
153.31 in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota
153.32 Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota
153.33 State Colleges and Universities system or members of the Minnesota Private College Council.

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

154.3 (1) the official name and address and the site addresses of the clinical medical education
154.4 programs where eligible trainees are hosted;

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

154.7 (3) for each applicant, the type and specialty orientation of trainees in the program; the
154.8 name, entity address, medical assistance provider number, and national provider identification
154.9 number of each training site used in the program, as appropriate; the federal tax identification

154.10 number of each training site, where available; the total number of eligible trainee FTEs at
154.11 each site; and

154.12 (4) other supporting information the commissioner deems necessary.

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

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

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

154.25 Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign
154.26 and submit a medical education grant verification report (GVR) to verify funding was
154.27 distributed as specified in the GVR. If the teaching institution fails to submit the GVR by
154.28 the stated deadline, the teaching institution is required to return the full amount of funds
154.29 received to the commissioner within 30 days of receiving notice from the commissioner.
154.30 The commissioner shall distribute returned funds to the appropriate training sites in
154.31 accordance with the commissioner's approval letter.

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

155.4 Sec. 55. Minnesota Statutes 2022, section 144.2151, is amended to read:

155.5 **144.2151 FETAL DEATH RECORD AND CERTIFICATE OF BIRTH**
155.6 **RESULTING IN STILLBIRTH.**

155.7 Subdivision 1. **Filing Registration.** A fetal death record of birth for each birth resulting
155.8 in a stillbirth in this state, on or after August 1, 2005, must be established for which a each
155.9 fetal death report is required reported and registered under section 144.222, subdivision 1,
155.10 shall be filed with the state registrar within five days after the birth if the parent or parents
155.11 of the stillbirth request to have a record of birth resulting in stillbirth prepared.

155.12 Subd. 2. **Information to parents.** The party responsible for filing a fetal death report
155.13 under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

155.14 (1) that they may request preparation of a record of birth resulting in stillbirth;

155.15 ~~(2) that preparation of the record is optional; and~~
155.16 ~~(3) how to obtain a certified copy of the record if one is requested and prepared.~~
155.17 ~~(1) that the parent or parents may choose to provide a full name or provide only a last~~
155.18 ~~name for the record;~~
155.19 ~~(2) that the parent or parents may request a certificate of birth resulting in stillbirth after~~
155.20 ~~the fetal death record is established;~~
155.21 ~~(3) that the parent who gave birth may request an informational copy of the fetal death~~
155.22 ~~record; and~~
155.23 ~~(4) that the parent or parents named on the fetal death record and the party responsible~~
155.24 ~~for reporting the fetal death may correct or amend the record to protect the integrity and~~
155.25 ~~accuracy of vital records.~~
155.26 Subd. 3. **Preparation Responsibilities of the state registrar.** (a) Within five days after
155.27 ~~delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record~~
155.28 ~~with the state registrar if the parent or parents of the stillbirth, after being advised as provided~~
155.29 ~~in subdivision 2, request to have a record of birth resulting in stillbirth prepared.~~
155.30 ~~(b) If the parent or parents of the stillbirth do not choose to provide a full name for the~~
155.31 ~~stillbirth, the parent or parents may choose to file only a last name.~~
156.1 ~~(c) Either parent of the stillbirth or, if neither parent is available, another person with~~
156.2 ~~knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered~~
156.3 ~~on the record in time to permit the filing of the record within five days after delivery.~~
156.4 The state registrar shall:
156.5 (1) prescribe the process to:
156.6 (i) register a fetal death;
156.7 (ii) request the certificate of birth resulting in stillbirth; and
156.8 (iii) request the informational copy of a fetal death record;
156.9 (2) prescribe a standardized format for the certificate of birth resulting in stillbirth, which
156.10 shall integrate security features and be as similar as possible to a birth certificate;
156.11 (3) issue a certificate of birth resulting in stillbirth or a statement of no vital record found
156.12 to the parent or parents named on the fetal death record upon the parent's proper completion
156.13 of an attestation provided by the commissioner and payment of the required fee;
156.14 (4) correct or amend the fetal death record upon a request from the parent who gave
156.15 birth, parents, or the person who registered the fetal death or filed the report; and
156.16 (5) refuse to amend or correct the fetal death record when an applicant does not submit
156.17 the minimum documentation required to amend the record or when the state registrar has

156.18 cause to question the validity or completeness of the applicant's statements or any
156.19 documentary evidence and the deficiencies are not corrected. The state registrar shall advise
156.20 the applicant of the reason for this action and shall further advise the applicant of the right
156.21 of appeal to a court with competent jurisdiction over the Department of Health.

156.22 Subd. 4. **Retrospective application Delayed registration.** Notwithstanding subdivisions
156.23 1 to 3, If a birth that fetal death occurred in this state at any time resulted in a stillbirth for
156.24 which a fetal death report was required under section 144.222, subdivision 1, but a record
156.25 of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth
156.26 may submit to the state registrar, on or after August 1, 2005, a written request for preparation
156.27 of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the
156.28 form and manner specified by the state registrar. The state registrar shall prepare and file
156.29 the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence
156.30 of the facts of the stillbirth. fetal death was not registered and a record was not established,
156.31 a person responsible for registering the fetal death, the medical examiner or coroner with
156.32 jurisdiction, or a parent may submit to the state registrar a written request to register the
156.33 fetal death and submit the evidence to support the request.

157.1 Subd. 5. **Responsibilities of state registrar.** The state registrar shall:

157.2 (1) prescribe the form of and information to be included on a record of birth resulting
157.3 in stillbirth, which shall be as similar as possible to the form of and information included
157.4 on a record of birth;

157.5 (2) prescribe the form of and information to be provided by the parent of a stillbirth
157.6 requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this
157.7 form available on the Department of Health's website;

157.8 (3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the
157.9 stillbirth that is the subject of the record if:

157.10 (i) a record of birth resulting in stillbirth has been prepared and filed under subdivision
157.11 3 or 4; and

157.12 (ii) the parent requesting a certified copy of the record submits the request in writing;
157.13 and

157.14 (4) create and implement a process for entering, preparing, and handling stillbirth records
157.15 identical or as close as possible to the processes for birth and fetal death records when
157.16 feasible, but no later than the date on which the next reprogramming of the Department of
157.17 Health's database for vital records is completed.

172.26 Sec. 25. Minnesota Statutes 2022, section 144.218, subdivision 1, is amended to read:

172.27 Subdivision 1. **Adoption.** Upon receipt of a certified copy of an order, decree, or
172.28 certificate of adoption, the state registrar shall register a replacement vital record in the new
172.29 name of the adopted person. The original record of birth is confidential private data pursuant
172.30 to section 13.02, subdivision 3 12, and shall not be disclosed except pursuant to court order

172.31 or section 144.2252. The information contained on the original birth record, except for the
172.32 registration number, shall be provided on request to a parent who is named on the original
173.1 birth record. Upon the receipt of a certified copy of a court order of annulment of adoption
173.2 the state registrar shall restore the original vital record to its original place in the file.

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

173.4 Sec. 26. Minnesota Statutes 2022, section 144.218, subdivision 2, is amended to read:

173.5 Subd. 2. **Adoption of foreign persons.** In proceedings for the adoption of a person who
173.6 was born in a foreign country, the court, upon evidence presented by the commissioner of
173.7 human services from information secured at the port of entry or upon evidence from other
173.8 reliable sources, may make findings of fact as to the date and place of birth and parentage.
173.9 Upon receipt of certified copies of the court findings and the order or decree of adoption,
173.10 a certificate of adoption, or a certified copy of a decree issued under section 259.60, the
173.11 state registrar shall register a birth record in the new name of the adopted person. The
173.12 certified copies of the court findings and the order or decree of adoption, certificate of
173.13 adoption, or decree issued under section 259.60 are ~~confidential~~ private data, pursuant to
173.14 section 13.02, subdivision 3 12, and shall not be disclosed except pursuant to court order
173.15 or section 144.2252. The birth record shall state the place of birth as specifically as possible
173.16 and that the vital record is not evidence of United States citizenship.

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

157.18 Sec. 56. Minnesota Statutes 2022, section 144.222, is amended to read:

157.19 **144.222 FETAL DEATH REPORTS OF FETAL OR INFANT DEATH AND
157.20 REGISTRATION.**

157.21 Subdivision 1. **Fetal death report required.** A fetal death report must be ~~filed~~ registered
157.22 or ~~reported~~ within five days of the death of a fetus for whom 20 or more weeks of gestation
157.23 have elapsed, except for abortions defined under section 145.4241. A fetal death report must
157.24 be ~~prepared~~ must be registered or ~~reported~~ in a format prescribed by the state registrar and
157.25 filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

157.26 (1) a person in charge of an institution or that person's authorized designee if a fetus is
157.27 delivered in the institution or en route to the institution;

157.28 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance
157.29 at or immediately after the delivery if a fetus is delivered outside an institution; or

157.30 (3) a parent or other person in charge of the disposition of the remains if a fetal death
157.31 occurred without medical attendance at or immediately after the delivery.

173.18 Sec. 27. Minnesota Statutes 2022, section 144.225, subdivision 2, is amended to read:

173.19 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data
173.20 pertaining to the birth of a child to a woman who was not married to the child's father when
173.21 the child was conceived nor when the child was born, including the original record of birth
173.22 and the certified vital record, are confidential data. At the time of the birth of a child to a
173.23 woman who was not married to the child's father when the child was conceived nor when
173.24 the child was born, the mother may designate demographic data pertaining to the birth as
173.25 public. Notwithstanding the designation of the data as confidential, it may be disclosed:

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

173.27 (2) to the child when the child is 16 years of age or older, except as provided in clause
173.28 (3);

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

173.30 (4) under paragraph (b), (e), or (f); or

174.1 (5) pursuant to a court order. For purposes of this section, a subpoena does not constitute
174.2 a court order.

174.3 (b) **Unless the child is adopted.** Data pertaining to the birth of a child that are not
174.4 accessible to the public become public data if 100 years have elapsed since the birth of the
174.5 child who is the subject of the data, or as provided under section 13.10, whichever occurs
174.6 first.

158.1 Subd. 2. **Sudden infant death.** Each infant death which is diagnosed as sudden infant
158.2 death syndrome shall be reported within five days to the state registrar.

158.3 Sec. 57. Minnesota Statutes 2022, section 144.222, subdivision 1, is amended to read:

158.4 Subdivision 1. **Fetal death report required.** A fetal death report must be filed within
158.5 five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed,
158.6 except for abortions defined under section 145.4244 145.411, subdivision 5. A fetal death
158.7 report must be prepared in a format prescribed by the state registrar and filed in accordance
158.8 with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

158.9 (1) a person in charge of an institution or that person's authorized designee if a fetus is
158.10 delivered in the institution or en route to the institution;

158.11 (2) a physician, certified nurse midwife, or other licensed medical personnel in attendance
158.12 at or immediately after the delivery if a fetus is delivered outside an institution; or

158.13 (3) a parent or other person in charge of the disposition of the remains if a fetal death
158.14 occurred without medical attendance at or immediately after the delivery.

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

174.7 (c) If a child is adopted, data pertaining to the child's birth are governed by the provisions
174.8 relating to adoption and birth records, including sections 13.10, subdivision 5; 144.218,
174.9 subdivision 1; and 144.2252; and 259.89.

174.10 (d) The name and address of a mother under paragraph (a) and the child's date of birth
174.11 may be disclosed to the county social services, Tribal health department, or public health
174.12 member of a family services collaborative for purposes of providing services under section
174.13 124D.23.

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

174.15 (1) the purposes of administering medical assistance and the MinnesotaCare program;
174.16 (2) child support enforcement purposes; and
174.17 (3) other public health purposes as determined by the commissioner of health.

174.18 (f) Tribal child support programs shall have access to birth records for child support
174.19 enforcement purposes.

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

174.21 Sec. 28. Minnesota Statutes 2022, section 144.2252, is amended to read:

174.22 **144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.**

174.23 Subdivision 1. **Definitions.** (a) Whenever an adopted person requests the state registrar
174.24 to disclose the information on the adopted person's original birth record, the state registrar
174.25 shall act according to section 259.89. For purposes of this section, the following terms have
174.26 the meanings given.

174.27 (b) "Person related to the adopted person" means:

174.28 (1) the spouse, child, or grandchild of an adopted person, if the spouse, child, or
174.29 grandchild is at least 18 years of age; or

174.30 (2) the legal representative of an adopted person.

175.1 The definition under this paragraph only applies when the adopted person is deceased.

175.2 (c) "Original birth record" means a copy of the original birth record for a person who is
175.3 born in Minnesota and whose original birth record was sealed and replaced by a replacement
175.4 birth record after the state registrar received a certified copy of an order, decree, or certificate
175.5 of adoption.

175.6 Subd. 2. **Release of original birth record.** (a) The state registrar must provide to an
175.7 adopted person who is 18 years of age or older or a person related to the adopted person a
175.8 copy of the adopted person's original birth record and any evidence of the adoption previously
175.9 filed with the state registrar. To receive a copy of an original birth record under this
175.10 subdivision, the adopted person or person related to the adopted person must make the

175.11 request to the state registrar in writing. The copy of the original birth record must clearly
175.12 indicate that it may not be used for identification purposes. All procedures, fees, and waiting
175.13 periods applicable to a nonadopted person's request for a copy of a birth record apply in the
175.14 same manner as requests made under this section.

175.15 (b) If a contact preference form is attached to the original birth record as authorized
175.16 under section 144.2253, the state registrar must provide a copy of the contact preference
175.17 form along with the copy of the adopted person's original birth record.

175.18 (c) The state registrar shall provide a transcript of an adopted person's original birth
175.19 record to an authorized representative of a federally recognized American Indian Tribe for
175.20 the sole purpose of determining the adopted person's eligibility for enrollment or membership.
175.21 Information contained in the birth record may not be used to provide the adopted person
175.22 information about the person's birth parents, except as provided in this section or section
175.23 259.83.

175.24 (d) For a replacement birth record issued under section 144.218, the adopted person or
175.25 a person related to the adopted person may obtain from the state registrar copies of the order
175.26 or decree of adoption, certificate of adoption, or decree issued under section 259.60, as filed
175.27 with the state registrar.

175.28 Subd. 3. **Adult adoptions.** Notwithstanding section 144.218, a person adopted as an
175.29 adult may access the person's birth records that existed before the person's adult adoption.
175.30 Access to the existing birth records shall be the same access that was permitted prior to the
175.31 adult adoption.

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

176.1 Sec. 29. **[144.2253] BIRTH PARENT CONTACT PREFERENCE FORM.**

176.2 (a) The commissioner must make available to the public a contact preference form as
176.3 described in paragraph (b).

176.4 (b) The contact preference form must provide the following information to be completed
176.5 at the option of a birth parent:

176.6 (1) "I would like to be contacted."

176.7 (2) "I would prefer to be contacted only through an intermediary."

176.8 (3) "I prefer not to be contacted at this time. If I decide later that I would like to be
176.9 contacted, I will submit an updated contact preference form to the Minnesota Department
176.10 of Health."

176.11 (c) If a birth parent of an adopted person submits a completed contact preference form
176.12 to the commissioner, the commissioner must:

176.13 (1) match the contact preference form to the adopted person's original birth record; and

176.14 (2) attach the contact preference form to the original birth record as required under
 176.15 section 144.2252.

176.16 (d) A contact preference form submitted to the commissioner under this section is private
 176.17 data on an individual as defined in section 13.02, subdivision 12, except that the contact
 176.18 preference form may be released as provided under section 144.2252, subdivision 2.

176.19 **EFFECTIVE DATE.** This section is effective August 1, 2023.

176.20 Sec. 30. **[144.2254] PREVIOUSLY FILED CONSENTS TO DISCLOSURE AND**
 176.21 **AFFIDAVITS OF NONDISCLOSURE.**

176.22 (a) The commissioner must inform a person applying for an original birth record under
 176.23 section 144.2252 of the existence of an unrevoked consent to disclosure or an affidavit of
 176.24 nondisclosure on file with the department, including the name of the birth parent who filed
 176.25 the consent or affidavit. If a birth parent authorized the release of the birth parent's address
 176.26 on an unrevoked consent to disclosure, the commissioner shall provide the address to the
 176.27 person who requests the original birth record.

176.28 (b) A birth parent's consent to disclosure or affidavit of nondisclosure filed with the
 176.29 commissioner of health expires and has no force or effect beginning on June 30, 2024.

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

177.1 Sec. 31. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

177.2 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision
 177.3 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record
 177.4 and for a certification that the vital record cannot be found. The state registrar or local
 177.5 issuance office shall forward this amount to the commissioner of management and budget
 177.6 each month following the collection of the surcharge for deposit into the account for the
 177.7 children's trust fund for the prevention of child abuse established under section 256E.22.
 177.8 This surcharge shall not be charged under those circumstances in which no fee for a certified
 177.9 birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification
 177.10 by the commissioner of management and budget that the assets in that fund exceed
 177.11 \$20,000,000, this surcharge shall be discontinued.

177.12 (b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable
 177.13 surcharge of \$10 for each certified birth record. The state registrar or local issuance office
 177.14 shall forward this amount to the commissioner of management and budget each month
 177.15 following the collection of the surcharge for deposit in the general fund.

177.16 Sec. 32. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

177.17 Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision
 177.18 1, there is a nonrefundable surcharge of \$4 for each certified and noncertified birth, stillbirth,
 177.19 or death record, and for a certification that the record cannot be found. The local issuance
 177.20 office or state registrar shall forward this amount to the commissioner of management and

158.16 Sec. 58. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

158.17 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision
 158.18 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record
 158.19 and for a certification that the vital record cannot be found. The state registrar or local
 158.20 issuance office shall forward this amount to the commissioner of management and budget
 158.21 each month following the collection of the surcharge for deposit into the account for the
 158.22 children's trust fund for the prevention of child abuse established under section 256E.22.
 158.23 This surcharge shall not be charged under those circumstances in which no fee for a certified
 158.24 birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification
 158.25 by the commissioner of management and budget that the assets in that fund exceed
 158.26 \$20,000,000, this surcharge shall be discontinued.

158.27 (b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable
 158.28 surcharge of \$10 for each certified birth record. The state registrar or local issuance office
 158.29 shall forward this amount to the commissioner of management and budget each month
 158.30 following the collection of the surcharge for deposit in the general fund.

159.1 Sec. 59. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

159.2 Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision
 159.3 1, there is a nonrefundable surcharge of \$4 for each certified and noncertified birth, stillbirth,
 159.4 or death record, and for a certification that the record cannot be found. The local issuance
 159.5 office or state registrar shall forward this amount to the commissioner of management and

177.21 budget each month following the collection of the surcharge to be deposited into the state
177.22 government special revenue fund.

159.6 budget each month following the collection of the surcharge to be deposited into the state
159.7 government special revenue fund.

159.8 Sec. 60. **[144.3431] NONRESIDENTIAL MENTAL HEALTH SERVICES.**

159.9 A minor who is age 16 or older may give effective consent for nonresidential mental
159.10 health services, and the consent of no other person is required. For purposes of this section,
159.11 "nonresidential mental health services" means outpatient services as defined in section
159.12 245.4871, subdivision 29, provided to a minor who is not residing in a hospital, inpatient
159.13 unit, or licensed residential treatment facility or program.

159.14 Sec. 61. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
159.15 to read:

159.16 Subd. 2a. **Connector.** "Connector" means gooseneck, pigtail, and other service line
159.17 connectors. A connector is typically a short section of piping not exceeding two feet that
159.18 can be bent and used for connections between rigid service piping.

159.19 Sec. 62. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
159.20 to read:

159.21 Subd. 3a. **Galvanized requiring replacement.** "Galvanized requiring replacement"
159.22 means a galvanized service line that is or was at any time connected to a lead service line
159.23 or lead status unknown service line, or is currently or was previously affixed to a lead
159.24 connector. The majority of galvanized service lines fall under this category.

159.25 Sec. 63. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
159.26 to read:

159.27 Subd. 3b. **Galvanized service line.** "Galvanized service line" means a service line made
159.28 of iron or piping that has been dipped in zinc to prevent corrosion and rusting.

160.1 Sec. 64. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
160.2 to read:

160.3 Subd. 3c. **Lead connector.** "Lead connector" means a connector made of lead.

160.4 Sec. 65. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
160.5 to read:

160.6 Subd. 3d. **Lead service line.** "Lead service line" means a portion of pipe that is made
160.7 of lead, which connects the water main to the building inlet. A lead service line may be
160.8 owned by the water system, by the property owner, or both.

160.9 Sec. 66. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
160.10 to read:

160.11 Subd. 3e. **Lead status unknown service line or unknown service line.** "Lead status
160.12 unknown service line" or "unknown service line" means a service line that has not been

160.13 demonstrated to meet or does not meet the definition of lead free in section 1417 of the Safe
160.14 Drinking Water Act.

160.15 Sec. 67. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
160.16 to read:

160.17 Subd. 3f. Nonlead service line. "Nonlead service line" means a service line determined
160.18 through an evidence-based record, method, or technique not to be a lead service line or
160.19 galvanized service line requiring replacement. Most nonlead service lines are made of copper
160.20 or plastic.

160.21 Sec. 68. Minnesota Statutes 2022, section 144.382, is amended by adding a subdivision
160.22 to read:

160.23 Subd. 4a. Service line. "Service line" means a portion of pipe that connects the water
160.24 main to the building inlet. A service line may be owned by the water system, by the property
160.25 owner, or both. A service line may be made of many materials, such as lead, copper,
160.26 galvanized steel, or plastic.

177.23 Sec. 33. **[144.3832] PUBLIC WATER SYSTEM INFRASTRUCTURE**

177.24 **STRENGTHENING GRANTS.**

177.25 Subdivision 1. Establishment; purpose. The commissioner of health shall establish a
177.26 grant program to ensure the uninterrupted delivery of safe water through emergency power
177.27 supplies and back-up wells, backflow prevention, water reuse, increased cybersecurity,
177.28 floodplain mapping, support for very small water system infrastructure, and piloting solar
177.29 farms in source water protection areas.

177.30 Subd. 2. Grants authorized. (a) The commissioner shall award grants for emergency
177.31 power supplies, back-up wells, and cross connection prevention programs through a request
177.32 for proposals process to public water systems. The commissioner shall give priority to small
177.33 and very small public water systems that serve populations of less than 3,300 and 500
178.1 respectively. The commissioner shall award matching grants to public water systems that
178.2 serve populations of less than 500 for infrastructure improvements supporting system
178.3 operations and resiliency.

178.4 (b) Grantees must address one or more areas of infrastructure strengthening with the
178.5 goals of:

178.6 (1) ensuring the uninterrupted delivery of safe and affordable water to their customers;
178.7 (2) anticipating and mitigating potential threats arising from climate change such as
178.8 flooding and drought;
178.9 (3) providing resiliency to maintain drinking water supply capacity in case of a loss of
178.10 power;

178.11 (4) providing redundancy by having more than one source of water in case the main
178.12 source of water fails; or

178.13 (5) preventing contamination by cross connections through a self-sustaining cross
178.14 connection control program.

160.27 Sec. 69. **[144.3853] CLASSIFICATION OF SERVICE LINES.**

160.28 Subdivision 1. **Classification of lead status of service line.** (a) A water system may
160.29 classify the actual material of a service line, such as copper or plastic, as an alternative to
161.1 classifying the service line as a nonlead service line, for the purpose of the lead service line
161.2 inventory.

161.3 (b) It is not necessary to physically verify the material composition, such as copper or
161.4 plastic, of a service line for its lead status to be identified. For example, if records demonstrate
161.5 the service line was installed after a municipal, state, or federal ban on the installation of
161.6 lead service lines, the service line may be classified as a nonlead service line.

161.7 Subd. 2. **Lead connector.** For the purposes of the lead service line inventory and lead
161.8 service line replacement plan, if a service line has a lead connector, the service line shall
161.9 be classified as a lead service line or a galvanized service line requiring replacement.

161.10 Subd. 3. **Galvanized service line.** A galvanized service line may only be classified as
161.11 a nonlead service line if there is documentation verifying it was never connected to a lead
161.12 service line or lead connector. Rarely will a galvanized service line be considered a nonlead
161.13 service line.

178.15 Sec. 34. **[144.3885] LABOR TRAFFICKING SERVICES GRANT PROGRAM.**

178.16 Subdivision 1. **Establishment.** The commissioner of health must establish a labor
178.17 trafficking services grant program to provide comprehensive, trauma-informed, and culturally
178.18 specific services for victims of labor trafficking or labor exploitation.

178.19 Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants
178.20 must be a nonprofit organization or a nongovernmental organization serving victims of
178.21 labor trafficking or labor exploitation. An organization seeking a grant under this section
178.22 must apply to the commissioner at a time and in a manner specified by the commissioner.
178.23 The commissioner must review each application to determine if the application is complete,
178.24 the organization is eligible for a grant, and the proposed project is an allowable use of grant
178.25 funds. The commissioner must determine the grant amount awarded to applicants that the
178.26 commissioner determines will receive a grant.

178.27 Subd. 3. **Reporting.** (a) The grantee must submit a report to the commissioner in a
178.28 manner and on a timeline specified by the commissioner on how the grant funds were spent
178.29 and how many individuals were served.

178.30 (b) By January 15 of each year, the commissioner must submit a report to the chairs and
 178.31 ranking minority members of the legislative committees with jurisdiction over health policy
 179.1 and finance. The report must include the names of the grant recipients, how the grant funds
 179.2 were spent, and how many individuals were served.

179.3 **Sec. 35. [144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT
 179.4 AND USES.**

179.5 Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have
 179.6 the meanings given.

179.7 (b) "Electronic delivery device" has the meaning given in section 609.685, subdivision
 179.8 1, paragraph (c).

179.9 (c) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

179.10 (d) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1,
 179.11 paragraph (b).

179.12 (e) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision
 179.13 1, paragraph (c).

179.14 Subd. 2. **Account created.** A tobacco use prevention account is created in the special
 179.15 revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner
 179.16 of management and budget shall deposit into the account any money received by the state
 179.17 resulting from a settlement agreement or an assurance of discontinuance entered into by the
 179.18 attorney general of the state, or a court order in litigation brought by the attorney general
 179.19 of the state on behalf of the state or a state agency related to alleged violations of consumer
 179.20 fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in
 179.21 this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine
 179.22 use.

179.23 Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year,
 179.24 the amount of money in the tobacco use prevention account is appropriated to the
 179.25 commissioner of health for:

179.26 (1) tobacco and electronic delivery device use prevention and cessation projects consistent
 179.27 with the duties specified in section 144.392;

179.28 (2) a public information program under section 144.393;

179.29 (3) the development of health promotion and health education materials about tobacco
 179.30 and electronic delivery device use prevention and cessation;

179.31 (4) tobacco and electronic delivery device use prevention activities under section 144.396;
 179.32 and

161.14 **Sec. 70. [144.398] TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT
 161.15 AND USES.**

161.16 Subdivision 1. **Definitions.** (a) As used in this section, the terms in this subdivision have
 161.17 the meanings given.

161.18 (b) "Electronic delivery device" has the meaning given in section 609.685, subdivision
 161.19 1, paragraph (c).

161.20 (c) "Nicotine delivery product" has the meaning given in section 609.6855, subdivision
 161.21 1, paragraph (c).

161.22 (d) "Tobacco" has the meaning given in section 609.685, subdivision 1, paragraph (a).

161.23 (e) "Tobacco-related devices" has the meaning given in section 609.685, subdivision 1,
 161.24 paragraph (b).

161.25 Subd. 2. **Account created.** A tobacco use prevention account is created in the special
 161.26 revenue fund. Pursuant to section 16A.151, subdivision 2, paragraph (h), the commissioner
 161.27 of management and budget shall deposit into the account any money received by the state
 161.28 resulting from a settlement agreement or an assurance of discontinuance entered into by the
 161.29 attorney general of the state, or a court order in litigation brought by the attorney general
 161.30 of the state on behalf of the state or a state agency related to alleged violations of consumer
 161.31 fraud laws in the marketing, sale, or distribution of electronic nicotine delivery systems in
 162.1 this state or other alleged illegal actions that contributed to the exacerbation of youth nicotine
 162.2 use.

162.3 Subd. 3. **Appropriations from tobacco use prevention account.** (a) Each fiscal year,
 162.4 the amount of money in the tobacco use prevention account is appropriated to the
 162.5 commissioner of health for:

162.6 (1) tobacco and electronic delivery device use prevention and cessation projects consistent
 162.7 with the duties specified in section 144.392;

162.8 (2) a public information program under section 144.393;

162.9 (3) the development of health promotion and health education materials about tobacco
 162.10 and electronic delivery device use prevention and cessation;

162.11 (4) tobacco and electronic delivery device use prevention activities under section 144.396;
 162.12 and

180.1 (5) statewide tobacco cessation services under section 144.397.

180.2 (b) In activities funded under this subdivision, the commissioner of health must:

180.3 (1) prioritize preventing persons under the age of 21 from using commercial tobacco,

180.4 electronic delivery devices, tobacco-related devices, and nicotine delivery products;

180.5 (2) promote racial and health equity; and

180.6 (3) use strategies that are evidence-based or based on promising practices.

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

180.8 Sec. 36. **[144.4962] LOCAL AND TRIBAL PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE GRANT PROGRAM.**

180.9 Subdivision 1. **Establishment.** The commissioner of health must establish a local and tribal public health emergency preparedness and response grant program.

180.10 Subd. 2. **Eligibility; application.** (a) Local and tribal public health organizations are eligible to receive grants as provided in this section. Grant proceeds must align with the Centers for Disease Control and Prevention's issued report: Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health.

180.11 (b) A local or tribal public health organization seeking a grant under this section must apply to the commissioner at a time and in a manner specified by the commissioner. The commissioner must review each application to determine if the application is complete, the organization is eligible for a grant, and the proposed project is an allowable use of grant funds. The commissioner must determine the grant amount awarded to applicants that the commissioner determines will receive a grant.

180.12 Subd. 3. **Reporting.** (a) The grantee must submit a report to the commissioner in a manner and on a timeline specified by the commissioner on how the grant funds were spent and how many individuals were served.

180.13 (b) By January 15 of each year, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health policy and finance. The report must include the names of the grant recipients, how the grant funds were spent, and how many individuals were served.

162.13 (5) statewide tobacco cessation services under section 144.397.

162.14 (b) In activities funded under this subdivision, the commissioner of health must:

162.15 (1) prioritize preventing persons under the age of 21 from using commercial tobacco,

162.16 electronic delivery devices, tobacco-related devices, and nicotine delivery products;

162.17 (2) promote racial and health equity; and

162.18 (3) use strategies that are evidence-based or based on promising practices.

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

162.20 Sec. 71. Minnesota Statutes 2022, section 144.55, subdivision 3, is amended to read:

162.21 Subd. 3. **Standards for licensure.** (a) Notwithstanding the provisions of section 144.56, for the purpose of hospital licensure, the commissioner of health shall use as minimum standards the hospital certification regulations promulgated pursuant to title XVIII of the Social Security Act, United States Code, title 42, section 1395, et seq. The commissioner

162.25 ~~may use as minimum standards changes in the federal hospital certification regulations promulgated after May 7, 1981, if the commissioner finds that such changes are reasonably necessary to protect public health and safety. The commissioner shall also promulgate in rules additional minimum standards for new construction.~~

162.29 ~~(b) Hospitals must meet the applicable provisions of the 2022 edition of the Facility Guidelines Institute *Guidelines for Design and Construction of Hospitals*. This minimum design standard must be met for all new licenses, new construction, change of use, or change of occupancy for which plan review packages are received on or after January 1, 2024.~~

163.3 ~~(c) If the commissioner decides to update the edition of the guidelines specified in paragraph (b) for purposes of this subdivision, the commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new edition will become effective. Following notice from the commissioner, the new edition shall become effective for hospitals beginning August 1 of that year, unless otherwise provided in law. The commissioner shall, by publication in the State Register, specify a date by which hospitals must comply with the updated edition. The date by which hospitals must comply shall not be sooner than 12 months after publication of the commissioner's notice in the State Register and shall apply only to plan review packages received on or after that date.~~

163.13 ~~(d) Hospitals shall be in compliance with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.~~

163.16 ~~(e) Each hospital and outpatient surgical center shall establish policies and procedures to prevent the transmission of human immunodeficiency virus and hepatitis B virus to patients and within the health care setting. The policies and procedures shall be developed in conformance with the most recent recommendations issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control. The commissioner of health shall evaluate a hospital's compliance with the policies and procedures according to subdivision 4.~~

163.23 ~~(f) An outpatient surgical center must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.~~

163.31 ~~(g) Written compliance with this subdivision must be maintained by the outpatient surgical center.~~

181.1 Sec. 37. **[144.557] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY**
 181.2 **TRANSACTIONS.**

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

181.5 (b) "Captive professional entity" means a professional corporation, limited liability
 181.6 company, or other entity formed to render professional services in which a beneficial owner
 181.7 is a health care provider employed by, controlled by, or subject to the direction of a hospital
 181.8 or hospital system.

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

181.10 (d) "Control," including the terms "controlling," "controlled by," and "under common
 181.11 control with," means the possession, direct or indirect, of the power to direct or cause the
 181.12 direction of the management and policies of a person, whether through the ownership of
 181.13 voting securities, membership in an entity formed under chapter 317A, by contract other
 181.14 than a commercial contract for goods or nonmanagement services, or otherwise, unless the
 181.15 power is the result of an official position with, corporate office held by, or court appointment
 181.16 of, the person. Control is presumed to exist if any person, directly or indirectly, owns,
 181.17 controls, holds with the power to vote, or holds proxies representing, 40 percent or more of
 181.18 the voting securities of any other person, or if any person, directly or indirectly, constitutes
 181.19 40 percent or more of the membership of an entity formed under chapter 317A. The
 181.20 commissioner may determine, after furnishing all persons in interest notice and opportunity
 181.21 to be heard and making specific findings of fact to support such determination, that control
 181.22 exists in fact, notwithstanding the absence of a presumption to that effect.

181.23 (e) "Health care entity" means:

- 181.24 (1) a hospital;
- 181.25 (2) a hospital system;
- 181.26 (3) a captive professional entity;
- 181.27 (4) a medical foundation;
- 181.28 (5) a health care provider group practice;
- 181.29 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or
- 181.30 (7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

181.31 (f) "Health care provider" means a physician licensed under chapter 147, a physician
 181.32 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined

163.33 **EFFECTIVE DATE.** This section is effective January 1, 2024.

174.4 Sec. 76. **[144.593] REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY**
 174.5 **TRANSACTIONS.**

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

174.8 (b) "Captive professional entity" means a professional corporation, limited liability
 174.9 company, or other entity formed to render professional services in which a beneficial owner
 174.10 is a health care provider employed by, controlled by, or subject to the direction of a hospital
 174.11 or hospital system.

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

174.13 (d) "Health care entity" means:

- 174.14 (1) a hospital;
- 174.15 (2) a hospital system;
- 174.16 (3) a captive professional entity;
- 174.17 (4) a medical foundation;
- 174.18 (5) a health care provider group practice;
- 174.19 (6) an entity organized or controlled by an entity listed in clauses (1) to (5); or
- 174.20 (7) an entity that owns or exercised substantial control over an entity listed in clauses
 174.21 (1) to (5).

174.22 (e) "Health care provider" means a physician licensed under chapter 147, a physician
 174.23 assistant licensed under chapter 147A, or an advanced practice registered nurse as defined

182.1 in section 148.171, subdivision 3, who provides health care services, including but not
 182.2 limited to medical care, consultation, diagnosis, or treatment.

182.3 (g) "Health care provider group practice" means two or more health care providers legally
 182.4 organized in a partnership, professional corporation, limited liability company, medical
 182.5 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

182.6 (1) in which each health care provider who is a member of the group provides
 182.7 substantially the full range of services that a health care provider routinely provides, including
 182.8 but not limited to medical care, consultation, diagnosis, and treatment, through the joint use
 182.9 of shared office space, facilities, equipment, or personnel;

182.10 (2) for which substantially all services of the health care providers who are group
 182.11 members are provided through the group and are billed in the name of the group practice
 182.12 and amounts so received are treated as receipts of the group; or

182.13 (3) in which the overhead expenses of, and the income from, the group are distributed
 182.14 in accordance with methods previously determined by members of the group.

182.15 An entity that otherwise meets the definition of health care provider group practice in this
 182.16 paragraph shall be considered a health care provider group practice even if its shareholders,
 182.17 partners, members, or owners include a single-health care provider professional corporation,
 182.18 limited liability company, or another entity in which any beneficial owner is an individual
 182.19 health care provider and which is formed to render professional services.

182.20 (h) "Hospital" means a health care facility licensed as a hospital under sections 144.50
 182.21 to 144.56.

182.22 (i) "Medical foundation" means a nonprofit legal entity through which physicians or
 182.23 other health care providers perform research or provide medical services.

182.24 (j) "Transaction" means a single action, or a series of actions within a five-year period,
 182.25 which occurs in part within the state of Minnesota or involves a health care entity formed
 182.26 or licensed in Minnesota, that constitutes:

182.27 (1) a merger or exchange of a health care entity with another entity;

182.28 (2) the sale, lease, or transfer of 40 percent or more of the assets of a health care entity
 182.29 to another entity;

182.30 (3) the granting of a security interest of 40 percent or more of the property and assets
 182.31 of a health care entity to another entity;

183.1 (4) the transfer of 40 percent or more of the shares or other ownership of the health care
 183.2 entity to another entity;

174.24 in section 148.171, subdivision 3, who provides health care services, including but not
 174.25 limited to medical care, consultation, diagnosis, or treatment.

174.26 (f) "Health care provider group practice" means two or more health care providers legally
 174.27 organized in a partnership, professional corporation, limited liability company, medical
 174.28 foundation, nonprofit corporation, faculty practice plan, or other similar entity:

174.29 (1) in which each health care provider who is a member of the group provides
 174.30 substantially the full range of services that a health care provider routinely provides, including
 175.1 but not limited to medical care, consultation, diagnosis, and treatment, through the joint use
 175.2 of shared office space, facilities, equipment, or personnel;

175.3 (2) for which substantially all services of the health care providers who are group
 175.4 members are provided through the group and are billed in the name of the group practice
 175.5 and amounts so received are treated as receipts of the group; or

175.6 (3) in which the overhead expenses of, and the income from, the group are distributed
 175.7 in accordance with methods previously determined by members of the group.

175.8 An entity that otherwise meets the definition of health care provider group practice in this
 175.9 paragraph shall be considered a health care provider group practice even if its shareholders,
 175.10 partners, or owners include single-health care provider professional corporations, limited
 175.11 liability companies formed to render professional services, or other entities in which
 175.12 beneficial owners are individual health care providers.

175.13 (g) "Hospital" means a health care facility licensed as a hospital under sections 144.50
 175.14 to 144.56.

175.15 (h) "Medical foundation" means a nonprofit legal entity through which physicians or
 175.16 other health care providers perform research or provide medical services.

175.17 (i) "Transaction" means a single action, or a series of actions within a five-year period,
 175.18 that constitutes:

175.19 (1) a merger or exchange of a health care entity with another entity;

175.20 (2) the sale, lease, or transfer of 30 percent or more of the assets of a health care entity
 175.21 to another entity;

175.22 (3) the granting of a security interest of 30 percent or more of the property and assets
 175.23 of a health care entity to another entity;

175.24 (4) the transfer of 30 percent or more of the shares or other ownership of the health care
 175.25 entity to another entity;

183.3 (5) an addition, removal, withdrawal, substitution, or other modification of one or more
 183.4 members of the health care entity's governing body that transfers control, responsibility for,
 183.5 or governance of the health care entity to another entity;

183.6 (6) the creation of a new health care entity;

183.7 (7) substantial investment of 40 percent or more in a health care entity that results in
 183.8 sharing of revenues without a change in ownership or voting shares;

183.9 (8) an addition, removal, withdrawal, substitution, or other modification of the members
 183.10 of a health care entity formed under chapter 317A that results in a change of 40 percent or
 183.11 more of the membership of the health care entity; or

183.12 (9) any other transfer of control of a health care entity to, or acquisition of control of a
 183.13 health care entity by, another entity.

183.14 A transaction does not include an action or series of actions which meets one or more of
 183.15 the criteria set forth in clauses (1) to (9) if, immediately prior to all such actions, the health
 183.16 care entity directly, or indirectly through one or more intermediaries, controls, or is controlled
 183.17 by, or is under common control with, all other parties to the action or series of actions.

183.18 Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

183.19 (1) the health care entity involved in the transaction has average revenue of at least
 183.20 \$40,000,000 per year; or

183.21 (2) an entity created by the transaction is projected to have average revenue of at least
 183.22 \$40,000,000 per year once the entity is operating at full capacity.

183.23 (b) A health care entity must provide notice to the attorney general and the commissioner
 183.24 and comply with this subdivision before entering into a transaction. Notice must be provided
 183.25 at least 90 days before the proposed completion date for the transaction.

183.26 (c) As part of the notice required under this subdivision, at least 90 days before the
 183.27 proposed completion date of the transaction, a health care entity must affirmatively disclose
 183.28 the following to the attorney general and the commissioner:

183.29 (1) the entities involved in the transaction;

183.30 (2) the leadership of the entities involved in the transaction, including all directors, board
 183.31 members, and officers;

184.1 (3) the services provided by each entity and the attributed revenue for each entity by
 184.2 location;

184.3 (4) the primary service area for each location;

184.4 (5) the proposed service area for each location;

175.26 (5) an addition or substitution of one or more members of the health care entity's
 175.27 governing body that effectively transfers control, responsibility for, or governance of the
 175.28 health care entity to another entity;

175.29 (6) the creation of a new health care entity; or

175.30 (7) substantial investment of 30 percent or more in a health care entity that results in
 175.31 sharing of revenues without a change in ownership or voting shares.

176.1 Subd. 2. **Notice required.** (a) This subdivision applies to all transactions where:

176.2 (1) the health care entity involved in the transaction has average revenue of at least
 176.3 \$10,000,000 per year; or

176.4 (2) an entity created by the transaction is projected to have average revenue of at least
 176.5 \$10,000,000 per year once the entity is operating at full capacity.

176.6 (b) A health care entity must provide notice to the attorney general and the commissioner
 176.7 and comply with this subdivision before entering into a transaction. Notice must be provided
 176.8 at least 180 days before the proposed completion date for the transaction.

176.9 (c) As part of the notice required under this subdivision, at least 180 days before the
 176.10 proposed completion date of the transaction, a health care entity must affirmatively disclose
 176.11 the following to the attorney general and the commissioner:

176.12 (1) the entities involved in the transaction;

176.13 (2) the leadership of the entities involved in the transaction, including all directors, board
 176.14 members, and officers;

176.15 (3) the services provided by each entity and the attributed revenue for each entity by
 176.16 location;

176.17 (4) the primary service area for each location;

176.18 (5) the proposed service area for each location;

184.5 (6) the current relationships between the entities and the health care providers and
184.6 practices affected, the locations of affected health care providers and practices, the services
184.7 provided by affected health care providers and practices, and the proposed relationships
184.8 between the entities and the health care providers and practices affected;

184.9 (7) the terms of the transaction agreement or agreements;

184.10 (8) the acquisition price;

184.11 (9) markets in which the entities expect postmerger synergies to produce a competitive
184.12 advantage;

184.13 (10) potential areas of expansion, whether in existing markets or new markets;

184.14 (11) plans to close facilities, reduce workforce, or reduce or eliminate services;

184.15 (12) the experts and consultants used to evaluate the transaction;

184.16 (13) the number of full-time equivalent positions at each location before and after the
184.17 transaction by job category, including administrative and contract positions; and

184.18 (14) any other information requested by the attorney general or commissioner.

184.19 (d) As part of the notice required under this subdivision, at least 90 days before the
184.20 proposed completion date of the transaction, a health care entity must affirmatively produce
184.21 the following to the attorney general and the commissioner:

184.22 (1) the current governing documents for all entities involved in the transaction and any
184.23 amendments to these documents;

184.24 (2) the transaction agreement or agreements and all related agreements;

184.25 (3) any collateral agreements related to the principal transaction, including leases,
184.26 management contracts, and service contracts;

184.27 (4) all expert or consultant reports or valuations conducted in evaluating the transaction,
184.28 including any valuation of the assets that are subject to the transaction prepared within three
184.29 years preceding the anticipated transaction completion date and any reports of financial or
184.30 economic analysis conducted in anticipation of the transaction;

185.1 (5) the results of any projections or modeling of health care utilization or financial
185.2 impacts related to the transaction, including but not limited to copies of reports by appraisers,
185.3 accountants, investment bankers, actuaries, and other experts;

185.4 (6) a financial and economic analysis and report prepared by an independent expert or
185.5 consultant on the effects of the transaction;

176.19 (6) the current relationships between the entities and the health care providers and
176.20 practices affected, the locations of affected health care providers and practices, the services
176.21 provided by affected health care providers and practices, and the proposed relationships
176.22 between the entities and the health care providers and practices affected;

176.23 (7) the terms of the transaction agreement or agreements;

176.24 (8) the acquisition price;

176.25 (9) markets in which the entities expect postmerger synergies to produce a competitive
176.26 advantage;

176.27 (10) potential areas of expansion, whether in existing markets or new markets;

176.28 (11) plans to close facilities, reduce workforce, or reduce or eliminate services;

176.29 (12) the experts and consultants used to evaluate the transaction;

177.1 (13) the number of full-time equivalent positions at each location before and after the
177.2 transaction by job category, including administrative and contract positions; and

177.3 (14) any other information requested by the attorney general or commissioner.

177.4 (d) As part of the notice required under this subdivision, at least 180 days before the
177.5 proposed completion date of the transaction, a health care entity must affirmatively produce
177.6 the following to the attorney general and the commissioner:

177.7 (1) the current governing documents for all entities involved in the transaction and any
177.8 amendments to these documents;

177.9 (2) the transaction agreement or agreements and all related agreements;

177.10 (3) any collateral agreements related to the principal transaction, including leases,
177.11 management contracts, and service contracts;

177.12 (4) all expert or consultant reports or valuations conducted in evaluating the transaction,
177.13 including any valuation of the assets that are subject to the transaction prepared within three
177.14 years preceding the anticipated transaction completion date and any reports of financial or
177.15 economic analysis conducted in anticipation of the transaction;

177.16 (5) the results of any projections or modeling of health care utilization or financial
177.17 impacts related to the transaction, including but not limited to copies of reports by appraisers,
177.18 accountants, investment bankers, actuaries, and other experts;

177.19 (6) a financial and economic analysis and report prepared by an independent expert or
177.20 consultant on the effects of the transaction;

185.6 (7) an impact analysis report prepared by an independent expert or consultant on the
 185.7 effects of the transaction on communities and the workforce, including any changes in
 185.8 availability or accessibility of services;

185.9 (8) all documents reflecting the purposes of or restrictions on any related nonprofit
 185.10 entity's charitable assets;

185.11 (9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino
 185.12 filing the entities submitted to the Federal Trade Commission in connection with the
 185.13 transaction;

185.14 (10) a certification sworn under oath by each board member and chief executive officer
 185.15 for any nonprofit entity involved in the transaction containing the following: an explanation
 185.16 of how the completed transaction is in the public interest, addressing the factors in subdivision
 185.17 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the
 185.18 transaction for the three years following the transaction's anticipated completion date; and
 185.19 a disclosure of any conflicts of interest;

185.20 (11) audited and unaudited financial statements from all entities involved in the
 185.21 transaction and tax filings for all entities involved in the transaction covering the preceding
 185.22 five fiscal years; and

185.23 (12) any other information or documents requested by the attorney general or
 185.24 commissioner.

185.25 (e) The attorney general may extend the notice and waiting period required under
 185.26 paragraph (b) for an additional 90 days by notifying the health care entity in writing of the
 185.27 extension.

185.28 (f) The attorney general may waive all or any part of the notice and waiting period
 185.29 required under paragraph (b).

185.30 (g) The attorney general or the commissioner may hold public listening sessions or
 185.31 forums to obtain input on the transaction from providers or community members who may
 185.32 be impacted by the transaction.

186.1 (h) The attorney general or the commissioner may bring an action in district court to
 186.2 compel compliance with the notice requirements in this subdivision.

186.3 Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction
 186.4 that will:

186.5 (1) substantially lessen competition; or

177.21 (7) an impact analysis report prepared by an independent expert or consultant on the
 177.22 effects of the transaction on communities and the workforce, including any changes in
 177.23 availability or accessibility of services;

177.24 (8) all documents reflecting the purposes of or restrictions on any related nonprofit
 177.25 entity's charitable assets;

177.26 (9) copies of all filings submitted to federal regulators, including any Hart-Scott-Rodino
 177.27 filing the entities submitted to the Federal Trade Commission in connection with the
 177.28 transaction;

177.29 (10) a certification sworn under oath by each board member and chief executive officer
 177.30 for any nonprofit entity involved in the transaction containing the following: an explanation
 177.31 of how the completed transaction is in the public interest, addressing the factors in subdivision
 177.32 5, paragraph (a); a disclosure of each declarant's compensation and benefits relating to the
 178.1 transaction for the three years following the transaction's anticipated completion date; and
 178.2 a disclosure of any conflicts of interest;

178.3 (11) audited and unaudited financial statements from all entities involved in the
 178.4 transaction and tax filings for all entities involved in the transaction covering the preceding
 178.5 five fiscal years; and

178.6 (12) any other information or documents requested by the attorney general or
 178.7 commissioner.

178.8 (e) The commissioner may adopt rules to implement this section, and may alter, amend,
 178.9 suspend, or repeal any of such rules. The requirements of section 14.125 do not apply to
 178.10 the adoption of rules under this paragraph.

178.11 (f) The attorney general may extend the notice and waiting period required under
 178.12 paragraph (b) for an additional 90 days by notifying the health care entity in writing of the
 178.13 extension.

178.14 (g) The attorney general may waive all or any part of the notice and waiting period
 178.15 required under paragraph (b).

178.16 (h) The attorney general or the commissioner may hold public listening sessions or
 178.17 forums to obtain input on the transaction from providers or community members who may
 178.18 be impacted by the transaction.

178.19 (i) The attorney general or the commissioner may bring an action in district court to
 178.20 compel compliance with the notice requirements in this subdivision.

178.21 Subd. 3. **Prohibited transactions.** No health care entity may enter into a transaction
 178.22 that will:

178.23 (1) substantially lessen competition; or

186.6 (2) tend to create a monopoly or monopsony.

186.7 **Subd. 4. Additional requirements for nonprofit health care entities.** A health care
186.8 entity that is incorporated under chapter 317A or organized under section 322C.1101, or
186.9 that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

186.10 (1) the transaction complies with chapters 317A and 501B and other applicable laws;

186.11 (2) the transaction does not involve or constitute a breach of charitable trust;

186.12 (3) the nonprofit health care entity will receive full and fair value for its public benefit
186.13 assets, provided that this requirement is waived if application for waiver is made to the
186.14 attorney general and the attorney general determines a waiver from this requirement is in
186.15 the public interest;

186.16 (4) the value of the public benefit assets to be transferred has not been manipulated in
186.17 a manner that causes or has caused the value of the assets to decrease;

186.18 (5) the proceeds of the transaction will be used in a manner consistent with the public
186.19 benefit for which the assets are held by the nonprofit health care entity;

186.20 (6) the transaction will not result in a breach of fiduciary duty; and

186.21 (7) there are procedures and policies in place to prohibit any officer, director, trustee,
186.22 or other executive of the nonprofit health care entity from directly or indirectly benefiting
186.23 from the transaction.

186.24 **Subd. 5. Attorney general enforcement and supplemental authority.** (a) The attorney
186.25 general may bring an action in district court to enjoin or unwind a transaction or seek other
186.26 equitable relief necessary to protect the public interest if a health care entity or transaction
186.27 violates this section, if the transaction is contrary to the public interest, or if both a health
186.28 care entity or transaction violates this section and the transaction is contrary to the public
186.29 interest. Factors informing whether a transaction is contrary to the public interest include
186.30 but are not limited to whether the transaction:

186.31 (1) will harm public health;

187.1 (2) will reduce the affected community's continued access to affordable and quality care
187.2 and to the range of services historically provided by the entities or will prevent members
187.3 in the affected community from receiving a comparable or better patient experience;

187.4 (3) will have a detrimental impact on competing health care options within primary and
187.5 dispersed service areas;

187.6 (4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and
187.7 underserved populations and to populations enrolled in public health care programs;

178.24 (2) tend to create a monopoly or monopsony.

178.25 **Subd. 4. Additional requirements for nonprofit health care entities.** A health care
178.26 entity that is incorporated under chapter 317A or organized under section 322C.1101, or
178.27 that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

178.28 (1) the transaction complies with chapters 317A and 501B and other applicable laws;

178.29 (2) the transaction does not involve or constitute a breach of charitable trust;

178.30 (3) the nonprofit health care entity will receive full and fair value for its public benefit
178.31 assets;

179.1 (4) the value of the public benefit assets to be transferred has not been manipulated in
179.2 a manner that causes or has caused the value of the assets to decrease;

179.3 (5) the proceeds of the transaction will be used in a manner consistent with the public
179.4 benefit for which the assets are held by the nonprofit health care entity;

179.5 (6) the transaction will not result in a breach of fiduciary duty; and

179.6 (7) there are procedures and policies in place to prohibit any officer, director, trustee,
179.7 or other executive of the nonprofit health care entity from directly or indirectly benefiting
179.8 from the transaction.

179.9 **Subd. 5. Attorney general enforcement and supplemental authority.** (a) The attorney
179.10 general may bring an action in district court to enjoin or unwind a transaction or seek other
179.11 equitable relief necessary to protect the public interest if a health care entity or transaction
179.12 violates this section, if the transaction is contrary to the public interest, or if both a health
179.13 care entity or transaction violates this section and the transaction is contrary to the public
179.14 interest. Factors informing whether a transaction is contrary to the public interest include
179.15 but are not limited to whether the transaction:

179.16 (1) will harm public health;

179.17 (2) will reduce the affected community's continued access to affordable and quality care
179.18 and to the range of services historically provided by the entities or will prevent members
179.19 in the affected community from receiving a comparable or better patient experience;

179.20 (3) will have a detrimental impact on competing health care options within primary and
179.21 dispersed service areas;

179.22 (4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and
179.23 underserved populations and to populations enrolled in public health care programs;

187.8 (5) will have a substantial negative impact on medical education and teaching programs,
 187.9 health care workforce training, or medical research;

187.10 (6) will have a negative impact on the market for health care services, health insurance
 187.11 services, or skilled health care workers;

187.12 (7) will increase health care costs for patients; or

187.13 (8) will adversely impact provider cost trends and containment of total health care
 187.14 spending.

187.15 (b) The attorney general may enforce this section under section 8.31.

187.16 (c) Failure of the entities involved in a transaction to provide timely information as
 187.17 required by the attorney general or the commissioner shall be an independent and sufficient
 187.18 ground for a court to enjoin or unwind the transaction or provide other equitable relief,
 187.19 provided the attorney general notified the entities of the inadequacy of the information
 187.20 provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

187.21 (d) The attorney general shall consult with the commissioner to determine whether a
 187.22 transaction is contrary to the public interest. Any information exchanged between the attorney
 187.23 general and the commissioner according to this subdivision is confidential data on individuals
 187.24 as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section
 187.25 13.02, subdivision 13. The commissioner may share with the attorney general, according
 187.26 to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision
 187.27 8a, held by the Department of Health to aid in the investigation and review of the transaction,
 187.28 and the attorney general must maintain this data with the same classification according to
 187.29 section 13.03, subdivision 4, paragraph (d).

187.30 Subd. 6. Supplemental authority of commissioner. (a) Notwithstanding any law to
 187.31 the contrary, the commissioner may use data or information submitted under this section,
 187.32 section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact
 188.1 of health care transactions on access to or the cost of health care services, health care market
 188.2 consolidation, and health care quality.

188.3 (b) The commissioner shall issue periodic public reports on the number and types of
 188.4 transactions subject to this section and on the aggregate impact of transactions on health
 188.5 care cost, quality, and competition in Minnesota.

188.6 Subd. 7. Relation to other law. (a) The powers and authority under this section are in
 188.7 addition to, and do not affect or limit, all other rights, powers, and authority of the attorney
 188.8 general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

188.9 (b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309,
 188.10 317A, 325D, 501B, or other law on the entities involved in a transaction.

188.11 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 188.12 applies to transactions completed on or after that date. In determining whether a transaction

179.24 (5) will have a substantial negative impact on medical education and teaching programs,
 179.25 health care workforce training, or medical research;

179.26 (6) will have a negative impact on the market for health care services, health insurance
 179.27 services, or skilled health care workers;

179.28 (7) will increase health care costs for patients; or

179.29 (8) will adversely impact provider cost trends and containment of total health care
 179.30 spending.

179.31 (b) The attorney general may enforce this section under section 8.31.

180.1 (c) Failure of the entities involved in a transaction to provide timely information as
 180.2 required by the attorney general or the commissioner shall be an independent and sufficient
 180.3 ground for a court to enjoin the transaction or provide other equitable relief, provided the
 180.4 attorney general notified the entities of the inadequacy of the information provided and
 180.5 provided the entities with a reasonable opportunity to remedy the inadequacy.

180.6 (d) The attorney general shall consult with the commissioner to determine whether a
 180.7 transaction is contrary to the public interest. Any information exchanged between the attorney
 180.8 general and the commissioner according to this subdivision is confidential data on individuals
 180.9 as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section
 180.10 13.02, subdivision 13. The commissioner may share with the attorney general, according
 180.11 to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision
 180.12 8a, held by the Department of Health to aid in the investigation and review of the transaction,
 180.13 and the attorney general must maintain this data with the same classification according to
 180.14 section 13.03, subdivision 4, paragraph (d).

180.15 Subd. 6. Supplemental authority of commissioner. (a) Notwithstanding any law to
 180.16 the contrary, the commissioner may use data or information submitted under this section,
 180.17 section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact
 180.18 of health care transactions on access to or the cost of health care services, health care market
 180.19 consolidation, and health care quality.

180.20 (b) The commissioner shall issue periodic public reports on the number and types of
 180.21 transactions subject to this section and on the aggregate impact of transactions on health
 180.22 care cost, quality, and competition in Minnesota.

180.23 Subd. 7. Relation to other law. (a) The powers and authority under this section are in
 180.24 addition to, and do not affect or limit, all other rights, powers, and authority of the attorney
 180.25 general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

180.26 (b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309,
 180.27 317A, 325D, 501B, or other law on the entities involved in a transaction.

180.28 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 180.29 applies to transactions completed on or after that date. In determining whether a transaction

188.13 was completed on or after the effective date, any actions or series of actions necessary to
 188.14 the completion of the transaction that occurred prior to the effective date must be considered.

188.15 Sec. 38. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR**
 188.16 **HEALTH COVERAGE OR ASSISTANCE.**

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

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

188.21 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections
 188.22 144.50 to 144.56.

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

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

188.26 (f) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision
 188.27 12.

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

188.29 (h) "Uninsured service or treatment" means any service or treatment that is not covered
 188.30 by:

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

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

180.30 was completed on or after the effective date, any actions or series of actions necessary to
 180.31 the completion of the transaction that occurred prior to the effective date must be considered.

FOR SECTION 72, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

170.18 Sec. 73. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR**
 170.19 **HEALTH COVERAGE OR ASSISTANCE.**

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

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

170.24 (c) "Hospital" means a private, nonprofit, or municipal hospital licensed under sections
 170.25 144.50 to 144.56.

170.26 (d) "Minnesota attorney general/hospital agreement" means the agreement between the
 170.27 attorney general and certain Minnesota hospitals that is filed in Ramsey County District
 170.28 Court and that establishes requirements for hospital litigation practices, garnishments, use
 170.29 of collection agencies, central billing office practices, and practices for billing uninsured
 170.30 patients.

170.31 (e) "Most favored insurer" means the nongovernmental third-party payor that provided
 170.32 the most revenue to the provider during the previous calendar year.

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

171.6 (h) "Presumptive eligibility" has the meaning given in section 256B.057, subdivision
 171.7 12.

171.2 (g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient
 171.3 Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal
 171.4 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any
 171.5 amendments to and federal guidance and regulations issued under these acts.

171.8 (i) "Revenue recapture" means the use of the procedures in chapter 270A to collect debt.

171.9 (j) "Uninsured service or treatment" means any service or treatment that is not covered
 171.10 by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2)
 171.11 any other type of insurance coverage, including but not limited to no-fault automobile
 171.12 coverage, workers' compensation coverage, or liability coverage.

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

189.6 Subd. 2. Screening. (a) A hospital participating in the hospital presumptive eligibility
 189.7 program under section 256B.057, subdivision 12, must determine whether a patient who is
 189.8 uninsured or whose insurance coverage status is not known by the hospital is eligible for
 189.9 hospital presumptive eligibility coverage.

189.10 (b) For any uninsured patient, including any patient the hospital determines is eligible
 189.11 for hospital presumptive eligibility coverage, and for any patient whose insurance coverage
 189.12 status is not known to the hospital, a hospital must:

189.13 (1) if it is a certified application counselor organization, schedule an appointment for
 189.14 the patient with a certified application counselor to occur prior to discharge unless the
 189.15 occurrence of the appointment would delay discharge;

189.16 (2) if the occurrence of the appointment under clause (1) would delay discharge or if
 189.17 the hospital is not a certified application counselor organization, schedule prior to discharge
 189.18 an appointment for the patient with a MNsure-certified navigator to occur after discharge
 189.19 unless the scheduling of an appointment would delay discharge; or

189.20 (3) if the scheduling of an appointment under clause (2) would delay discharge or if the
 189.21 patient declines the scheduling of an appointment under clause (1) or (2), provide the patient
 189.22 with contact information for available MNsure-certified navigators who can meet the needs
 189.23 of the patient.

189.24 (c) For any uninsured patient, including any patient the hospital determines is eligible
 189.25 for hospital presumptive eligibility coverage, and any patient whose insurance coverage
 189.26 status is not known to the hospital, a hospital must screen the patient for eligibility for charity
 189.27 care from the hospital. The hospital must attempt to complete the screening process for
 189.28 charity care in person or by telephone within 30 days after the patient receives services at
 189.29 the hospital or at the emergency department associated with the hospital.

189.30 Subd. 3. Charity care. (a) Upon completion of the screening process in subdivision 2,
 189.31 paragraph (c), the hospital must determine whether the patient is ineligible or potentially
 189.32 eligible for charity care. When a hospital evaluates a patient's eligibility for charity care,
 190.1 hospital requests to the responsible party for verification of assets or income shall be limited
 190.2 to:

171.13 (k) "Unreasonable burden" includes requiring a patient to apply for enrollment in a state
 171.14 or federal program for which the patient is obviously or categorically ineligible or has been
 171.15 found to be ineligible in the previous 12 months.

171.16 Subd. 2. Screening. A hospital must screen a patient who is uninsured or whose insurance
 171.17 coverage status is not known by the hospital for: eligibility for charity care from the hospital;
 171.18 eligibility for state or federal public health care programs using presumptive eligibility or
 171.19 another similar process; and eligibility for a premium tax credit. The hospital must attempt
 171.20 to complete this screening process in person or by telephone within 30 days after the patient
 171.21 receives services at the hospital or at the emergency department associated with the hospital.

171.22 Subd. 3. Charity care. (a) Upon completion of the screening process in subdivision 2,
 171.23 the hospital must either assist the patient with applying for charity care and refer the patient
 171.24 to the appropriate department in the hospital for follow-up or make a determination that the
 171.25 patient is ineligible for charity care. A hospital may initiate one or more of the following
 171.26 steps only after the hospital determines that the patient is ineligible for charity care and may
 171.27 not initiate any of the following steps while the patient's application for charity care is
 171.28 pending:

172.11 (c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to
 172.12 the responsible party for verification of assets or income shall be limited to:

190.3 (1) information that is reasonably necessary and readily available to determine eligibility;
 190.4 and
 190.5 (2) facts that are relevant to determine eligibility.
 190.6 A hospital must not demand duplicate forms of verification of assets.
 190.7 (b) If the patient is not ineligible for charity care, the hospital must assist the patient
 190.8 with applying for charity care and refer the patient to the appropriate department in the
 190.9 hospital for follow-up. A hospital may not impose application procedures for charity care
 190.10 that place an unreasonable burden on the individual patient, taking into account the individual
 190.11 patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may
 190.12 hinder the patient's ability to comply with application procedures.
 190.13 (c) A hospital may not initiate any of the actions described in subdivision 4 while the
 190.14 patient's application for charity care is pending.
 190.15 Subd. 4. Prohibited actions. A hospital must not initiate one or more of the following
 190.16 actions until the hospital determines that the patient is ineligible for charity care or denies
 190.17 an application for charity care:
 190.18 (1) offering to enroll or enrolling the patient in a payment plan;
 190.19 (2) changing the terms of a patient's payment plan;
 190.20 (3) offering the patient a loan or line of credit, application materials for a loan or line of
 190.21 credit, or assistance with applying for a loan or line of credit, for the payment of medical
 190.22 debt;
 190.23 (4) referring a patient's debt for collections, including in-house collections, third-party
 190.24 collections, revenue recapture, or any other process for the collection of debt;
 190.25 (5) denying health care services to the patient or any member of the patient's household
 190.26 because of outstanding medical debt, regardless of whether the services are deemed necessary
 190.27 or may be available from another provider; or
 190.28 (6) accepting a credit card payment of over \$500 for the medical debt owed to the hospital.
 190.29 Subd. 5. Notice. (a) A hospital must post notice of the availability of charity care from
 190.30 the hospital in at least the following locations: (1) areas of the hospital where patients are
 190.31 admitted or registered; (2) emergency departments; and (3) the portion of the hospital's
 190.32 financial services or billing department that is accessible to patients. The posted notice must
 191.1 be in all languages spoken by more than five percent of the population in the hospital's
 191.2 service area.
 191.3 (b) A hospital must make available on the hospital's website the current version of the
 191.4 hospital's charity care policy, a plain-language summary of the policy, and the hospital's

172.13 (1) information that is reasonably necessary and readily available to determine eligibility;
 172.14 and
 172.15 (2) facts that are relevant to determine eligibility.
 172.16 A hospital must not demand duplicate forms of verification of assets.
 172.7 (b) A hospital may not impose application procedures for charity care that place an
 172.8 unreasonable burden on the individual patient, taking into account the individual patient's
 172.9 physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder
 172.10 the patient's ability to comply with application procedures.
 171.29 (1) offering to enroll or enrolling the patient in a payment plan;
 171.30 (2) changing the terms of a patient's payment plan;
 171.31 (3) offering the patient a loan or line of credit, application materials for a loan or line of
 171.32 credit, or assistance with applying for a loan or line of credit, for the payment of medical
 171.33 debt;
 172.1 (4) referring a patient's debt for collections, including in-house collections, third-party
 172.2 collections, revenue recapture, or any other process for the collection of debt;
 172.3 (5) denying health care services to the patient or any member of the patient's household
 172.4 because of outstanding medical debt, regardless of whether the services are deemed necessary
 172.5 or may be available from another provider; or
 172.6 (6) accepting a credit card payment of over \$500 for the medical debt owed to the hospital.
 172.30 Subd. 6. Notice. (a) A hospital must post notice of the availability of charity care from
 172.31 the hospital in at least the following locations: (1) areas of the hospital where patients are
 172.32 admitted or registered; (2) emergency departments; and (3) the portion of the hospital's
 173.1 financial services or billing department that is accessible to patients. The posted notice must
 173.2 be in all languages spoken by more than five percent of the population in the hospital's
 173.3 service area.
 173.4 (b) A hospital must make available on the hospital's website, the current version of the
 173.5 hospital's charity care policy, a plain-language summary of the policy, and the hospital's

191.5 charity care application form. The summary and application form must be available in all
191.6 languages spoken by more than five percent of the population in the hospital's service area.

191.7 Subd. 6. Patient may decline services. A patient may decline to complete an insurance
191.8 affordability program application to schedule an appointment with a certified application
191.9 counselor, to schedule an appointment with a MNSure-certified navigator, to accept
191.10 information about navigator services, to participate in the charity care screening process,
191.11 or to apply for charity care.

191.12 Subd. 7. Enforcement. In addition to the enforcement of this section by the
191.13 commissioner, the attorney general may enforce this section under section 8.31.

191.14 EFFECTIVE DATE. This section is effective November 1, 2023, and applies to services
191.15 and treatments provided on or after that date.

191.16 Sec. 39. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

191.17 Subdivision 1. Requirement; action to collect medical debt or garnish wages or bank
191.18 accounts. (a) In an action against a patient or guarantor for collection of medical debt owed
191.19 to a hospital or for garnishment of the patient's or guarantor's wages or bank accounts to
191.20 collect medical debt owed to a hospital, the hospital must serve on the defendant with the
191.21 summons and complaint an affidavit of expert review certifying that:

191.22 (1) unless the patient declined to participate, the hospital complied with the requirements
191.23 in section 144.587;

191.24 (2) there is a reasonable basis to believe that the patient owes the debt;

191.25 (3) all known third-party payors have been properly billed by the hospital, such that any
191.26 remaining debt is the financial responsibility of the patient, and the hospital will not bill the
191.27 patient for any amount that an insurance company is obligated to pay;

191.28 (4) the patient has been given a reasonable opportunity to apply for charity care, if the
191.29 facts and circumstances suggest that the patient may be eligible for charity care;

191.30 (5) where the patient has indicated an inability to pay the full amount of the debt in one
191.31 payment and provided reasonable verification of the inability to pay the full amount of the

173.6 charity care application form. The summary and application form must be available in all
173.7 languages spoken by more than five percent of the population in the hospital's service area.

172.17 Subd. 4. Public health care program; premium tax credit. (a) If a patient is
172.18 presumptively eligible for a public health care program, the hospital must assist the patient
172.19 in completing an insurance affordability program application, help the patient schedule an
172.20 appointment with a navigator organization, or provide the patient with contact information
172.21 for the nearest available navigator or certified application counselor services.

172.22 (b) If a patient is eligible for a premium tax credit, the hospital may schedule an
172.23 appointment for the patient with a navigator or a MNSure-certified insurance broker
172.24 organization or provide the patient with contact information for the nearest available navigator
172.25 services or a MNSure-certified insurance broker.

172.26 Subd. 5. Patient may decline services. A patient may decline to participate in the
172.27 screening process, to apply for charity care, to complete an insurance affordability program
172.28 application, to schedule an appointment with a navigator organization, or to accept
172.29 information about navigator services.

173.8 EFFECTIVE DATE. This section is effective November 1, 2023.

173.9 Sec. 74. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

192.1 debt in one payment if requested by the hospital, the hospital has offered the patient a
192.2 reasonable payment plan;

192.3 (6) there is no reasonable basis to believe that the patient's or guarantor's wages or funds
192.4 at a financial institution are likely to be exempt from garnishment; and

192.5 (7) in the case of a default judgment proceeding, there is not a reasonable basis to believe:

192.6 (i) that the patient may already consider that the patient has adequately answered the
192.7 complaint by calling or writing to the hospital, its debt collection agency, or its attorney;

192.8 (ii) that the patient is potentially unable to answer the complaint due to age, disability,
192.9 or medical condition; or

192.10 (iii) the patient may not have received service of the complaint.

192.11 (b) The affidavit of expert review must be completed by a designated employee of the
192.12 hospital seeking to initiate the action or garnishment.

192.13 Subd. 2. Requirement; referral to third-party debt collection agency. (a) In order to
192.14 refer a patient's account to a third-party debt collection agency, a hospital must complete
192.15 an affidavit of expert review certifying that:

192.16 (1) unless the patient declined to participate, the hospital complied with the requirements
192.17 in section 144.587;

192.18 (2) there is a reasonable basis to believe that the patient owes the debt;

192.19 (3) all known third-party payors have been properly billed by the hospital, such that any
192.20 remaining debt is the financial responsibility of the patient, and the hospital will not bill the
192.21 patient for any amount that an insurance company is obligated to pay;

192.22 (4) the patient has been given a reasonable opportunity to apply for charity care, if the
192.23 facts and circumstances suggest that the patient may be eligible for charity care; and

192.24 (5) where the patient has indicated an inability to pay the full amount of the debt in one
192.25 payment and provided reasonable verification of the inability to pay the full amount of the
192.26 debt in one payment if requested by the hospital, the hospital has offered the patient a
192.27 reasonable payment plan.

192.28 (b) The affidavit of expert review must be completed by a designated employee of the
192.29 hospital seeking to refer the patient's account to a third-party debt collection agency.

173.10 Subdivision 1. Requirement; referral to third-party debt collection agency. (a) In
173.11 order to refer a patient's account to a third-party debt collection agency, a hospital must
173.12 complete an affidavit of expert review certifying that the hospital:

173.13 (1) confirmed the information required of the hospital in the most recent version of the
173.14 Minnesota attorney general/hospital agreement for referral of a specific patient's account
173.15 to a third-party debt collection agency; and

173.16 (2) unless the patient declined to participate, complied with the requirements in section
173.17 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for
173.18 charity care, assist the patient with completing an insurance affordability program application,
173.19 or refer the patient to a navigator organization.

173.20 (b) The affidavit of expert review must be completed by a designated employee of the
173.21 hospital seeking to refer the patient's account to a third-party debt collection agency.

192.30 **Subd. 3. Penalty for noncompliance.** Failure to comply with subdivision 1 shall result,
 192.31 upon motion, in mandatory dismissal with prejudice of the action to collect the medical
 193.1 debt or to garnish the patient's or guarantor's wages or bank accounts. Failure to comply
 193.2 with subdivision 2 shall subject a hospital to a fine assessed by the commissioner of health.
 193.3 In addition to the enforcement of this section by the commissioner, the attorney general
 193.4 may enforce this section under section 8.31.

193.5 **Subd. 4. Collection agency; immunity.** A collection agency, as defined in section
 193.6 332.31, subdivision 3, is not liable under section 144.588, subdivision 3, for inaccuracies
 193.7 in an affidavit of expert review completed by a designated employee of the hospital.

193.8 **EFFECTIVE DATE.** This section is effective November 1, 2023, and applies to actions
 193.9 and referrals to third-party debt collection agencies stemming from services and treatments
 193.10 provided on or after that date.

193.11 **Sec. 40. [144.589] BILLING OF UNINSURED PATIENTS.**

193.12 **Subdivision 1. Limits on charges.** A hospital must not charge a patient whose annual
 193.13 household income is less than \$125,000 for any uninsured service or treatment in an amount
 193.14 that exceeds the lowest total amount the provider would be reimbursed for that service or
 193.15 treatment from a nongovernmental third-party payor. The lowest total amount the provider
 193.16 would be reimbursed for that service or treatment from a nongovernmental third-party payor
 193.17 includes both the amount the provider would be reimbursed directly from the
 193.18 nongovernmental third-party payor and the amount the provider would be reimbursed from
 193.19 the insured's policyholder under any applicable co-payments, deductibles, and coinsurance.
 193.20 This statute supersedes the language in the Minnesota Attorney General Hospital Agreement.

193.21 **Subd. 2. Enforcement.** In addition to the enforcement of this section by the
 193.22 commissioner, the attorney general may enforce this section under section 8.31.

193.23 **EFFECTIVE DATE.** This section is effective November 1, 2023, and applies to services
 193.24 and treatments provided on or after that date.

173.22 **Subd. 2. Penalty for noncompliance.** Failure to comply with subdivision 1 shall subject
 173.23 a hospital to a fine assessed by the commissioner of health.

173.24 **EFFECTIVE DATE.** This section is effective November 1, 2023.

173.25 **Sec. 75. [144.589] BILLING OF UNINSURED PATIENTS.**

173.26 A hospital shall not charge a patient whose annual household income is less than \$125,000
 173.27 for any uninsured service or treatment in an amount that exceeds the total amount the
 173.28 provider would be reimbursed for that service or treatment from its most favored insurer.
 173.29 The total amount the provider would be reimbursed for that service or treatment from its
 173.30 most favored insurer includes both the amount the provider would be reimbursed directly
 174.1 from its most favored insurer, and the amount the provider would be reimbursed from the
 174.2 insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

174.3 **EFFECTIVE DATE.** This section is effective November 1, 2023.

FOR SECTION 77, SEE ARTICLE 2, HEALTH INSURANCE

182.18 **Sec. 78. Minnesota Statutes 2022, section 144.615, subdivision 7, is amended to read:**

182.19 **Subd. 7. Limitations of services.** (a) The following limitations apply to the services
 182.20 performed at a birth center:

182.21 (1) surgical procedures must be limited to those normally accomplished during an
 182.22 uncomplicated birth, including episiotomy and repair; and

182.23 (2) no abortions may be administered; and

182.24 (3) (2) no general or regional anesthesia may be administered.

182.25 (b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center
182.26 if the administration of the anesthetic is performed within the scope of practice of a health
182.27 care professional.

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

193.25 Sec. 41. **[144.645] SUPPORTING HEALTHY DEVELOPMENT OF BABIES GRANT**

193.26 **PROGRAM.**

193.27 Subdivision 1. **Establishment.** The commissioner of health must establish a grant
193.28 program to support healthy development of babies. Grant proceeds must be used for
193.29 community-driven training and education on best practices for supporting healthy
193.30 development of babies during pregnancy and postpartum. The grant money must be used
193.31 to build capacity in, train, educate, or improve practices among individuals, from youth to
194.1 elders, serving families with members who are Black, Indigenous, or People of Color during
194.2 pregnancy and postpartum.

194.3 Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants
194.4 must be a nonprofit organization. A nonprofit organization seeking a grant under this section
194.5 must apply to the commissioner at a time and in a manner specified by the commissioner.
194.6 The commissioner shall review each application to determine if the application is complete,
194.7 the nonprofit organization is eligible for a grant, and the proposed project is an allowable
194.8 use of grant funds. The commissioner must determine the grant amount awarded to applicants
194.9 that the commissioner determines will receive a grant.

194.10 Sec. 42. **[144.6504] ALZHEIMER'S DISEASE AND DEMENTIA CARE TRAINING**

194.11 **PROGRAM.**

194.12 (a) The commissioner of health, in collaboration with interested stakeholders, shall
194.13 develop and provide a training program for community health workers on recognizing and
194.14 understanding Alzheimer's disease and dementia. The training program may be conducted
194.15 either virtually or in person and must, at a minimum, include instruction on:

194.16 (1) recognizing the common warning signs of Alzheimer's disease and dementia;
194.17 (2) understanding how Alzheimer's disease and dementia affect communication and
194.18 behavior;
194.19 (3) recognizing potential safety risks for individuals living with dementia, including the
194.20 risks of wandering and elder abuse; and
194.21 (4) identifying appropriate techniques to communicate with individuals living with
194.22 dementia and how to appropriately respond to dementia-related behaviors.
194.23 (b) The commissioner shall work with the Minnesota State Colleges and University
194.24 System (MNSCU) to explore the possibility of including a training program that meets the

194.25 requirements of this section to the MNSCU-approved community health worker certification
 194.26 program.

194.27 (c) Notwithstanding paragraph (a), if a training program already exists that meets the
 194.28 requirements of this section, the commissioner may approve the existing training program
 194.29 or programs instead of developing a new program, and, in collaboration with interested
 194.30 stakeholders, ensure that the approved training program or programs are available to all
 194.31 community health workers.

195.1 Sec. 43. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision
 195.2 to read:

195.3 Subd. 10a. **Designated support person for pregnant patient.** (a) Subject to paragraph
 195.4 (c), a health care provider and a health care facility must allow, at a minimum, one designated
 195.5 support person of a pregnant patient's choosing to be physically present while the patient
 195.6 is receiving health care services including during a hospital stay.

195.7 (b) For purposes of this subdivision, "designated support person" means any person
 195.8 chosen by the patient to provide comfort to the patient including but not limited to the
 195.9 patient's spouse, partner, family member, or another person related by affinity. Certified
 195.10 doula and traditional midwives may not be counted toward the limit of one designated
 195.11 support person.

195.12 (c) A facility may restrict or prohibit the presence of a designated support person in
 195.13 treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition
 195.14 is strictly necessary to meet the appropriate standard of care. A facility may also restrict or
 195.15 prohibit the presence of a designated support person if the designated support person is
 195.16 acting in a violent or threatening manner towards others. Any restriction or prohibition of
 195.17 a designated support person by the facility is subject to the facility's written internal grievance
 195.18 procedure required by subdivision 20.

183.1 Sec. 79. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision
 183.2 to read:

183.3 Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider
 183.4 and a health care facility must allow, at a minimum, one designated support person of a
 183.5 pregnant patient's choosing to be physically present while the patient is receiving health
 183.6 care services including during a hospital stay.

183.7 (b) For purposes of this subdivision, "designated support person" means any person
 183.8 necessary to provide comfort to the patient including but not limited to the patient's spouse,
 183.9 partner, family member, or another person related by affinity. Certified doula and traditional
 183.10 midwives may not be counted toward the limit of one designated support person.

FOR SECTION 80, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

183.19 Sec. 81. Minnesota Statutes 2022, section 144.6535, subdivision 1, is amended to read:

183.20 Subdivision 1. **Request for variance or waiver.** A hospital may request that the
 183.21 commissioner grant a variance or waiver from the provisions of Minnesota Rules, chapter
 183.22 4640 or 4645 section 144.55, subdivision 3, paragraph (b). A request for a variance or waiver
 183.23 must be submitted to the commissioner in writing. Each request must contain:

- 183.24 (1) the specific rule or rules requirement for which the variance or waiver is requested;
- 183.25 (2) the reasons for the request;
- 183.26 (3) the alternative measures that will be taken if a variance or waiver is granted;
- 183.27 (4) the length of time for which the variance or waiver is requested; and

183.28 (5) other relevant information deemed necessary by the commissioner to properly evaluate
183.29 the request for the variance or waiver.

183.30 **EFFECTIVE DATE.** This section is effective January 1, 2024.

184.1 Sec. 82. Minnesota Statutes 2022, section 144.6535, subdivision 2, is amended to read:

184.2 Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver
184.3 must be based on the commissioner's evaluation of the following criteria:

184.4 (1) whether the variance or waiver will adversely affect the health, treatment, comfort,
184.5 safety, or well-being of a patient;

184.6 (2) whether the alternative measures to be taken, if any, are equivalent to or superior to
184.7 those prescribed in Minnesota Rules, chapter 4640 or 4645 section 144.55, subdivision 3,
184.8 paragraph (b); and

184.9 (3) whether compliance with the rule or rules requirements would impose an undue
184.10 burden upon the applicant.

184.11 **EFFECTIVE DATE.** This section is effective January 1, 2024.

184.12 Sec. 83. Minnesota Statutes 2022, section 144.6535, subdivision 4, is amended to read:

184.13 Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or
184.14 conditions attached to a variance or waiver have the same force and effect as the rules
184.15 requirement under Minnesota Rules, chapter 4640 or 4645 section 144.55, subdivision 3,
184.16 paragraph (b), and are subject to the issuance of correction orders and penalty assessments
184.17 in accordance with section 144.55.

184.18 (b) Fines for a violation of this section shall be in the same amount as that specified for
184.19 the particular rule requirement for which the variance or waiver was requested.

184.20 **EFFECTIVE DATE.** This section is effective January 1, 2024.

184.21 Sec. 84. Minnesota Statutes 2022, section 144.69, is amended to read:

184.22 **144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.**

184.23 **Subdivision 1. Data collected by the cancer reporting system.** Notwithstanding any
184.24 law to the contrary, including section 13.05, subdivision 9, data collected on individuals by
184.25 the cancer surveillance reporting system, including the names and personal identifiers of
184.26 persons required in section 144.68 to report, shall be private and may only be used for the
184.27 purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure
184.28 other than is provided for in this section and sections 144.671, 144.672, and 144.68, is
184.29 declared to be a misdemeanor and punishable as such. Except as provided by rule, and as
184.30 part of an epidemiologic investigation, an officer or employee of the commissioner of health
184.31 may interview patients named in any such report, or relatives of any such patient, only after
185.1 the consent of notifying the attending physician, advanced practice registered nurse, physician

195.19 Sec. 44. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:
195.20 Subd. 9. **Elevated blood lead level.** "Elevated blood lead level" means a diagnostic
195.21 blood lead test with a result that is equal to or greater than ten 3.5 micrograms of lead per
195.22 deciliter of whole blood in any person, unless the commissioner finds that a lower
195.23 concentration is necessary to protect public health.

185.2 assistant, or surgeon is obtained. Research protections for patients must be consistent with
185.3 section 13.04, subdivision 2, and Code of Federal Regulations, title 45, part 46.

185.4 Subd. 2. Transfers of information to state cancer registries and federal government
185.5 agencies. (a) Information containing personal identifiers of a non-Minnesota resident
185.6 collected by the cancer reporting system may be provided to the statewide cancer registry
185.7 of the nonresident's home state solely for the purposes consistent with this section and
185.8 sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the
185.9 classification of the information as provided under subdivision 1.

185.10 (b) Information, excluding direct identifiers such as name, Social Security number,
185.11 telephone number, and street address, collected by the cancer reporting system may be
185.12 provided to the Centers for Disease Control and Prevention's National Program of Cancer
185.13 Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results
185.14 Program registry.

FOR SECTIONS 85 TO 93, SEE ARTICLE 3, KEEPING NURSES AT THE
BEDSIDE

198.13 Sec. 94. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

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

198.18 Sec. 95. Minnesota Statutes 2022, section 144.9501, subdivision 17, is amended to read:

198.19 Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab
198.20 team services, or interim controls undertaken to make a residence, child care facility, school,
198.21 playground, or other location where lead hazards are identified lead-safe by complying with
198.22 the lead standards and methods adopted under section 144.9508.

198.23 (b) Lead hazard reduction does not include renovation activity that is primarily intended
198.24 to remodel, repair, or restore a given structure or dwelling rather than abate or control
198.25 lead-based paint hazards.

198.26 (c) Lead hazard reduction does not include activities that disturb painted surfaces that
198.27 total:

198.28 (1) less than 20 square feet (two square meters) on exterior surfaces; or
198.29 (2) less than two square feet (0.2 square meters) in an interior room.

199.1 Sec. 96. Minnesota Statutes 2022, section 144.9501, subdivision 26a, is amended to read:

199.2 Subd. 26a. **Regulated lead work.** (a) "Regulated lead work" means:

199.3 (1) abatement;

199.4 (2) interim controls;
199.5 (3) a clearance inspection;
199.6 (4) a lead hazard screen;
199.7 (5) a lead inspection;
199.8 (6) a lead risk assessment;
199.9 (7) lead project designer services;
199.10 (8) lead sampling technician services;
199.11 (9) swab team services;
199.12 (10) renovation activities; or
199.13 (11) lead hazard reduction; or
199.14 (11) (12) activities performed to comply with lead orders issued by a community health
199.15 board or assessing agency.
199.16 (b) Regulated lead work does not include abatement, interim controls, swab team services,
199.17 or renovation activities that disturb painted surfaces that total no more than:
199.18 (1) 20 square feet (two square meters) on exterior surfaces; or
199.19 (2) six square feet (0.6 square meters) in an interior room.
199.20 Sec. 97. Minnesota Statutes 2022, section 144.9501, subdivision 26b, is amended to read:
199.21 Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978
199.22 affected property for compensation that results in the disturbance of known or presumed
199.23 lead-containing painted surfaces defined under section 144.9508, unless that activity is
199.24 performed as lead hazard reduction. A renovation performed for the purpose of converting
199.25 a building or part of a building into an affected property is a renovation under this
199.26 subdivision.
199.27 (b) Renovation does not include minor repair and maintenance activities described in
199.28 this paragraph. All activities that disturb painted surfaces and are performed within 30 days
199.29 of other activities that disturb painted surfaces in the same room must be considered a single
200.1 project when applying the criteria below. Unless the activity involves window replacement
200.2 or demolition of a painted surface, building component, or portion of a structure, for purposes
200.3 of this paragraph, "minor repair and maintenance" means activities that disturb painted
200.4 surfaces totaling:
200.5 (1) less than 20 square feet (two square meters) on exterior surfaces; or
200.6 (2) less than six square feet (0.6 square meters) in an interior room.

200.7 (c) Renovation does not include total demolition of a freestanding structure. For purposes
200.8 of this paragraph, "total demolition" means demolition and disposal of all interior and
200.9 exterior painted surfaces, including windows. Unpainted foundation building components
200.10 remaining after total demolition may be reused.

200.11 Sec. 98. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision
200.12 to read:

200.13 Subd. 33. Compensation. "Compensation" means money or other mutually agreed upon
200.14 form of payment given or received for regulated lead work, including rental payments,
200.15 rental income, or salaries derived from rental payments.

200.16 Sec. 99. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision
200.17 to read:

200.18 Subd. 34. Individual. "Individual" means a natural person.

200.19 Sec. 100. Minnesota Statutes 2022, section 144.9505, subdivision 1, is amended to read:

200.20 Subdivision 1. Licensing, certification, and permitting. (a) Fees collected under this
200.21 section shall be deposited into the state treasury and credited to the state government special
200.22 revenue fund.

200.23 (b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead
200.24 workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers,
200.25 renovation firms, or lead firms unless they have licenses or certificates issued by the
200.26 commissioner under this section.

200.27 (c) The fees required in this section for inspectors, risk assessors, and certified lead firms
200.28 are waived for state or local government employees performing services for or as an assessing
200.29 agency.

200.30 (d) An individual who is the owner of property on which regulated lead work is to be
200.31 performed or an adult individual who is related to the property owner, as defined under
201.1 section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and
201.2 pay a fee according to this section. Individual residential property owners who perform
201.3 regulated lead work on their own residence are exempt from the licensure and firm
201.4 certification requirements of this section. Notwithstanding the provisions of paragraphs (a)
201.5 to (c), this exemption does not apply when the regulated lead work is a renovation performed
201.6 for compensation, when a child with an elevated blood level has been identified in the
201.7 residence or the building in which the residence is located, or when the residence is occupied
201.8 by one or more individuals who are not related to the property owner, as defined under
201.9 section 245A.02, subdivision 13.

201.10 (e) A person that employs individuals to perform regulated lead work outside of the
201.11 person's property must obtain certification as a certified lead firm. An individual who
201.12 performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments,
201.13 clearance inspections, lead project designer services, lead sampling technician services,

201.14 ~~swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm, unless the individual is a sole proprietor and does not employ any other individuals, the individual is employed by a person that does not perform regulated lead work outside of the person's property, or the individual is employed by an assessing agency.~~

201.19 Sec. 101. Minnesota Statutes 2022, section 144.9505, subdivision 1g, is amended to read:

201.20 Subd. 1g. **Certified lead firm.** A person who performs or employs individuals to perform regulated lead work, with the exception of renovation, ~~outside of the person's property~~ must obtain certification as a lead firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A lead firm certificate is valid for one year. The certification fee is \$100, is nonrefundable, and must be submitted with each application. The lead firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

201.29 Sec. 102. Minnesota Statutes 2022, section 144.9505, subdivision 1h, is amended to read:

201.30 Subd. 1h. **Certified renovation firm.** A person who performs or employs individuals to perform renovation activities ~~outside of the person's property~~ for compensation must obtain certification as a renovation firm. The certificate must be in writing, contain an expiration date, be signed by the commissioner, and give the name and address of the person to whom it is issued. A renovation firm certificate is valid for two years. The certification fee is \$100, is nonrefundable, and must be submitted with each application. The renovation firm certificate or a copy of the certificate must be readily available at the worksite for review by the contracting entity, the commissioner, and other public health officials charged with the health, safety, and welfare of the state's citizens.

202.6 Sec. 103. Minnesota Statutes 2022, section 144.9508, subdivision 2, is amended to read:

202.7 Subd. 2. **Regulated lead work standards and methods.** (a) The commissioner shall adopt rules establishing regulated lead work standards and methods in accordance with the provisions of this section, for lead in paint, dust, drinking water, and soil in a manner that protects public health and the environment for all residences, including residences also used for a commercial purpose, child care facilities, playgrounds, and schools.

202.12 (b) In the rules required by this section, the commissioner shall require lead hazard reduction of intact paint only if the commissioner finds that the intact paint is on a chewable or lead-dust producing surface that is a known source of actual lead exposure to a specific individual. The commissioner shall prohibit methods that disperse lead dust into the air that could accumulate to a level that would exceed the lead dust standard specified under this section. The commissioner shall work cooperatively with the commissioner of administration to determine which lead hazard reduction methods adopted under this section may be used for lead-safe practices including prohibited practices, preparation, disposal, and cleanup.

202.20 The commissioner shall work cooperatively with the commissioner of the Pollution Control
202.21 Agency to develop disposal procedures. In adopting rules under this section, the
202.22 commissioner shall require the best available technology for regulated lead work methods,
202.23 paint stabilization, and repainting.

202.24 (c) The commissioner of health shall adopt regulated lead work standards and methods
202.25 for lead in bare soil in a manner to protect public health and the environment. The
202.26 commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil.
202.27 The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per
202.28 million. Soil lead hazard reduction methods shall focus on erosion control and covering of
202.29 bare soil.

202.30 (d) The commissioner shall adopt regulated lead work standards and methods for lead
202.31 in dust in a manner to protect the public health and environment. Dust standards shall use
202.32 a weight of lead per area measure and include dust on the floor, on the window sills, and
202.33 on window wells. Lead hazard reduction methods for dust shall focus on dust removal and
202.34 other practices which minimize the formation of lead dust from paint, soil, or other sources.

203.1 (e) The commissioner shall adopt lead hazard reduction standards and methods for lead
203.2 in drinking water both at the tap and public water supply system or private well in a manner
203.3 to protect the public health and the environment. The commissioner may adopt the rules
203.4 for controlling lead in drinking water as contained in Code of Federal Regulations, title 40,
203.5 part 141. Drinking water lead hazard reduction methods may include an educational approach
203.6 of minimizing lead exposure from lead in drinking water.

203.7 (f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that
203.8 removal of exterior lead-based coatings from residences and steel structures by abrasive
203.9 blasting methods is conducted in a manner that protects health and the environment.

203.10 (g) All regulated lead work standards shall provide reasonable margins of safety that
203.11 are consistent with more than a summary review of scientific evidence and an emphasis on
203.12 overprotection rather than underprotection when the scientific evidence is ambiguous.

203.13 (h) No unit of local government shall have an ordinance or regulation governing regulated
203.14 lead work standards or methods for lead in paint, dust, drinking water, or soil that require
203.15 a different regulated lead work standard or method than the standards or methods established
203.16 under this section.

203.17 (i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of
203.18 local government of an innovative lead hazard reduction method which is consistent in
203.19 approach with methods established under this section.

203.20 (j) The commissioner shall adopt rules for issuing lead orders required under section
203.21 144.9504, rules for notification of abatement or interim control activities requirements, and
203.22 other rules necessary to implement sections 144.9501 to 144.9512.

195.24 Sec. 45. **[144.9821] ADVANCING HEALTH EQUITY THROUGH CAPACITY**
 195.25 **BUILDING AND RESOURCE ALLOCATION.**

195.26 Subdivision 1. **Establishment of grant program.** (a) The commissioner of health shall
 195.27 establish an annual grant program to award infrastructure capacity building grants to help
 195.28 metro and rural community and faith-based organizations serving people of color, American
 195.29 Indians, LGBTQIA+ people, and people with disabilities in Minnesota who have been
 195.30 disproportionately impacted by health and other inequities to be better equipped and prepared
 195.31 for success in procuring grants and contracts at the department and addressing inequities.

196.1 (b) The commissioner of health shall create a framework at the department to maintain
 196.2 equitable practices in grantmaking to ensure that internal grantmaking and procurement
 196.3 policies and practices prioritize equity, transparency, and accessibility to include:

196.4 (1) a tracking system for the department to better monitor and evaluate equitable
 196.5 procurement and grantmaking processes and their impacts; and
 196.6 (2) technical assistance and coaching to department leadership in grantmaking and
 196.7 procurement processes and programs and providing tools and guidance to ensure equitable
 196.8 and transparent competitive grantmaking processes and award distribution across
 196.9 communities most impacted by inequities and develop measures to track progress over time.

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

196.11 (1) in consultation with community stakeholders, community health boards and Tribal
 196.12 nations, develop a request for proposals for infrastructure capacity building grant program
 196.13 to help community-based organizations, including faith-based organizations, to be better
 196.14 equipped and prepared for success in procuring grants and contracts at the department and
 196.15 beyond;

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

203.23 (k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic
 203.24 Substances Control Act and all regulations adopted thereunder to ensure that renovation in
 203.25 a pre-1978 affected property where a child or pregnant female resides is conducted in a
 203.26 manner that protects health and the environment. Notwithstanding sections 14.125 and
 203.27 14.128, the authority to adopt these rules does not expire.

203.28 (l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the
 203.29 Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority
 203.30 to adopt these rules does not expire.

268.3 Sec. 181. **ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING**
 268.4 **AND RESOURCE ALLOCATION.**

268.5 Subdivision 1. **Establishment of grant program.** The commissioner of health shall:
 268.6 (1) establish an annual grant program to award infrastructure capacity building grants
 268.7 to help metro and rural community and faith-based organizations serving populations of
 268.8 color, American Indians, LGBTQIA+ communities, and those with disabilities in Minnesota
 268.9 who have been disproportionately impacted by health and other inequities to be better
 268.10 equipped and prepared for success in procuring grants and contracts at the department and
 268.11 addressing inequities; and

268.12 (2) create a framework at the department to maintain equitable practices in grantmaking
 268.13 to ensure that internal grantmaking and procurement policies and practices prioritize equity,
 268.14 transparency, and accessibility to include:

268.15 (i) a tracking system for the department to better monitor and evaluate equitable
 268.16 procurement and grantmaking processes and their impacts; and

268.17 (ii) technical assistance and coaching to department leadership in grantmaking and
 268.18 procurement processes and programs and providing tools and guidance to ensure equitable
 268.19 and transparent competitive grantmaking processes and award distribution across
 268.20 communities most impacted by inequities and develop measures to track progress over time.

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

268.22 (1) in consultation with community stakeholders, community health boards, and Tribal
 268.23 nations, develop a request for proposals for an infrastructure capacity building grant program
 268.24 to help community-based organizations, including faith-based organizations, to be better
 268.25 equipped and prepared for success in procuring grants and contracts at the department and
 268.26 beyond;

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

196.20 (3) in consultation with community stakeholders, review responses to requests for
 196.21 proposals and award grants under this section;

196.22 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
 196.23 Minnesota Council on Disability, Minnesota Commission of the Deaf, Deafblind, and Hard
 196.24 of Hearing, and the governor's office on the request for proposal process;

196.25 (5) in consultation with community stakeholders, establish a transparent and objective
 196.26 accountability process focused on outcomes that grantees agree to achieve;

196.27 (6) maintain data on outcomes reported by grantees; and

196.28 (7) establish a process or mechanism to evaluate the success of the capacity building
 196.29 grant program and to build the evidence base for effective community-based organizational
 196.30 capacity building in reducing disparities.

196.31 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
 196.32 section include: organizations or entities that work with diverse communities such as populations
 197.1 of color, American Indian, LGBTQIA+, and those with disabilities in metro and rural
 197.2 communities.

197.3 Subd. 4. **Strategic consideration and priority of proposals; eligible populations;**
 197.4 **grant awards.** (a) The commissioner, in consultation with community stakeholders, shall
 197.5 develop a request for proposals for equity in procurement and grantmaking capacity building
 197.6 grant program to help community-based organizations, including faith-based organizations
 197.7 to be better equipped and prepared for success in procuring grants and contracts at the
 197.8 department and addressing inequities.

197.9 (b) In awarding the grants, the commissioner shall provide strategic consideration and
 197.10 give priority to proposals from organizations or entities led by populations of color, American
 197.11 Indians and those serving communities of color, American Indians, LGBTQIA+, and
 197.12 disability communities.

197.13 Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant
 197.14 funds are prioritized and awarded to organizations and entities that are within counties that
 197.15 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,
 197.16 and disability communities to the extent possible.

197.17 Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on
 197.18 the forms and according to the timelines established by the commissioner.

197.19 Sec. 46. **[144.9981] CLIMATE RESILIENCY.**

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

197.22 (1) increase awareness of climate change;

268.31 (3) in consultation with community stakeholders, review responses to requests for
 268.32 proposals and award grants under this section;

269.1 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,
 269.2 Minnesota Council on Disability, Minnesota Commission of the Deaf, Deafblind, and Hard
 269.3 of Hearing, and the governor's office on the request for proposal process;

269.4 (5) in consultation with community stakeholders, establish a transparent and objective
 269.5 accountability process focused on outcomes that grantees agree to achieve;

269.6 (6) maintain data on outcomes reported by grantees; and

269.7 (7) establish a process or mechanism to evaluate the success of the capacity building
 269.8 grant program and to build the evidence base for effective community-based organizational
 269.9 capacity building in reducing disparities.

269.10 Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this
 269.11 section include: organizations or entities that work with diverse communities such as
 269.12 populations of color, American Indians, LGBTQIA+ communities, and those with disabilities
 269.13 in metro and rural communities.

269.14 Subd. 4. **Strategic consideration and priority of proposals; eligible populations;**
 269.15 **grant awards.** (a) The commissioner, in consultation with community stakeholders, shall
 269.16 develop a request for proposals for equity in procurement and grantmaking capacity building
 269.17 grant program to help community-based organizations, including faith-based organizations
 269.18 to be better equipped and prepared for success in procuring grants and contracts at the
 269.19 department and addressing inequities.

269.20 (b) In awarding the grants, the commissioner shall provide strategic consideration and
 269.21 give priority to proposals from organizations or entities led by populations of color or
 269.22 American Indians, and those serving communities of color, American Indians, LGBTQIA+
 269.23 communities, and disability communities.

269.24 Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant
 269.25 funds are prioritized and awarded to organizations and entities that are within counties that
 269.26 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,
 269.27 and disability communities to the extent possible.

269.28 Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on
 269.29 the forms and according to the timelines established by the commissioner.

269.30 Sec. 182. **CLIMATE RESILIENCY.**

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

270.1 (1) increase awareness of climate change;

197.23 (2) track the public health impacts of climate change and extreme weather events;

197.24 (3) provide technical assistance and tools that support climate resiliency to local public

197.25 health, Tribal health, soil and water conservation districts, and other local governmental

197.26 and nongovernmental organizations; and

197.27 (4) coordinate with the commissioners of the pollution control agency, natural resources,

197.28 and agriculture and other state agencies in climate resiliency related planning and

197.29 implementation.

197.30 Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage

197.31 a grant program for the purpose of climate resiliency planning. The commissioner shall

197.32 award grants through a request for proposals process to local public health, Tribal health,

198.1 soil and water conservation districts, or other local organizations for planning for the health

198.2 impacts of extreme weather events and developing adaptation actions. Priority shall be given

198.3 to organizations that serve communities that are disproportionately impacted by climate

198.4 change.

198.5 (b) Grantees must use the funds to develop a plan or implement strategies that will reduce

198.6 the risk of health impacts from extreme weather events. The grant application must include:

198.7 (1) a description of the plan or project for which the grant funds will be used;

198.8 (2) a description of the pathway between the plan or project and its impacts on health;

198.9 (3) a description of the objectives, a work plan, and a timeline for implementation; and

198.10 (4) the community or group the grant proposes to focus on.

270.2 (2) track the public health impacts of climate change and extreme weather events;

270.3 (3) provide technical assistance and tools that support climate resiliency to local public

270.4 health departments, Tribal health departments, soil and water conservation districts, and

270.5 other local governmental and nongovernmental organizations; and

270.6 (4) coordinate with the commissioners of the Pollution Control Agency, natural resources,

270.7 and agriculture and other state agencies in climate resiliency related planning and

270.8 implementation.

270.9 Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage

270.10 a grant program for the purpose of climate resiliency planning. The commissioner shall

270.11 award grants through a request for proposals process to local public health departments,

270.12 Tribal health departments, soil and water conservation districts, or other local organizations

270.13 for planning for the health impacts of extreme weather events and developing adaptation

270.14 actions. Priority shall be given to organizations that serve communities that are

270.15 disproportionately impacted by climate change.

270.16 (b) Grantees must use the funds to develop a plan or implement strategies that will reduce

270.17 the risk of health impacts from extreme weather events. The grant application must include:

270.18 (1) a description of the plan or project for which the grant funds will be used;

270.19 (2) a description of the pathway between the plan or project and its impacts on health;

270.20 (3) a description of the objectives, a work plan, and a timeline for implementation; and

270.21 (4) the community or group on which the grant proposes to focus.

203.31 Sec. 104. Minnesota Statutes 2022, section 144A.06, subdivision 2, is amended to read:

203.32 Subd. 2. **New license required; change of ownership.** (a) The commissioner of health

203.33 by rule shall prescribe procedures for licensure under this section.

204.1 (b) A new license is required and the prospective licensee must apply for a license prior

204.2 to operating a currently licensed nursing home. The licensee must change whenever one of

204.3 the following events occur:

204.4 (1) the form of the licensee's legal entity structure is converted or changed to a different

204.5 type of legal entity structure;

204.6 (2) the licensee dissolves, consolidates, or merges with another legal organization and

204.7 the licensee's legal organization does not survive;

204.8 (3) within the previous 24 months, 50 percent or more of the licensee's ownership interest

204.9 is transferred, whether by a single transaction or multiple transactions to:

204.10 (i) a different person or multiple different persons; or

204.11 (ii) a person or multiple persons who had less than a five percent ownership interest in
204.12 the facility at the time of the first transaction; or

204.13 (4) any other event or combination of events that results in a substitution, elimination,
204.14 or withdrawal of the licensee's responsibility for the facility.

204.15 Sec. 105. Minnesota Statutes 2022, section 144A.071, subdivision 2, is amended to read:

204.16 Subd. 2. **Moratorium.** (a) The commissioner of health, in coordination with the
204.17 commissioner of human services, shall deny each request for new licensed or certified
204.18 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or
204.19 section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified
204.20 by the commissioner of health for the purposes of the medical assistance program, under
204.21 United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not
204.22 allow medical assistance intake shall be deemed to be decertified for purposes of this section
204.23 only.

204.24 (b) The commissioner of human services, in coordination with the commissioner of
204.25 health, shall deny any request to issue a license under section 252.28 and chapter 245A to
204.26 a nursing home or boarding care home, if that license would result in an increase in the
204.27 medical assistance reimbursement amount.

204.28 (c) In addition, the commissioner of health must not approve any construction project
204.29 whose cost exceeds \$1,000,000, unless:

204.30 (1) any construction costs exceeding \$1,000,000 are not added to the facility's
204.31 appraised value and are not included in the facility's payment rate for reimbursement under
204.32 the medical assistance program; or

205.1 (2) the project:

205.2 (1) has been approved through the process described in section 144A.073;

205.3 (2) meets an exception in subdivision 3 or 4a;

205.4 (3) is necessary to correct violations of state or federal law issued by the
205.5 commissioner of health;

205.6 (4) is necessary to repair or replace a portion of the facility that was damaged by
205.7 fire, lightning, ground shifts, or other such hazards, including environmental hazards,
205.8 provided that the provisions of subdivision 4a, clause (a), are met; or

205.9 (5) is being proposed by a licensed nursing facility that is not certified to participate
205.10 in the medical assistance program and will not result in new licensed or certified beds.

205.11 (d) Prior to the final plan approval of any construction project, the commissioners of
205.12 health and human services shall be provided with an itemized cost estimate for the project
205.13 construction costs. If a construction project is anticipated to be completed in phases, the
205.14 total estimated cost of all phases of the project shall be submitted to the commissioners and

205.15 shall be considered as one construction project. Once the construction project is completed
205.16 and prior to the final clearance by the commissioners, the total project construction costs
205.17 for the construction project shall be submitted to the commissioners. If the final project
205.18 construction cost exceeds the dollar threshold in this subdivision, the commissioner of
205.19 human services shall not recognize any of the project construction costs or the related
205.20 financing costs in excess of this threshold in establishing the facility's property-related
205.21 payment rate.

205.22 (e) The dollar thresholds for construction projects are as follows: for construction projects
205.23 other than those authorized in clauses (1) to (6) paragraph (c), clause (2), items (i) to (v),
205.24 the dollar threshold is \$1,000,000. For projects authorized after July 1, 1993, under clause
205.25 (1) paragraph (c), clause (2), item (i), the dollar threshold is the cost estimate submitted
205.26 with a proposal for an exception under section 144A.073, plus inflation as calculated
205.27 according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under
205.28 clauses (2) to (4) paragraph (c), clause (2), items (ii) to (iv), the dollar threshold is the
205.29 itemized estimate project construction costs submitted to the commissioner of health at the
205.30 time of final plan approval, plus inflation as calculated according to section 256B.431,
205.31 subdivision 3f, paragraph (a).

206.1 (f) The commissioner of health shall adopt rules to implement this section or to amend
206.2 the emergency rules for granting exceptions to the moratorium on nursing homes under
206.3 section 144A.073.

206.4 (g) All construction projects approved through section 144A.073, subdivision 3, after
206.5 March 1, 2020, are subject to the fair rental value property rate as described in section
206.6 256R.26.

206.7 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

206.8 Sec. 106. Minnesota Statutes 2022, section 144A.073, subdivision 3b, is amended to read:

206.9 Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received
206.10 approval on or after July 1, 1993, for exceptions to the moratorium on nursing homes through
206.11 the process described in this section may request amendments to the designs of the projects
206.12 by writing the commissioner within 15 months of receiving approval. Applicants shall
206.13 submit supporting materials that demonstrate how the amended projects meet the criteria
206.14 described in paragraph (b).

206.15 (b) The commissioner shall approve requests for amendments for projects approved on
206.16 or after July 1, 1993, according to the following criteria:

206.17 (1) the amended project designs must provide solutions to all of the problems addressed
206.18 by the original application that are at least as effective as the original solutions;

206.19 (2) the amended project designs may not reduce the space in each resident's living area
206.20 or in the total amount of common space devoted to resident and family uses by more than
206.21 five percent;

206.22 (3) the costs ~~recognized for reimbursement~~ of amended project designs shall be the
206.23 ~~threshold amount of the original proposal as identified according to section 144A.071,~~
206.24 ~~subdivision 2 the cost estimate associated with the project as originally approved, except~~
206.25 ~~under conditions described in clause (4); and~~

206.26 (4) total costs ~~up to ten percent greater than the cost identified in clause (3) may be~~
206.27 ~~recognized for reimbursement if of the amendment are no greater than ten percent of the~~
206.28 ~~cost estimate associated with the project as initially approved if the proposer can document~~
206.29 ~~that one of the following circumstances is true:~~

206.30 (i) changes are needed due to a natural disaster;

206.31 (ii) conditions that affect the safety or durability of the project that could not have
206.32 ~~reasonably been known prior to approval are discovered;~~

207.1 (iii) state or federal law require changes in project design; or

207.2 (iv) documentable circumstances occur that are beyond the control of the owner and
207.3 ~~require changes in the design.~~

207.4 (c) Approval of a request for an amendment does not alter the expiration of approval of
207.5 ~~the project according to subdivision 3.~~

207.6 (d) Reimbursement for amendments to approved projects is independent of the actual
207.7 ~~construction costs and based on the allowable appraised value of the completed project. An~~
207.8 ~~approved project may not be amended to reduce the scope of an approved project.~~

207.9 **EFFECTIVE DATE.** This section is effective retroactively from March 1, 2020.

207.10 Sec. 107. Minnesota Statutes 2022, section 144A.474, subdivision 3, is amended to read:

207.11 Subd. 3. **Survey process.** The survey process for core surveys shall include the following
207.12 ~~as applicable to the particular licensee and setting surveyed:~~

207.13 (1) presurvey review of pertinent documents and notification to the ombudsman for
207.14 ~~long-term care;~~

207.15 (2) an entrance conference with available staff;

207.16 (3) communication with managerial officials or the registered nurse in charge, if available,
207.17 ~~and ongoing communication with key staff throughout the survey regarding information~~
207.18 ~~needed by the surveyor, clarifications regarding home care requirements, and applicable~~
207.19 ~~standards of practice;~~

207.20 (4) presentation of written contact information to the provider about the survey staff
207.21 ~~conducting the survey, the supervisor, and the process for requesting a reconsideration of~~
207.22 ~~the survey results;~~

207.23 (5) a brief tour of ~~a sample of the housing with services establishments~~ establishment
207.24 ~~in which the provider is providing home care services;~~

207.25 (6) a sample selection of home care clients;

207.26 (7) information-gathering through client and staff observations, client and staff interviews,

207.27 and reviews of records, policies, procedures, practices, and other agency information;

207.28 (8) interviews of clients' family members, if available, with clients' consent when the

207.29 client can legally give consent;

207.30 (9) except for complaint surveys conducted by the Office of Health Facilities Complaints,

207.31 an on-site exit conference, with preliminary findings shared and discussed with the provider

208.1 within one business day after completion of survey activities, documentation that an exit

208.2 conference occurred, and with written information provided on the process for requesting

208.3 a reconsideration of the survey results; and

208.4 (10) postsurvey analysis of findings and formulation of survey results, including

208.5 correction orders when applicable.

208.6 Sec. 108. Minnesota Statutes 2022, section 144A.474, subdivision 9, is amended to read:

208.7 Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under

208.8 subdivision 11, or any violations determined to be widespread, the department shall conduct

208.9 a follow-up survey within 90 calendar days of the survey. When conducting a follow-up

208.10 survey, the surveyor will focus on whether the previous violations have been corrected and

208.11 may also address any new violations that are observed while evaluating the corrections that

208.12 have been made.

208.13 Sec. 109. Minnesota Statutes 2022, section 144A.474, subdivision 12, is amended to read:

208.14 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care

208.15 providers a correction order reconsideration process. This process may be used to challenge

208.16 the correction order issued, including the level and scope described in subdivision 11, and

208.17 any fine assessed. During the correction order reconsideration request, the issuance for the

208.18 correction orders under reconsideration are not stayed, but the department shall post

208.19 information on the website with the correction order that the licensee has requested a

208.20 reconsideration and that the review is pending.

208.21 (b) A licensed home care provider may request from the commissioner, in writing, a

208.22 correction order reconsideration regarding any correction order issued to the provider. The

208.23 written request for reconsideration must be received by the commissioner within 15 calendar

208.24 business days of the correction order receipt date. The correction order reconsideration shall

208.25 not be reviewed by any surveyor, investigator, or supervisor that participated in the writing

208.26 or reviewing of the correction order being disputed. The correction order reconsiderations

208.27 may be conducted in person, by telephone, by another electronic form, or in writing, as

208.28 determined by the commissioner. The commissioner shall respond in writing to the request

208.29 from a home care provider for a correction order reconsideration within 60 days of the date

208.30 the provider requests a reconsideration. The commissioner's response shall identify the

208.31 commissioner's decision regarding each citation challenged by the home care provider.

208.32 (c) The findings of a correction order reconsideration process shall be one or more of
208.33 the following:
209.1 (1) supported in full, the correction order is supported in full, with no deletion of findings
209.2 to the citation;
209.3 (2) supported in substance, the correction order is supported, but one or more findings
209.4 are deleted or modified without any change in the citation;
209.5 (3) correction order cited an incorrect home care licensing requirement, the correction
209.6 order is amended by changing the correction order to the appropriate statutory reference;
209.7 (4) correction order was issued under an incorrect citation, the correction order is amended
209.8 to be issued under the more appropriate correction order citation;
209.9 (5) the correction order is rescinded;
209.10 (6) fine is amended, it is determined that the fine assigned to the correction order was
209.11 applied incorrectly; or
209.12 (7) the level or scope of the citation is modified based on the reconsideration.
209.13 (d) If the correction order findings are changed by the commissioner, the commissioner
209.14 shall update the correction order website.
209.15 (e) This subdivision does not apply to temporary licensees.
209.16 Sec. 110. Minnesota Statutes 2022, section 144A.4791, subdivision 10, is amended to
209.17 read:
209.18 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service
209.19 plan with a client, and the client continues to need home care services, the home care provider
209.20 shall provide the client and the client's representative, if any, with a written notice of
209.21 termination which includes the following information:
209.22 (1) the effective date of termination;
209.23 (2) the reason for termination;
209.24 (3) a statement that the client may contact the Office of Ombudsman for Long-Term
209.25 Care to request an advocate to assist regarding the termination and contact information for
209.26 the office, including the office's central telephone number;
209.27 (3) a list of known licensed home care providers in the client's immediate geographic
209.28 area;
209.29 (4) a statement that the home care provider will participate in a coordinated transfer
209.30 of care of the client to another home care provider, health care provider, or caregiver, as
209.31 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

210.1 ~~(5)~~(6) the name and contact information of a person employed by the home care provider
210.2 with whom the client may discuss the notice of termination; and

210.3 ~~(6)~~(7) if applicable, a statement that the notice of termination of home care services
210.4 does not constitute notice of termination of the housing with services contract with a housing
210.5 with services establishment any housing contract.

210.6 (b) When the home care provider voluntarily discontinues services to all clients, the
210.7 home care provider must notify the commissioner, lead agencies, and ombudsman for
210.8 long-term care about its clients and comply with the requirements in this subdivision.

210.9 Sec. 111. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

210.10 Subd. 7. **Fines and penalties.** (a) The ~~fee~~ fine for failure to comply with the notification
210.11 requirements in section 144G.52, subdivision 7, is \$1,000.

210.12 (b) Fines and penalties collected under this section shall be deposited in a dedicated
210.13 special revenue account. On an annual basis, the balance in the special revenue account
210.14 shall be appropriated to the commissioner to implement the recommendations of the advisory
210.15 council established in section 144A.4799.

210.16 Sec. 112. Minnesota Statutes 2022, section 144G.18, is amended to read:

210.17 **144G.18 NOTIFICATION OF CHANGES IN INFORMATION.**

210.18 Subdivision 1. **Notification.** A provisional licensee or licensee shall notify the
210.19 commissioner in writing prior to a change in the manager or authorized agent and within
210.20 60 calendar days after any change in the information required in section 144G.12, subdivision
210.21 1, clause (1), (3), (4), (17), or (18).

210.22 Subd. 2. **Fines and penalties.** (a) The fine for failure to comply with the notification
210.23 requirements of this section is \$1,000.

210.24 (b) Fines and penalties collected under this subdivision shall be deposited in a dedicated
210.25 special revenue account. On an annual basis, the balance in the special revenue account
210.26 shall be appropriated to the commissioner to implement the recommendations of the advisory
210.27 council established in section 144A.4799.

210.28 Sec. 113. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

210.29 Subd. 8. **Fine Fines and penalties.** (a) The commissioner may impose a fine for failure
210.30 to follow the requirements of this section.

211.1 (b) The fine for failure to comply with this section is \$1,000.

211.2 (c) Fines and penalties collected under this section shall be deposited in a dedicated
211.3 special revenue account. On an annual basis, the balance in the special revenue account

198.11 Sec. 47. **[145.361] LONG COVID AND RELATED CONDITIONS; ASSESSMENT
198.12 AND MONITORING.**198.13 Subdivision 1. **Definition.** (a) For the purposes of this section, the following terms have
198.14 the meanings given.198.15 (b) "Long COVID" means health problems that people experience four or more weeks
198.16 after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is
198.17 also called post-COVID conditions, long-haul COVID, chronic COVID, post-acute COVID,
198.18 or post-acute sequelae of COVID-19 (PASC).198.19 (c) "Related conditions" means conditions related to or similar to long COVID, including
198.20 but not limited to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and
198.21 dysautonomia, and postural orthostatic tachycardia syndrome (POTS).198.22 Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct
198.23 community assessments and epidemiologic investigations to monitor and address impacts
198.24 of long COVID and related conditions. The purposes of these activities are to:198.25 (1) monitor trends in: incidence, prevalence, mortality, and health outcomes; changes
198.26 in disability status, employment, and quality of life; and service needs of individuals with
198.27 long COVID or related conditions and to detect potential public health problems, predict
198.28 risks, and assist in investigating long COVID and related conditions health inequities;198.29 (2) more accurately target information and resources for communities and patients and
198.30 their families;

198.31 (3) inform health professionals and citizens about risks and early detection;

199.1 (4) promote evidence-based practices around long COVID and related conditions
199.2 prevention and management and to address public concerns and questions about long COVID
199.3 and related conditions; and

199.4 (5) research and track related conditions.

199.5 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health
199.6 care professionals, the commissioner of human services, local public health entities, health
199.7 insurers, employers, schools, survivors of long COVID or related conditions, and community
199.8 organizations serving people at high risk of long COVID or related conditions, identify
199.9 priority actions and activities to address the needs for communication, services, resources,
199.10 tools, strategies, and policies to support survivors of long COVID or related conditions and
199.11 their families.211.4 shall be appropriated to the commissioner to implement the recommendations of the advisory
211.5 council established in section 144A.4799.280.20 Sec. 190. **LONG COVID.**280.21 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health
280.22 problems that people experience four or more weeks after being infected with SARS-CoV-2,
280.23 the virus that causes COVID-19. Long COVID is also called post-COVID conditions,
280.24 long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19
280.25 (PASC).280.26 Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct
280.27 community assessments and epidemiologic investigations to monitor and address impacts
280.28 of long COVID. The purposes of these activities are to:280.29 (1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care
280.30 management and costs; changes in disability status, employment, and quality of life; and
280.31 service needs of individuals with long COVID and to detect potential public health problems,
280.32 predict risks, and assist in investigating long COVID health inequities;281.1 (2) more accurately target information and resources for communities and patients and
281.2 their families;281.3 (3) inform health professionals and citizens about risks and early detection of long
281.4 COVID known to be elevated in their communities; and281.5 (4) promote evidence-based practices around long COVID prevention and management
281.6 and to address public concerns and questions about long COVID.281.7 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health
281.8 care professionals, the Department of Human Services, local public health, health insurers,
281.9 employers, schools, long COVID survivors, and community organizations serving people
281.10 at high risk of long COVID, identify priority actions and activities to address the needs for
281.11 communication, services, resources, tools, strategies, and policies to support long COVID
281.12 survivors and their families.

199.12 **Subd. 4. Grants and contracts.** The commissioner of health shall coordinate and
199.13 collaborate with community and organizational partners to implement evidence-informed
199.14 priority actions through community-based grants and contracts. The commissioner of health
199.15 shall award grants and enter into contracts to organizations that serve communities
199.16 disproportionately impacted by COVID-19, long COVID, or related conditions, including
199.17 but not limited to rural and low-income areas, Black and African Americans, African
199.18 immigrants, American Indians, Asian American-Pacific Islanders, Latino(a), LGBTQ+, and
199.19 persons with disabilities. Organizations may also address intersectionality within the groups.
199.20 The commissioner shall award grants and award contracts to eligible organizations to plan,
199.21 construct, and disseminate resources and information to support survivors of long COVID
199.22 or related conditions, including caregivers, health care providers, ancillary health care
199.23 workers, workplaces, schools, communities, and local and Tribal public health.

281.13 **Subd. 4. Grants and contracts.** The commissioner of health shall coordinate and
281.14 collaborate with community and organizational partners to implement evidence-informed
281.15 priority actions through community-based grants and contracts. The commissioner of health
281.16 shall award contracts and grants to organizations that serve communities disproportionately
281.17 impacted by COVID-19 and long COVID, including but not limited to rural and low-income
281.18 areas, Black and African Americans, African immigrants, American Indians, Asian
281.19 American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons
281.20 with disabilities. Organizations may also address intersectionality within the groups. The
281.21 commissioner shall award grants and contracts to eligible organizations to plan, construct,
281.22 and disseminate resources and information to support survivors of long COVID, including
281.23 caregivers, health care providers, ancillary health care workers, workplaces, schools,
281.24 communities, and local and Tribal public health.

199.24 Sec. 48. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

199.27 (b) "Commissioner" means the commissioner of health.
199.28 (c) "Department" means the Department of Health.

211.6 Sec. 114. Minnesota Statutes 2022, section 145.411, subdivision 1, is amended to read:

211.7 Subdivision 1. **Terms.** As used in sections 145.411 to **[145.416] 145.414**, the terms defined
211.8 in this section have the meanings given to them.

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

211.10 Sec. 115. Minnesota Statutes 2022, section 145.411, subdivision 5, is amended to read:

211.11 Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument,
211.12 medicine or drug which is supplied or prescribed for or administered to a pregnant woman
211.13 an individual with the intention of terminating, and which results in the termination of
211.14 pregnancy.

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

211.16 Sec. 116. Minnesota Statutes 2022, section 145.423, subdivision 1, is amended to read:

211.17 Subdivision 1. **Recognition; medical care.** A born alive An infant as a result of an
211.18 abortion who is born alive shall be fully recognized as a human person, and accorded
211.19 immediate protection under the law. All reasonable measures consistent with good medical
211.20 practice, including the compilation of appropriate medical records, shall be taken by the
211.21 responsible medical personnel to preserve the life and health of the born alive infant care
211.22 for the infant who is born alive.

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

211.24 Sec. 117. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

211.27 (b) "Commissioner" means the commissioner of health.
211.28 (c) "Department" means the Department of Health.

199.29 (d) "Lifeline center" means a state-identified center that is a member of the Suicide and
 199.30 Crisis Lifeline network that responds to statewide or regional 988 contacts.

199.31 (e) "988" or "988 hotline" means the universal telephone number for the national suicide
 199.32 prevention and mental health crisis hotline system within the United States operating through
 200.1 the Suicide and Crisis Lifeline, or its successor, maintained by the assistant secretary for
 200.2 mental health and substance use under section 520E-2 of the Public Health Service Act.

200.3 (f) "988 administrator" means the administrator of the 988 Suicide and Crisis Lifeline
 200.4 maintained by the assistant secretary for mental health and substance use under section
 200.5 520E-3 of the Public Health Service Act.

200.6 (g) "988 contact" means a communication with the 988 national suicide prevention and
 200.7 mental health crisis hotline system within the United States via modalities offered that may
 200.8 include call, chat, or text.

200.9 (h) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the secretary
 200.10 of veterans affairs under United States Code, title 38, section 170F(h).

200.11 Subd. 2. **988 hotline; lifeline centers.** (a) The commissioner shall administer the
 200.12 designation of and oversee a lifeline center or network of lifeline centers to answer 988
 200.13 contacts from individuals accessing the Suicide and Crisis Lifeline from any location in
 200.14 Minnesota 24 hours per day, seven days per week.

200.15 (b) The designated lifeline center or centers must:

200.16 (1) have an active agreement with the 988 administrator for participation within the
 200.17 network and with the department;

200.18 (2) meet the 988 administrator's requirements and best practice guidelines for operational
 200.19 and clinical standards;

200.20 (3) provide data, engage in reporting, and participate in evaluations and related quality
 200.21 improvement activities as required by the 988 administrator and the department;

200.22 (4) identify or adapt technology that is demonstrated to be interoperable across crisis
 200.23 and emergency response systems used in the state for the purpose of crisis care coordination;

212.12 (g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide
 212.13 Crisis Lifeline network that responds to statewide or regional 988 contacts.

212.1 (d) "988" means the universal telephone number designated as the universal telephone
 212.2 number within the United States for the purpose of the national suicide prevention and
 212.3 mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline,
 212.4 or its successor, maintained by the Assistant Secretary for Mental Health and Substance
 212.5 Use under section 520E-3 of the Public Health Service Act (United States Code, title 42,
 212.6 sections 290bb-36c).

212.7 (e) "988 administrator" means the administrator of the national 988 Suicide and Crisis
 212.8 Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under
 212.9 section 520E-3 of the Public Health Service Act.

212.10 (f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system
 212.11 within the United States via modalities offered including call, chat, or text.

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

212.14 (h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide
 212.15 prevention and mental health crisis hotline system maintained by the Assistant Secretary
 212.16 for Mental Health and Substance Use under section 520E-3 of the Public Health Service
 212.17 Act (United States Code, title 42, sections 290bb-36c).

212.20 Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and
 212.21 oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts
 212.22 from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the
 212.23 state 24 hours per day, seven days per week.

212.24 (b) The designated 988 Lifeline Center must:

212.25 (1) have an active agreement with the 988 Suicide and Crisis Lifeline program for
 212.26 participation in the network and the department;

212.27 (2) meet the 988 Lifeline program requirements and best practice guidelines for
 212.28 operational and clinical standards;

212.29 (3) provide data and reports, and participate in evaluations and related quality
 212.30 improvement activities as required by the 988 Lifeline program and the department;

213.1 (4) identify or adapt technology that is demonstrated to be interoperable across mobile
 213.2 crisis and public safety answering points used in the state for the purpose of crisis care
 213.3 coordination;

200.24 (5) connect people to crisis response and outgoing services, including mobile crisis
 200.25 teams, in accordance with guidelines established by the 988 administrator and the department
 200.26 and in collaboration with the Department of Human Services;

200.27 (6) actively collaborate and coordinate service linkages with mental health and substance
 200.28 use disorder treatment providers, local community mental health centers, including certified
 200.29 community behavioral health clinics and community behavioral health centers, mobile crisis
 200.30 teams, and emergency departments;

200.31 (7) offer follow-up services to individuals accessing the lifeline center that are consistent
 200.32 with guidelines established by the 988 administrator and the department; and

201.1 (8) meet requirements set by the 988 administrator and the department for serving
 201.2 high-risk and specialized populations and culturally or ethnically diverse populations.

201.3 (c) The commissioner shall use the commissioner's rulemaking authority to allow
 201.4 appropriate information sharing and communication between and across crisis and emergency
 201.5 response systems.

201.6 (d) The commissioner, having primary oversight of suicide prevention, shall work with
 201.7 the Suicide and Crisis Lifeline, Veterans Crisis Line, and other SAMHSA-approved networks
 201.8 to ensure consistency of public messaging about 988 services. The commissioner may
 201.9 engage in activities to publicize and raise awareness about 988 services, or may provide
 201.10 grants to other organizations for these purposes.

201.11 (e) The commissioner shall provide an annual report to the legislature on usage of the
 201.12 988 hotline, including answer rates, rates of abandoned calls, and referral rates to 911
 201.13 emergency response and to mental health crisis teams. Notwithstanding section 144.05,
 201.14 subdivision 7, the reports required under this paragraph do not expire.

201.15 Subd. 3. **988 special revenue account.** (a) A 988 special revenue account is established
 201.16 as a dedicated account in the special revenue fund to create and maintain a statewide 988
 201.17 suicide prevention crisis system according to the National Suicide Hotline Designation Act
 201.18 of 2020, the Federal Communications Commission's report and order FCC 20-100 adopted
 201.19 July 16, 2020, and national guidelines for crisis care.

201.20 (b) The 988 special revenue account shall consist of:

201.21 (1) a 988 telecommunications fee imposed under subdivision 4;
 201.22 (2) a prepaid wireless 988 fee imposed under section 403.161;

213.4 (5) facilitate crisis and outgoing services, including mobile crisis teams in accordance
 213.5 with guidelines established by the 988 Lifeline program and the department;

213.6 (6) actively collaborate and coordinate service linkages with mental health and substance
 213.7 use disorder treatment providers, local community mental health centers including certified
 213.8 community behavioral health clinics and community behavioral health centers, mobile crisis
 213.9 teams, and community based and hospital emergency departments;

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

213.12 (8) meet the requirements set by the 988 Lifeline program and the department for serving
 213.13 at-risk and specialized populations.

213.14 (c) The commissioner shall adopt rules to allow appropriate information sharing and
 213.15 communication between and across crisis and emergency response systems.

213.16 (d) The department, having primary oversight of suicide prevention, shall work with the
 213.17 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the
 213.18 purpose of ensuring consistency of public messaging about 988 services.

213.24 (f) The commissioner shall provide an annual public report on 988 Lifeline usage,
 213.25 including data on answer rates, abandoned calls, and referrals to 911 emergency response.

213.19 (e) The department shall work with representatives from 988 Lifeline Centers and public
 213.20 safety answering points, other public safety agencies, and the commissioner of public safety
 213.21 to facilitate the development of protocols and procedures for interactions between 988 and
 213.22 911 services across Minnesota. Protocols and procedures shall be developed following
 213.23 available national standards and guidelines.

213.26 Subd. 3. **Activities to support the 988 system.** The commissioner shall use money
 213.27 appropriated for the 988 system to fund:

201.23 (3) transfers of state money into the account;
201.24 (4) grants and gifts intended for deposit in the account;
201.25 (5) interest, premiums, gains, and other earnings of the account; and
201.26 (6) money from any other source that is deposited in or transferred to the account.
201.27 (c) The account shall be administered by the commissioner. Money in the account shall
201.28 only be used to offset costs that are or may reasonably be attributed to:
201.29 (1) implementing, maintaining, and improving the 988 suicide and crisis lifeline, including
201.30 staff and technology infrastructure enhancements needed to achieve the operational standards
201.31 and best practices set forth by the 988 administrator and the department;
202.1 (2) data collection, reporting, participation in evaluations, public promotion, and related
202.2 quality improvement activities as required by the 988 administrator and the department;
202.3 and
202.4 (3) administration, oversight, and evaluation of the account.
202.5 (d) Money in the account:
202.6 (1) does not cancel at the end of any state fiscal year and is carried forward in subsequent
202.7 state fiscal years;
202.8 (2) is not subject to transfer to any other account or fund or to transfer, assignment, or
202.9 reassignment for any use or purpose other than the purposes specified in this subdivision;
202.10 and
202.11 (3) is appropriated to the commissioner for the purposes specified in this subdivision.
202.12 (e) The commissioner shall submit an annual report to the legislature and to the Federal
202.13 Communications Commission on deposits to and expenditures from the account.
202.14 Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph
202.15 do not expire.
202.16 Subd. 4. 988 telecommunications fee. (a) In compliance with the National Suicide
202.17 Hotline Designation Act of 2020, the commissioner shall impose a monthly statewide fee
202.18 on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides
213.28 (1) implementing, maintaining, and improving the 988 Suicide and Crisis Lifeline to
213.29 ensure the efficient and effective routing and handing of calls, chats, and texts made to the
213.30 988 Lifeline Centers, including staffing and technological infrastructure enhancements
213.31 necessary to achieve operational standards and best practices set by the 988 Lifeline and
213.32 the department;
214.1 (2) personnel for 988 Lifeline Centers;
214.2 (3) the provision of acute mental health and crisis outreach services to persons who
214.3 contact a 988 Lifeline Center;
214.4 (4) publicizing and raising awareness of 988 services, or providing grants to organizations
214.5 to publicize and raise awareness of 988 services;
214.6 (5) data collection, reporting, participation in evaluations, public promotion, and related
214.7 quality improvement activities as required by the 988 administrator and the department;
214.8 and
214.9 (6) administration, oversight, and evaluation.

202.19 for the robust creation, operation, and maintenance of a statewide 988 suicide prevention
202.20 and crisis system.

202.21 (b) The commissioner shall annually recommend to the Public Utilities Commission an
202.22 adequate and appropriate fee to implement this section. The amount of the fee must comply
202.23 with the limits in paragraph (c). The commissioner shall provide telecommunication service
202.24 providers and carriers a minimum of 30 days' notice of each fee change.

202.25 (c) The amount of the 988 telecommunications fee must not be more than 25 cents per
202.26 month on or after January 1, 2024, for each consumer access line, including trunk equivalents
202.27 as designated by the commission pursuant to section 403.11, subdivision 1. The 988
202.28 telecommunications fee must be the same for all subscribers.

202.29 (d) Each wireline, wireless, and IP-enabled voice telecommunication service provider
202.30 shall collect the 988 telecommunications fee and transfer the amounts collected to the
202.31 commissioner of public safety in the same manner as provided in section 403.11, subdivision
202.32 1, paragraph (d).

203.1 (e) The commissioner of public safety shall deposit the money collected from the 988
203.2 telecommunications fee to the 988 special revenue account established in subdivision 3.

203.3 (f) All 988 telecommunications fee revenue must be used to supplement, and not supplant,
203.4 federal, state, and local funding for suicide prevention.

203.5 (g) The 988 telecommunications fee amount shall be adjusted as needed to provide for
203.6 continuous operation of the lifeline centers and 988 hotline, volume increases, and
203.7 maintenance.

203.8 (h) The commissioner shall annually report to the Federal Communications Commission
203.9 on revenue generated by the 988 telecommunications fee.

203.10 Subd. 5. 988 fee for prepaid wireless telecommunications services. (a) The 988
203.11 telecommunications fee established in subdivision 4 does not apply to prepaid wireless
203.12 telecommunications services. Prepaid wireless telecommunications services are subject to
203.13 the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

203.14 (b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by
203.15 sections 403.161 and 403.162.

203.16 Subd. 6. Biennial budget; annual financial report. The commissioner must prepare a
203.17 biennial budget for maintaining the 988 system. By December 15 of each year, the
203.18 commissioner must submit a report to the legislature detailing the expenditures for
203.19 maintaining the 988 system, the 988 fees collected, the balance of the 988 fund, the
203.20 988-related administrative expenses, and the most recent forecast of revenues and
203.21 expenditures for the 988 special revenue account, including a separate projection of 988
203.22 fees from prepaid wireless customers and projections of year-end fund balances.

214.10 Subd. 4. 988 Lifeline operating budget; report on data to legislature. The
214.11 commissioner shall provide to the legislature a biennial report for maintaining the 988
214.12 system. The report must include data on direct and indirect expenditures to maintain the
214.13 988 system.

203.23 **Subd. 7. Waiver.** A wireless telecommunications service provider or wire-line
203.24 telecommunications service provider may petition the commissioner for a waiver of all or
203.25 portions of the requirements of this section. The commissioner may grant a waiver upon a
203.26 demonstration by the petitioner that the requirement is economically infeasible.

203.27 Sec. 49. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

203.28 **Subd. 4. Administrative costs Administration.** The commissioner may ~~use up to seven~~
203.29 percent of the annual appropriation under this section to provide training and technical
203.30 assistance and to administer and evaluate the program. The commissioner may contract for
203.31 training, capacity-building support for grantees or potential grantees, technical assistance,
203.32 and evaluation support.

204.1 Sec. 50. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

204.2 Subdivision 1. **Access to data.** (a) For purposes of this section, the subject of the data
204.3 is defined as any of the following:

204.4 (1) a live born infant that died within the first year of life;
204.5 (2) a fetal death which meets the criteria required for reporting as defined in section
204.6 144.222; or
204.7 (3) the biological mother of an infant as defined in clause (1) or of a fetal death as defined
204.8 in clause (2).

204.9 (b) To conduct fetal and infant death studies, the commissioner of health must have
204.10 access to:

204.11 (1) medical data as defined in section 13.384, subdivision 1, paragraph (b); medical
204.12 examiner data as defined in section 13.83, subdivision 1; and health records created,
204.13 maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph
204.14 (i), on the subject of the data;

204.15 (2) data on health and social support services, including but not limited to family home
204.16 visiting programs and the women, infants, and children (WIC) program; prescription
204.17 monitoring programs data; and data on behavioral health services, on the subject of the data;

204.18 (3) the name of a health care provider that provided prenatal, postpartum, pediatric, and
204.19 other health services to the subject of the data, which must be provided by a coroner or
204.20 medical examiner; and

204.21 (4) Department of Human Services and other state agency data to identify and receive
204.22 information on the types and nature of other sources of care and social support received by
204.23 the subject of the data, and parents and guardians of the subject of the data, to assist with
204.24 evaluation of social service systems.

214.14 Sec. 118. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

214.15 **Subd. 4. Administrative costs Administration.** The commissioner may ~~use up to seven~~
214.16 percent of the annual appropriation under this section to provide training and technical
214.17 assistance and to administer and evaluate the program. The commissioner may contract for
214.18 training, capacity-building support for grantees or potential grantees, technical assistance,
214.19 and evaluation support.

204.25 (c) When necessary to conduct a fetal and infant death study, the commissioner must
204.26 have access to:

204.27 (1) data described in this subdivision relevant to fetal and infant death studies from
204.28 before, during, and after pregnancy or birth for the subject of the data; and

204.29 (2) law enforcement reports or incident reports related to the subject of the data and
204.30 must receive the reports when requested from law enforcement.

204.31 (d) The commissioner does not have access to coroner or medical examiner data that
204.32 are part of an active investigation as described in section 13.83.

205.1 (e) The commissioner must have access to all data described within this section without
205.2 the consent of the subject of the data and without the consent of the parent, other guardian,
205.3 or legal representative of the subject of the data. The commissioner has access to the data
205.4 in this subdivision to study fetal or infant deaths that occur on or after July 1, 2021.

205.5 (f) The commissioner must make a good faith reasonable effort to notify the subject of
205.6 the data, parent, spouse, other guardian, or legal representative of the subject of the data
205.7 before collecting data on the subject of the data. For purposes of this paragraph, "reasonable
205.8 effort" means one notice is sent by certified mail to the last known address of the subject
205.9 of the data, parent, spouse, other guardian, or legal representative informing of the data
205.10 collection and offering a public health nurse support visit if desired.

205.11 Subd. 2. **Management of records.** After the commissioner has collected all data about
205.12 the subject of a fetal or infant death study necessary to perform the study, the data extracted
205.13 from source records obtained under subdivision 2, other than data identifying the subject
205.14 of the data, must be transferred to separate records that must be maintained by the
205.15 commissioner. Notwithstanding section 138.17, after the data have been transferred, all
205.16 source records obtained under subdivision 2 that are possessed by the commissioner must
205.17 be destroyed.

205.18 Subd. 3. **Classification of data.** (a) Data provided to the commissioner from source
205.19 records under subdivision 2, including identifying information on individual providers,
205.20 subjects of the data, their family, or guardians, and data derived by the commissioner under
205.21 subdivision 3 for the purpose of carrying out fetal or infant death studies, are classified as
205.22 confidential data on individuals or confidential data on decedents, as defined in sections
205.23 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

205.24 (b) Data classified under subdivision 4, paragraph (a), must not be subject to discovery
205.25 or introduction into evidence in any administrative, civil, or criminal proceeding. Such
205.26 information otherwise available from an original source must not be immune from discovery
205.27 or barred from introduction into evidence merely because it was utilized by the commissioner
205.28 in carrying out fetal or infant death studies.

205.29 (c) Summary data on fetal and infant death studies created by the commissioner, which
205.30 does not identify individual subjects of the data, their families, guardians, or individual
205.31 providers, must be public in accordance with section 13.05, subdivision 7.

205.32 (d) Data provided by the commissioner of human services or other state agency to the
205.33 commissioner of health under this section retains the same classification as the data held
206.1 when retained by the commissioner of human services, as required under section 13.03,
206.2 subdivision 4, paragraph (c).

206.3 Subd. 4. **Fetal and infant mortality reviews.** (a) The commissioner of health must
206.4 convene case review committees to conduct death study reviews, make recommendations,
206.5 and publicly share summary information, especially for and about racial and ethnic groups,
206.6 including American Indians and African Americans, that experience significantly disparate
206.7 rates of fetal and infant mortality.

206.8 (b) The case review committees may include, but are not limited to, medical examiners
206.9 or coroners, representative from health care institutions that provide care to pregnant people
206.10 and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency
206.11 women and infant program representatives, and individuals from the communities that
206.12 experience disparate rates of fetal and infant deaths, and other subject matter experts as
206.13 necessary.

206.14 (c) The case review committees will review data from source records obtained under
206.15 subdivision 2, other than data identifying the subject, the subject's family, or guardians, or
206.16 the provider involved in the care of the subject.

206.17 (d) A person attending a fetal and infant mortality review committee meeting must not
206.18 disclose what transpired at the meeting, except as necessary to carry out the purposes of the
206.19 review committee. The proceedings and records of the review committee are protected
206.20 nonpublic data as defined in section 13.02, subdivision 13. Discovery and introduction into
206.21 evidence in legal proceedings of case review committee proceedings and records, and
206.22 testimony in legal proceedings by review committee members and persons presenting
206.23 information to the review committee, must occur in compliance with the requirements in
206.24 section 256.01, subdivision 12, paragraph (e).

206.25 (e) Every three years beginning December 1, 2024, the case review committees will
206.26 provide findings and recommendations to the Maternal and Child Health Advisory Task
206.27 Force and the commissioner from the committee's review of fetal and infant deaths and
206.28 provide specific recommendations designed to reduce population-based disparities in fetal
206.29 and infant deaths.

206.30 (f) This paragraph governs case review committee member compensation and expense
206.31 reimbursement, notwithstanding any other law or policy to the contrary. Members of the
206.32 case review committee must be compensated by the commissioner of health for actual time
206.33 spent in work on case reviews at a per diem rate established by the commissioner of health
206.34 according to funding availability. Compensable time includes preparation for case reviews,

207.1 time spent on collaborative review, including subcommittee meetings, committee meetings, and other preparation work for the committee review as identified by the commissioner of health. Members must also be reimbursed for expenses in the same manner and amount as provided in the Department of Management and Budget's commissioner's plan under section 43A.18, subdivision 2. To receive compensation or reimbursement, committee members must invoice the Department of Health on an invoice form provided by the commissioner.

207.7 Subd. 5. **Expiration.** Notwithstanding any other law or policy to the contrary, the fetal and infant mortality review committee must not expire.

207.9 **Sec. 51. [145.903] SCHOOL-BASED HEALTH CENTERS.**

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

207.12 (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, provided 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 to primarily serve those student groups.

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

207.21 (1) health care providers;

207.22 (2) community clinics;

207.23 (3) hospitals;

207.24 (4) federally qualified health centers and look-alikes as defined in section 145.9269;

207.25 (5) health care foundations or nonprofit organizations;

207.26 (6) higher education institutions; or

207.27 (7) local health departments.

207.28 Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

208.1 (b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

214.20 **Sec. 119. [145.903] SCHOOL-BASED HEALTH CENTERS.**

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

214.23 (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, provided 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 to primarily serve those student groups.

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

215.1 (1) health care providers;

215.2 (2) community clinics;

215.3 (3) hospitals;

215.4 (4) federally qualified health centers and look-alikes as defined in section 145.9269;

215.5 (5) health care foundations or nonprofit organizations;

215.6 (6) higher education institutions; or

215.7 (7) local health departments.

215.8 Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

215.12 (b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

208.3 (1) operate in partnership with a school or school district and with the permission of the
208.4 school or school district board;

208.5 (2) provide health services through a sponsoring organization that meets the requirements
208.6 in subdivision 1, paragraph (c); and

208.7 (3) provide health services to all students and youth within a school or school district,
208.8 regardless of ability to pay, insurance coverage, or immigration status, and in accordance
208.9 with federal, state, and local law.

208.10 (c) The commissioner of health shall administer a grant to a nonprofit organization to
208.11 facilitate a community of practice among school-based health centers to improve quality,
208.12 equity, and sustainability of care delivered through school-based health centers; encourage
208.13 cross-sharing among school-based health centers; support existing clinics; and expand
208.14 school-based health centers in new communities in Minnesota.

208.15 (d) Grant recipients shall report their activities and annual performance measures as
208.16 defined by the commissioner in a format and time specified by the commissioner.

208.17 (e) The commissioners of health and of education shall coordinate the projects and
208.18 initiatives funded under this section with other efforts at the local, state, or national level
208.19 to avoid duplication and promote coordinated efforts.

208.20 Subd. 3. **School-based health center services.** (a) Services provided by a school-based
208.21 health center may include but are not limited to:

208.22 (1) preventive health care;

208.23 (2) chronic medical condition management, including diabetes and asthma care;

208.24 (3) mental health care and crisis management;

208.25 (4) acute care for illness and injury;

208.26 (5) oral health care;

208.27 (6) vision care;

208.28 (7) nutritional counseling;

208.29 (8) substance abuse counseling;

208.30 (9) referral to a specialist, medical home, or hospital for care;

209.1 (10) additional services that address social determinants of health; and

209.2 (11) emerging services such as mobile health and telehealth.

209.3 (b) Services provided by a school-based health center must not replace the daily student
209.4 support provided in the school by educational student service providers, including but not

215.14 (1) operate in partnership with a school or school district and with the permission of the
215.15 school or school district board;

215.16 (2) provide health services through a sponsoring organization; and

215.17 (3) provide health services to all students and youth within a school or school district,
215.18 regardless of ability to pay, insurance coverage, or immigration status, and in accordance
215.19 with federal, state, and local law.

215.20 (c) The commissioner of health shall administer a grant to a nonprofit organization to
215.21 facilitate a community of practice among school-based health centers to improve quality,
215.22 equity, and sustainability of care delivered through school-based health centers; encourage
215.23 cross-sharing among school-based health centers; support existing clinics; and expand
215.24 school-based health centers in new communities in Minnesota.

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215.26 defined by the commissioner in a format and time specified by the commissioner.

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216.2 (2) chronic medical condition management, including diabetes and asthma care;

216.3 (3) mental health care and crisis management;

216.4 (4) acute care for illness and injury;

216.5 (5) oral health care;

216.6 (6) vision care;

216.7 (7) nutritional counseling;

216.8 (8) substance abuse counseling;

216.9 (9) referral to a specialist, medical home, or hospital for care;

216.10 (10) additional services that address social determinants of health; and

216.11 (11) emerging services such as mobile health and telehealth.

209.5 limited to licensed school nurses, educational psychologists, school social workers, and
209.6 school counselors.

209.7 Subd. 4. Sponsoring organizations. A sponsoring organization that agrees to operate
209.8 a school-based health center must enter into a memorandum of agreement with the school
209.9 or school district. The memorandum of agreement must require the sponsoring organization
209.10 to be financially responsible for the operation of school-based health centers in the school
209.11 or school district and must identify the costs that are the responsibility of the school or
209.12 school district, such as Internet access, custodial services, utilities, and facility maintenance.
209.13 To the greatest extent possible, a sponsoring organization must bill private insurers, medical
209.14 assistance, and other public programs for services provided in the school-based health
209.15 centers in order to maintain the financial sustainability of school-based health centers.

209.16 Sec. 52. Minnesota Statutes 2022, section 145.924, is amended to read:

209.17 **145.924 AIDS HIV PREVENTION GRANTS.**

209.18 (a) The commissioner may award grants to community health boards as defined in section
209.19 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
209.20 evaluation and counseling services to populations at risk for acquiring human
209.21 immunodeficiency virus infection, including, but not limited to, minorities communities of
209.22 color, adolescents, intravenous drug users women, people who inject drugs, and homosexual
209.23 men gay, bisexual, and transgender individuals.

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

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

210.6 (d) The commissioner shall administer a grant program to provide funds to organizations,
210.7 including Tribal health agencies, to assist with HIV outbreaks.

216.12 Subd. 4. Sponsoring organizations. A sponsoring organization that agrees to operate
216.13 a school-based health center must enter into a memorandum of agreement with the school
216.14 or school district. The memorandum of agreement must require the sponsoring organization
216.15 to be financially responsible for the operation of school-based health centers in the school
216.16 or school district and must identify the costs that are the responsibility of the school or
216.17 school district, such as Internet access, custodial services, utilities, and facility maintenance.
216.18 To the greatest extent possible, a sponsoring organization must bill private insurers, medical
216.19 assistance, and other public programs for services provided in the school-based health
216.20 centers in order to maintain the financial sustainability of school-based health centers.

216.21 Sec. 120. Minnesota Statutes 2022, section 145.924, is amended to read:

216.22 **145.924 AIDS HIV PREVENTION GRANTS.**

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216.24 145A.02, subdivision 5, state agencies, state councils, or nonprofit corporations to provide
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216.26 immunodeficiency virus infection, including, but not limited to, minorities communities of
216.27 color, adolescents, intravenous drug users women, people who inject drugs, and homosexual
216.28 men gay, bisexual, and transgender individuals.

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

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

217.13 (d) The commissioner shall administer a grant program to provide funds to organizations,
217.14 including Tribal health agencies, to assist with HIV/AIDS outbreaks.

217.15 Sec. 121. Minnesota Statutes 2022, section 145.925, is amended to read:

217.16 **145.925 FAMILY PLANNING SEXUAL AND REPRODUCTIVE HEALTH**
217.17 **SERVICES GRANTS.**

217.18 Subdivision 1. **Eligible organizations; purpose Goal and establishment.** The
217.19 ~~commissioner of health may make special grants to cities, counties, groups of cities or~~
217.20 ~~counties, or nonprofit corporations to provide prepregnancy family planning services.~~ (a)
217.21 It is the goal of the state to increase access to sexual and reproductive health services for
217.22 people who experience barriers, whether geographic, cultural, financial, or other, in access
217.23 to such services. The commissioner of health shall administer grants to facilitate access to
217.24 sexual and reproductive health services for people of reproductive age, particularly those
217.25 from populations that experience barriers to these services.

217.26 (b) The commissioner of health shall coordinate with other efforts at the local, state, or
217.27 national level to avoid duplication and promote complementary efforts in sexual and
217.28 reproductive health service promotion among people of reproductive age.

217.29 Subd. 1a. **Family planning services; defined.** "Family planning services" means
217.30 ~~counseling by trained personnel regarding family planning; distribution of information~~
217.31 ~~relating to family planning; referral to licensed physicians or local health agencies for~~
217.32 ~~consultation, examination, medical treatment, genetic counseling, and prescriptions for the~~
217.33 ~~purpose of family planning; and the distribution of family planning products, such as charts,~~
218.1 ~~thermometers, drugs, medical preparations, and contraceptive devices. For purposes of~~
218.2 ~~sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals~~
218.3 ~~to prevent or aid conception but does not include the performance, or make referrals for~~
218.4 ~~encouragement of voluntary termination of pregnancy.~~

218.5 Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this
218.6 ~~section to any nonprofit corporation which performs abortions. No state funds shall be used~~
218.7 ~~under contract from a grantee to any nonprofit corporation which performs abortions. This~~
218.8 ~~provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or~~
218.9 ~~health maintenance organizations certified pursuant to chapter 62D.~~

218.10 Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section,
218.11 "sexual and reproductive health services" means services that promote a state of complete
218.12 physical, mental, and social well-being in relation to sexuality, reproduction, and the
218.13 reproductive system and its functions and processes, and not merely the absence of disease
218.14 or infirmity. These services must be provided in accord with nationally recognized standards
218.15 and include but are not limited to sexual and reproductive health counseling, voluntary and
218.16 informed decision-making on sexual and reproductive health, information on and provision
218.17 of contraceptive methods, sexual and reproductive health screenings and treatment, pregnancy
218.18 testing and counseling, and other preconception services.

218.19 Subd. 3. **Minors Grants authorized.** No funds provided by grants made pursuant to
218.20 ~~this section shall be used to support any family planning services for any unemancipated~~

218.21 ~~minor in any elementary or secondary school building.~~ (a) The commissioner of health shall
218.22 award grants to eligible community organizations, including nonprofit organizations,
218.23 community health boards, and Tribal communities in rural and metropolitan areas of the
218.24 state to support, sustain, expand, or implement reproductive and sexual health programs for
218.25 people of reproductive age to increase access to and availability of medically accurate sexual
218.26 and reproductive health services.

218.27 (b) The commissioner of health shall establish application scoring criteria to use in the
218.28 evaluation of applications submitted for award under this section. These criteria shall include
218.29 but are not limited to the degree to which applicants' programming responds to demographic
218.30 factors relevant to subdivision 1, paragraph (a), and paragraph (f).

218.31 (c) When determining whether to award a grant or the amount of a grant under this
218.32 section, the commissioner of health may identify and stratify geographic regions based on
218.33 the region's need for sexual and reproductive health services. In this stratification, the
219.1 commissioner may consider data on the prevalence of poverty and other factors relevant to
219.2 a geographic region's need for sexual and reproductive health services.

219.3 (d) The commissioner of health may consider geographic and Tribal communities'
219.4 representation in the award of grants.

219.5 (e) Current recipients of funding under this section shall not be afforded priority over
219.6 new applicants.

219.7 (f) Grant funds shall be used to support new or existing sexual and reproductive health
219.8 programs that provide person-centered, accessible services; that are culturally and
219.9 linguistically appropriate, inclusive of all people, and trauma-informed; that protect the
219.10 dignity of the individual; and that ensure equitable, quality services consistent with nationally
219.11 recognized standards of care. These services shall include:

219.12 (1) education and outreach on medically accurate sexual and reproductive health
219.13 information;

219.14 (2) contraceptive counseling, provision of contraceptive methods, and follow-up;

219.15 (3) screening, testing, and treatment of sexually transmitted infections and other sexual
219.16 or reproductive concerns; and

219.17 (4) referral and follow-up for medical, financial, mental health, and other services in
219.18 accord with a service recipient's needs.

219.19 Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342,
219.20 any person employed to provide family planning services who is paid in whole or in part
219.21 from funds provided under this section who advises an abortion or sterilization to any
219.22 emancipated minor shall, following such a recommendation, so notify the parent or
219.23 guardian of the reasons for such an action.

219.24 Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans
219.25 and budgets of prospective grant recipients, for the submission of annual financial and
219.26 statistical reports, and the maintenance of statements of source and application of funds by
219.27 grant recipients. The commissioner of health may not require that any home rule charter or
219.28 statutory city or county apply for or receive grants under this subdivision as a condition for
219.29 the receipt of any state or federal funds unrelated to family planning services.

219.30 Subd. 6. **Public services; individual and employee rights.** The request of any person
219.31 for family planning sexual and reproductive health services or the refusal to accept any
219.32 service shall in no way affect the right of the person to receive public assistance, public
219.33 health services, or any other public service. Nothing in this section shall abridge the right
220.1 of the individual person to make decisions concerning family planning sexual and
220.2 reproductive health, nor shall any individual person be required to state a reason for refusing
220.3 any offer of family planning sexual and reproductive health services.

220.4 Any employee of the agencies engaged in the administration of the provisions of this
220.5 section may refuse to accept the duty of offering family planning services to the extent that
220.6 the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal,
220.7 suspension, demotion, or any other discrimination in employment. The directors or
220.8 supervisors of the agencies shall reassign the duties of employees in order to carry out the
220.9 provisions of this section.

220.10 All information gathered by any agency, entity, or individual conducting programs in
220.11 family planning sexual and reproductive health is private data on individuals within the
220.12 meaning of section 13.02, subdivision 12. For any person or entity meeting the definition
220.13 of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and
220.14 reproductive health services information provided to, gathered about, or received from a
220.15 person under this section is also subject to the Minnesota Health Records Act, in sections
220.16 144.291 to 144.298.

220.17 Subd. 7. **Family planning services; information required.** A grant recipient shall
220.18 inform any person requesting counseling on family planning methods or procedures of:

220.19 (1) Any methods or procedures which may be followed, including identification of any
220.20 which are experimental or any which may pose a health hazard to the person;

220.21 (2) A description of any attendant discomforts or risks which might reasonably be
220.22 expected;

220.23 (3) A fair explanation of the likely results, should a method fail;

220.24 (4) A description of any benefits which might reasonably be expected of any method;

220.25 (5) A disclosure of appropriate alternative methods or procedures;

220.26 (6) An offer to answer any inquiries concerning methods or procedures; and

220.27 (7) An instruction that the person is free either to decline commencement of any method
220.28 or procedure or to withdraw consent to a method or procedure at any reasonable time.

220.29 Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under
220.30 any program receiving financial assistance under this section, who coerces or endeavors to
220.31 coerce any person to undergo an abortion or sterilization procedure by threatening the person
221.1 with the loss of or disqualification for the receipt of any benefit or service under a program
221.2 receiving state or federal financial assistance shall be guilty of a misdemeanor.

221.3 Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including
221.4 rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant
221.5 funds for family planning special projects, shall not limit the total amount of funds that can
221.6 be allocated to an organization. The commissioner shall allocate to an organization receiving
221.7 grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999
221.8 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the
221.9 organization submits an application that meets grant funding criteria. This subdivision does
221.10 not affect any procedure established in rule for allocating special project money to the
221.11 different regions. The commissioner shall revise the rules for family planning special project
221.12 grants so that they conform to the requirements of this subdivision. In adopting these
221.13 revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but
221.14 is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph
221.15 (b), does not apply to these rules.

224.23 Sec. 123. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE**
224.24 **SETTINGS GRANT PROGRAM.**

224.25 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a
224.26 grant program for the purpose of remediating identified sources of lead in drinking water
224.27 in schools and licensed child care settings.

224.28 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
224.29 for proposals process to schools and licensed child care settings. Priority shall be given to
224.30 schools and licensed child care settings with higher levels of lead detected in water samples,
224.31 evidence of lead service lines, or lead plumbing materials and school districts that serve
224.32 disadvantaged communities.

225.1 Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead
225.2 contamination in their facilities including but not limited to service connections and premise
225.3 plumbing, and to implement best practices for water management within the building.

225.4 Sec. 124. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD**
225.5 **CARE SETTINGS.**

225.6 Subdivision 1. **Requirement to test.** (a) By July 1, 2024, licensed or certified child care
225.7 providers must develop a plan to accurately and efficiently test for the presence of lead in
225.8 drinking water in child care facilities following either the Department of Health's document
225.9 "Reducing Lead in Drinking Water: A Technical Guidance for Minnesota's School and

210.8 Sec. 53. 145.9275 SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND
210.9 EDUCATION GRANT PROGRAM.210.10 Subdivision 1. Grant program. The commissioner of health shall award grants through
210.11 a request for proposal process to community-based organizations that serve ethnic
210.12 communities and focus on public health outreach to Black and people of color communities
210.13 on the issues of colorism, skin-lightening products, and chemical exposures from these
210.14 products. Priority in awarding grants shall be given to organizations that have historically
210.15 provided services to ethnic communities on the skin-lightening and chemical exposure issue
210.16 for the past four years.210.17 Subd. 2. Uses of grant funds. Grant recipients must use grant funds awarded under this
210.18 section to conduct public awareness and education activities that are culturally specific and
210.19 community-based and that focus on:225.10 Child Care Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing,
225.11 Taking Action" guidance materials.225.12 (b) For purposes of this section, "licensed or certified child care provider" means a child
225.13 care center licensed under Minnesota Rules, chapter 9503, or a certified license-exempt
225.14 child care center under chapter 245H.225.15 Subd. 2. Scope and frequency of testing. The plan under subdivision 1 must include
225.16 testing every building serving children and all water fixtures used for consumption of water,
225.17 including water used in food preparation. All taps must be tested at least once every five
225.18 years. A licensed or certified child care provider must begin testing in buildings by July 1,
225.19 2024, and complete testing in all buildings that serve students within five years.225.20 Subd. 3. Remediation of lead in drinking water. The plan under subdivision 1 must
225.21 include steps to remediate if lead is present in drinking water. A licensed or certified child
225.22 care provider that finds lead at concentrations at or exceeding five parts per billion at a
225.23 specific location providing water to children within its facilities must take action to reduce
225.24 lead exposure following guidance and verify the success of remediation by retesting the
225.25 location for lead. Remediation actions are actions that reduce lead levels from the drinking
225.26 water fixture as demonstrated by testing. This includes using certified filters, implementing
225.27 and documenting a building-wide flushing program, and replacing or removing fixtures
225.28 with elevated lead levels.225.29 Subd. 4. Reporting results. (a) A licensed or certified child care provider that tested its
225.30 buildings for the presence of lead shall make the results of the testing and any remediation
225.31 steps taken available to parents and staff and notify them of the availability of results.
225.32 Reporting shall occur no later than 30 days from receipt of results and annually thereafter.226.1 (b) Beginning July 1, 2024, a licensed or certified child care provider must report the
226.2 provider's test results and remediation activities to the commissioner of health annually on
226.3 or before July 1 of each year.286.11 Sec. 195. SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND
286.12 EDUCATION GRANT.286.13 An organization receiving a grant from the commissioner of health for public awareness
286.14 and education activities to address issues of colorism, skin-lightening products, and chemical
286.15 exposure from skin-lightening products must use the grant funds for activities that are
286.16 culturally specific and community-based and that focus on:

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

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

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

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

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

211.5 Sec. 54. **[145.9571] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

211.6 Sections 145.9571 to 145.9576 are the Healthy Beginnings, Healthy Families Act.

211.7 Sec. 55. **[145.9572] MINNESOTA PERINATAL QUALITY COLLABORATIVE.**

211.8 Subdivision 1. **Duties.** The Minnesota perinatal quality collaborative is established to
 211.9 improve pregnancy outcomes for pregnant people and newborns through efforts to:

211.10 (1) advance evidence-based and evidence-informed clinics and other health service
 211.11 practices and processes through quality care review, chart audits, and continuous quality
 211.12 improvement initiatives that enable equitable outcomes;

211.13 (2) review current data, trends, and research on best practices to inform and prioritize
 211.14 quality improvement initiatives;

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

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

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

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

287.1 (5) building the capacity of community-based organizations to continue to combat
 287.2 skin-lightening practices and chemical exposures from skin-lightening products.

274.1 Sec. 187. **HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

274.2 Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act
 274.3 is to build equitable, inclusive, and culturally and linguistically responsive systems that
 274.4 ensure the health and well-being of young children and their families by supporting the
 274.5 Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent
 274.6 infant mortality, increasing access to culturally relevant developmental and social-emotional
 274.7 screening with follow-up, and sustaining and expanding the model jail practices for children
 274.8 of incarcerated parents in Minnesota jails.

274.9 Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality
 274.10 collaborative is established to improve pregnancy outcomes for pregnant people and
 274.11 newborns through efforts to:

274.12 (1) advance evidence-based and evidence-informed clinics and other health service
 274.13 practices and processes through quality care review, chart audits, and continuous quality
 274.14 improvement initiatives that enable equitable outcomes;

274.15 (2) review current data, trends, and research on best practices to inform and prioritize
 274.16 quality improvement initiatives;

211.15 (3) identify methods that incorporate antiracism into individual practice and organizational
 211.16 guidelines in the delivery of perinatal health services;

211.17 (4) support quality improvement initiatives to address substance use disorders in pregnant
 211.18 people and infants with neonatal abstinence syndrome or other effects of substance use;

211.19 (5) provide a forum to discuss state-specific system and policy issues to guide quality
 211.20 improvement efforts that improve population-level perinatal outcomes;

211.21 (6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated
 211.22 effort across system organizations to reinforce a continuum of care model; and

211.23 (7) support health care facilities in monitoring interventions through rapid data collection
 211.24 and applying system changes to provide improved care in perinatal health.

211.25 **Subd. 2. Grants authorized.** The commissioner must award one grant to a nonprofit
 211.26 organization to support efforts that improve maternal and infant health outcomes aligned
 211.27 with the purpose outlined in subdivision 1. The commissioner must give preference to a
 211.28 nonprofit organization that has the ability to provide these services throughout the state.
 211.29 The commissioner must provide content expertise to the grant recipient to further the
 211.30 accomplishment of the purpose.

212.1 Sec. 56. **[145.9573] MINNESOTA PARTNERSHIP TO PREVENT INFANT
 212.2 MORTALITY.**

212.3 (a) The commissioner of health must establish the Minnesota partnership to prevent
 212.4 infant mortality program that is a statewide partnership program to engage communities,
 212.5 exchange best practices, share summary data on infant health, and promote policies to
 212.6 improve birth outcomes and eliminate preventable infant mortality.

212.7 (b) The goal of the Minnesota partnership to prevent infant mortality program is to:

212.8 (1) build a statewide multisectoral partnership including the state government, local
 212.9 public health agencies, Tribes, private sector, and community nonprofit organizations with
 212.10 the shared goal of decreasing infant mortality rates among populations with significant
 212.11 disparities, including among Black, American Indian, other nonwhite communities, and
 212.12 rural populations;

212.13 (2) address the leading causes of poor infant health outcomes such as premature birth,
 212.14 infant sleep-related deaths, and congenital anomalies through strategies to change social
 212.15 and environmental determinants of health; and

212.16 (3) promote the development, availability, and use of data-informed, community-driven
 212.17 strategies to improve infant health outcomes.

212.18 Sec. 57. **[145.9574] GRANTS.**

212.19 Subdivision 1. **Improving pregnancy and infant outcomes grant.** The commissioner
 212.20 of health must make a grant to a nonprofit organization to create or sustain a multidisciplinary

274.17 (3) identify methods that incorporate antiracism into individual practice and organizational
 274.18 guidelines in the delivery of perinatal health services;

274.19 (4) support quality improvement initiatives to address substance use disorders in pregnant
 274.20 people and infants with neonatal abstinence syndrome or other effects of substance use;

274.21 (5) provide a forum to discuss state-specific system and policy issues to guide quality
 274.22 improvement efforts that improve population-level perinatal outcomes;

274.23 (6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated
 274.24 effort across system organizations to reinforce a continuum of care model; and

274.25 (7) support health care facilities in monitoring interventions through rapid data collection
 274.26 and applying system changes to provide improved care in perinatal health.

275.1 **Subd. 4. Grants authorized.** The commissioner shall award one grant to a nonprofit
 275.2 organization to support efforts that improve maternal and infant health outcomes aligned
 275.3 with the purpose outlined in subdivision 2. The commissioner shall give preference to a
 275.4 nonprofit organization that has the ability to provide these services throughout the state.
 275.5 The commissioner shall provide content expertise to the grant recipient to further the
 275.6 accomplishment of the purpose.

275.7 **Subd. 5. Minnesota partnership to prevent infant mortality program.** (a) The
 275.8 commissioner of health shall establish the Minnesota partnership to prevent infant mortality
 275.9 program that is a statewide partnership program to engage communities, exchange best
 275.10 practices, share summary data on infant health, and promote policies to improve birth
 275.11 outcomes and eliminate preventable infant mortality.

275.12 (b) The goals of the Minnesota partnership to prevent infant mortality program are to:

275.13 (1) build a statewide multisectoral partnership including the state government, local
 275.14 public health agencies, Tribes, private sector, and community nonprofit organizations with
 275.15 the shared goal of decreasing infant mortality rates among populations with significant
 275.16 disparities, including among Black, American Indian, and other nonwhite communities,
 275.17 and rural populations;

275.18 (2) address the leading causes of poor infant health outcomes such as premature birth,
 275.19 infant sleep-related deaths, and congenital anomalies through strategies to change social
 275.20 and environmental determinants of health; and

275.21 (3) promote the development, availability, and use of data-informed, community-driven
 275.22 strategies to improve infant health outcomes.

274.27 **Subd. 3. Eligible organizations.** The commissioner of health shall make a grant to a
 274.28 nonprofit organization to create or sustain a multidisciplinary network of representatives

212.21 network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

212.25 Subd. 2. **Improving infant health grants.** (a) The commissioner of health must award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally relevant activities to improve infant health by reducing preterm birth, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Grants must be awarded to support community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, grants must be noncompetitively awarded to the eleven sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 1 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner must award all other grants competitively to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

213.5 (b) Grantee activities must:

213.6 (1) address the leading cause or causes of infant mortality;
213.7 (2) be based on community input;
213.8 (3) focus on policy, systems, and environmental changes that support infant health; and
213.9 (4) address the health disparities and inequities that are experienced in the grantee's community.

213.11 (c) The commissioner must 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 according to this subdivision, the commissioner must establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

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

213.22 Subd. 3. **Technical assistance.** (a) The commissioner must provide grant recipients receiving a grant under sections 145.9572 to 145.9576 with content expertise, technical expertise, training, and advice on data-driven strategies.

274.29 of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

275.23 Subd. 5a. **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 birth, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, grants shall be noncompetitively awarded to the eleven sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 5 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner shall award all other grants competitively to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

276.3 (b) Grantee activities shall:

276.4 (1) address the leading cause or causes of infant mortality;
276.5 (2) be based on community input;
276.6 (3) focus on policy, systems, and environmental changes that support infant health; and
276.7 (4) address the health disparities and inequities that are experienced in the grantee's community.

276.9 (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 according to subdivision 5, the commissioner shall establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

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

276.20 Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

213.25 (b) For the purposes of carrying out the grant program under section 145.9573, including
213.26 for administrative purposes, the commissioner must award contracts to appropriate entities
213.27 to assist in training and provide technical assistance to grantees.

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

213.30 (1) partnership development and capacity building;

213.31 (2) Tribal support;

213.32 (3) implementation support for specific infant health strategies;

214.1 (4) communications by convening and sharing lessons learned; and

214.2 (5) health equity.

214.3 Sec. 58. **[145.9575] DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING WITH FOLLOW-UP.**

214.5 Subdivision 1. **Developmental and social-emotional screening with follow-up.** The
214.6 goal of the developmental and social-emotional screening is to identify young children at
214.7 risk for developmental and behavioral concerns and provide follow-up services to connect
214.8 families and young children to appropriate community-based resources and programs. The
214.9 commissioner of health must work with the commissioners of human services and education
214.10 to implement this section and promote interagency coordination with other early childhood
214.11 programs including those that provide screening and assessment.

214.12 Subd. 2. **Duties.** The commissioner must:

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

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

214.17 (3) provide screening for developmental and social-emotional delays based on current
214.18 recommended best practices;

214.19 (4) review and share the results of the screening with the parent or guardian and support
214.20 families in their role as caregivers by providing anticipatory guidance around typical growth
214.21 and development;

214.22 (5) ensure children and families are referred to and linked with appropriate
214.23 community-based services and resources when any developmental or social-emotional
214.24 concerns are identified through screening; and

276.22 (b) For the purposes of carrying out the grant program under subdivision 5a, including
276.23 for administrative purposes, the commissioner shall award contracts to appropriate entities
276.24 to assist in training and provide technical assistance to grantees.

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

276.27 (1) partnership development and capacity building;

276.28 (2) Tribal support;

276.29 (3) implementation support for specific infant health strategies;

276.30 (4) communications by convening and sharing lessons learned; and

276.31 (5) health equity.

277.1 Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of
277.2 the developmental and social-emotional screening is to identify young children at risk for
277.3 developmental and behavioral concerns and provide follow-up services to connect families
277.4 and young children to appropriate community-based resources and programs. The
277.5 commissioner of health shall work with the commissioners of human services and education
277.6 to implement this section and promote interagency coordination with other early childhood
277.7 programs including those that provide screening and assessment.

277.8 Subd. 6a. **Duties.** The commissioner shall:

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

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

277.13 (3) provide screening for developmental and social-emotional delays based on current
277.14 recommended best practices;

277.15 (4) review and share the results of the screening with the parent or guardian and support
277.16 families in their role as caregivers by providing anticipatory guidance around typical growth
277.17 and development;

277.18 (5) ensure children and families are referred to and linked with appropriate
277.19 community-based services and resources when any developmental or social-emotional
277.20 concerns are identified through screening; and

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

214.28 Subd. 3. **Grants.** The commissioner must award grants to community-based
 214.29 organizations, community health boards, and Tribal Nations to support follow-up services
 214.30 for children with developmental or social-emotional concerns identified through screening
 214.31 in order to link children and their families to appropriate community-based services and
 214.32 resources. Grants must also be awarded to community-based organizations to train and
 215.1 utilize cultural liaisons to help families navigate the screening and follow-up process in a
 215.2 culturally and linguistically responsive manner. The commissioner must provide technical
 215.3 assistance, content expertise, and training to grant recipients to ensure that follow-up services
 215.4 are effectively provided.

215.5 Sec. 59. **[145.9576] MODEL JAIL PRACTICES.**

215.6 Subdivision 1. **Model jail practices for incarcerated parents.** (a) The commissioner
 215.7 of health may make special grants to counties and groups of counties to implement model
 215.8 jail practices and to county governments, Tribal governments, or nonprofit organizations
 215.9 in corresponding geographic areas to build partnerships with county jails to support children
 215.10 of incarcerated parents and their caregivers.

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

215.15 Subd. 2. **Grants authorized; model jail practices.** (a) The commissioner of health must
 215.16 award grants to eligible county jails to implement model jail practices and separate grants
 215.17 to county governments, Tribal governments, or nonprofit organizations in corresponding
 215.18 geographic areas to build partnerships with county jails to support children of incarcerated
 215.19 parents and their caregivers.

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

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

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

277.24 Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based
 277.25 organizations, community health boards, and Tribal nations to support follow-up services
 277.26 for children with developmental or social-emotional concerns identified through screening
 277.27 in order to link children and their families to appropriate community-based services and
 277.28 resources. Grants shall also be awarded to community-based organizations to train and
 277.29 utilize cultural liaisons to help families navigate the screening and follow-up process in a
 277.30 culturally and linguistically responsive manner. The commissioner shall provide technical
 277.31 assistance, content expertise, and training to grant recipients to ensure that follow-up services
 277.32 are effectively provided.

278.1 Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health
 278.2 may make special grants to counties and groups of counties to implement model jail practices
 278.3 and to county governments, Tribal governments, or nonprofit organizations in corresponding
 278.4 geographic areas to build partnerships with county jails to support children of incarcerated
 278.5 parents and their caregivers.

278.6 (b) "Model jail practices" means a set of practices that correctional administrators can
 278.7 implement, without compromising the safety or security of the correctional facility, to
 278.8 remove barriers that may prevent children from cultivating or maintaining relationships
 278.9 with their incarcerated parents during and immediately after incarceration.

278.10 Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health
 278.11 shall award grants to eligible county jails to implement model jail practices and separate
 278.12 grants to county governments, Tribal governments, or nonprofit organizations in
 278.13 corresponding geographic areas to build partnerships with county jails to support children
 278.14 of incarcerated parents and their caregivers.

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

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

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

215.27 (c) Grant recipients must report their activities to the commissioner in a format and at
 215.28 a time specified by the commissioner.

215.29 **Subd. 3. Technical assistance and oversight; model jail practices.** (a) The
 215.30 commissioner must provide content expertise, training to grant recipients, and advice on
 215.31 evidence-based strategies, including evidence-based training to support incarcerated parents.

216.1 (b) For the purposes of carrying out the grant program under subdivision 2, including
 216.2 for administrative purposes, the commissioner must award contracts to appropriate entities
 216.3 to assist in training and provide technical assistance to grantees.

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

216.6 (1) evidence-based training for incarcerated parents;

216.7 (2) partnership building and community engagement;

216.8 (3) evaluation of process and outcomes of model jail practices; and

216.9 (4) expert guidance on reducing the harm caused to children of incarcerated parents and
 216.10 application of model jail practices.

216.11 Sec. 60. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)**
 216.12 **COUNCIL.**

216.13 **Subdivision 1. Establishment; composition of advisory council.** The health equity
 216.14 advisory and leadership (HEAL) council consists of 18 members appointed by the
 216.15 commissioner of health who will provide representation from the following groups:

216.16 (1) African American and African heritage communities;

216.17 (2) Asian American and Pacific Islander communities;

216.18 (3) Latina/o/x communities;

216.19 (4) American Indian communities and Tribal governments and nations;

216.20 (5) disability communities;

216.21 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

216.22 (7) representatives who reside outside the seven-county metropolitan area.

216.23 **Subd. 2. Organization and meetings.** The advisory council shall be organized and
 216.24 administered under section 15.059, except that the council shall not expire under subdivision

278.24 **Subd. 7b. Technical assistance and oversight; model jail practices.** (a) The
 278.25 commissioner shall provide content expertise, training to grant recipients, and advice on
 278.26 evidence-based strategies, including evidence-based training to support incarcerated parents.

278.27 (b) For the purposes of carrying out the grant program under subdivision 7a, including
 278.28 for administrative purposes, the commissioner shall award contracts to appropriate entities
 278.29 to assist in training and provide technical assistance to grantees.

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

279.1 (1) evidence-based training for incarcerated parents;

279.2 (2) partnership building and community engagement;

279.3 (3) evaluation of process and outcomes of model jail practices; and

279.4 (4) expert guidance on reducing the harm caused to children of incarcerated parents and
 279.5 application of model jail practices.

226.4 **Sec. 125. [145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)**
 226.5 **COUNCIL.**

226.6 **Subdivision 1. Establishment; composition of advisory council.** The commissioner
 226.7 shall establish and appoint a health equity advisory and leadership (HEAL) council to
 226.8 provide guidance to the commissioner of health regarding strengthening and improving the
 226.9 health of communities most impacted by health inequities across the state. The council shall
 226.10 consist of 18 members who will provide representation from the following groups:

226.11 (1) African American and African heritage communities;

226.12 (2) Asian American and Pacific Islander communities;

226.13 (3) Latina/o/x communities;

226.14 (4) American Indian communities and Tribal governments and nations;

226.15 (5) disability communities;

226.16 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

226.17 (7) representatives who reside outside the seven-county metropolitan area.

226.18 **Subd. 2. Organization and meetings.** The advisory council shall be organized and
 226.19 administered under section 15.059. Meetings shall be held at least quarterly and hosted by

216.25 **6. The commissioner of health must convene meetings at least quarterly and must provide**
 216.26 **meeting space and administrative support to the council. Subcommittees may be convened**
 216.27 **as necessary. Advisory council meetings are subject to the open meeting law under chapter**
 216.28 **13D.**

216.29 **Subd. 3. Duties. The advisory council shall:**

217.1 **(1) advise the commissioner on health equity issues and the health equity priorities and**
 217.2 **concerns of the populations specified in subdivision 1;**

217.3 **(2) assist the agency in efforts to advance health equity, including consulting ~~in~~ specific**
 217.4 **agency policies and programs, providing ideas and input about potential budget and policy**
 217.5 **proposals, and recommending review of agency policies, standards, or procedures that may**
 217.6 **create or perpetuate health inequities; and**

217.7 **(3) assist the agency in developing and monitoring meaningful performance measures**
 217.8 **related to advancing health equity.**

217.9 **Subd. 4. Expiration. The advisory council shall remain in existence until health inequities**
 217.10 **in the state are eliminated. Health inequities will be considered eliminated when race,**
 217.11 **ethnicity, income, gender, gender identity, geographic location, or other identity or social**
 217.12 **marker will no longer be predictors of health outcomes in the state. Section 145.928 describes**
 217.13 **nine health disparities that must be considered when determining whether health inequities**
 217.14 **have been eliminated in the state.**

217.15 **Subd. 5. Annual report. The advisory council must submit a report annually by January**
 217.16 **15 to the chairs and ranking minority members of the legislative committees with primary**
 217.17 **jurisdiction over health policy and finance summarizing the work of the council over the**
 217.18 **previous year and setting goals for the following year.**

217.19 **Sec. 61. [145.988] COMPREHENSIVE AND COLLABORATIVE RESOURCE AND**
 217.20 **REFERRAL SYSTEM FOR CHILDREN.**

217.21 **Subdivision 1. Establishment; purpose. The commissioner shall establish the**
 217.22 **Comprehensive and Collaborative Resource and Referral System for Children to support a**
 217.23 **comprehensive, collaborative resource and referral system for children from prenatal stage**
 217.24 **through age eight and their families. The commissioner of health shall work collaboratively**
 217.25 **with the commissioners of human services and education to implement this section.**

217.26 **Subd. 2. Duties. (a) The Help Me Connect system shall facilitate collaboration across**
 217.27 **sectors, including child health, early learning and education, child welfare, and family**
 217.28 **supports by:**

217.29 **(1) providing early childhood provider outreach to support knowledge of and access to**
 217.30 **local resources that provide early detection and intervention services;**

226.20 **the department. Subcommittees may be convened as necessary. Advisory council meetings**
 226.21 **are subject to the open meeting law under chapter 13D.**

226.22 **Subd. 3. Duties. The advisory council shall:**

226.23 **(1) advise the commissioner on health equity issues and the health equity priorities and**
 226.24 **concerns of the populations specified in subdivision 1;**

226.25 **(2) assist the agency in efforts to advance health equity, including consulting ~~on~~ specific**
 226.26 **agency policies and programs, providing ideas and input about potential budget and policy**
 226.27 **proposals, and recommending review of agency policies, standards, or procedures that may**
 226.28 **create or perpetuate health inequities; and**

226.29 **(3) assist the agency in developing and monitoring meaningful performance measures**
 226.30 **related to advancing health equity.**

227.1 **Subd. 4. Expiration. The advisory council shall remain in existence until health inequities**
 227.2 **in the state are eliminated. Health inequities will be considered eliminated when race,**
 227.3 **ethnicity, income, gender, gender identity, geographic location, or other identity or social**
 227.4 **marker will no longer be predictors of health outcomes in the state. Section 145.928 describes**
 227.5 **nine health disparities that must be considered when determining whether health inequities**
 227.6 **have been eliminated in the state.**

279.6 **Sec. 188. HELP ME CONNECT RESOURCE AND REFERRAL SYSTEM FOR**
 279.7 **CHILDREN.**

279.8 **Subdivision 1. Establishment; purpose. The commissioner shall establish the Help Me**
 279.9 **Connect resource and referral system for children as a comprehensive, collaborative resource**
 279.10 **and referral system for children from the prenatal stage through age eight, and their families.**
 279.11 **The commissioner of health shall work collaboratively with the commissioners of human**
 279.12 **services and education to implement this section.**

279.13 **Subd. 2. Duties. (a) The Help Me Connect system shall facilitate collaboration across**
 279.14 **sectors, including child health, early learning and education, child welfare, and family**
 279.15 **supports by:**

279.16 **(1) providing early childhood provider outreach to support knowledge of and access to**
 279.17 **local resources that provide early detection and intervention services;**

217.31 (2) identifying and providing access to early childhood and family support navigation
217.32 specialists that can support families and their children's needs; and

218.1 (3) linking children and families to appropriate community-based services.

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

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

218.11 (d) The Help Me Connect system shall collect data to increase understanding of the
218.12 current and ongoing system of support and resources for expectant families and children
218.13 through age eight and their families, including identification of gaps in service, barriers to
218.14 finding and receiving appropriate services, and lack of resources.

218.15 Sec. 62. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

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

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

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

218.32 (d) The State Community Health Advisory Committee may recommend a formula to
218.33 the commissioner to use in distributing funds to community health boards.

219.1 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
219.2 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
219.3 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive

279.18 (2) identifying and providing access to early childhood and family support navigation
279.19 specialists that can support families and their children's needs; and

279.20 (3) linking children and families to appropriate community-based services.

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

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

279.30 (d) The Help Me Connect system shall collect data to increase understanding of the
279.31 current and ongoing system of support and resources for expectant families and children
280.1 through age eight and their families, including identification of gaps in service, barriers to
280.2 finding and receiving appropriate services, and lack of resources.

227.7 Sec. 126. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

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

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

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

227.24 (d) The State Community Health Services Advisory Committee may recommend a
227.25 formula to the commissioner to use in distributing funds to community health boards.

227.26 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or
227.27 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,
227.28 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive

219.4 an increase equal to ten percent of the grant award to the community health board under
 219.5 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
 219.6 the last six months of the year. For calendar years beginning on or after January 1, 2016,
 219.7 the amount distributed under this paragraph shall be adjusted each year based on available
 219.8 funding and the number of eligible community health boards.

219.9 (f) Funding for foundational public health responsibilities will be distributed based on
 219.10 a formula determined by the Commissioner in consultation with the State Community Health
 219.11 Services Advisory Committee. These funds must be used as described in subdivision 5.

219.12 Sec. 63. Minnesota Statutes 2022, section 145A.131, subdivision 2, is amended to read:

219.13 Subd. 2. **Local match.** (a) A community health board that receives a local public health
 219.14 grant shall provide at least a 75 percent match for the state funds received through the local
 219.15 public health grant described in subdivision 1 and subject to paragraphs (b) to (e) (f).

219.16 (b) Eligible funds must be used to meet match requirements. Eligible funds include funds
 219.17 from local property taxes, reimbursements from third parties, fees, other local funds, and
 219.18 donations or nonfederal grants that are used for community health services described in
 219.19 section 145A.02, subdivision 6.

219.20 (c) When the amount of local matching funds for a community health board is less than
 219.21 the amount required under paragraph (a), the local public health grant provided for that
 219.22 community health board under this section shall be reduced proportionally.

219.23 (d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a
 219.24 tax for provision of community health services is exempt from any county levy for the same
 219.25 services to the extent of the levy imposed by the city.

219.26 Sec. 64. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

219.27 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their
 219.28 local public health grant funds as described in subdivision 1, paragraphs (a) to (e), to address
 219.29 the areas of public health responsibility and local priorities developed through the community
 219.30 health assessment and community health improvement planning process.

219.31 (b) Except as otherwise provided in this paragraph, funding for foundational public
 219.32 health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill
 220.1 foundational public health responsibilities as defined by the commissioner in consultation
 220.2 with the state community health service advisory committee. If a community health board
 220.3 can demonstrate foundational public health responsibilities are fulfilled, the board may use
 220.4 funds for local priorities developed through the community health assessment and community
 220.5 health improvement planning process.

227.29 an increase equal to ten percent of the grant award to the community health board under
 227.30 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for
 227.31 the last six months of the year. For calendar years beginning on or after January 1, 2016,
 227.32 the amount distributed under this paragraph shall be adjusted each year based on available
 227.33 funding and the number of eligible community health boards.

228.1 (f) Funding for foundational public health responsibilities must be distributed based on
 228.2 a formula determined by the commissioner in consultation with the State Community Health
 228.3 Services Advisory Committee. A portion of these funds may be used to fund new
 228.4 organizational models, including multijurisdictional and regional partnerships. These funds
 228.5 shall be used in accordance with subdivision 5.

228.6 Sec. 127. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

228.7 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their
 228.8 local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address
 228.9 the areas of public health responsibility and local priorities developed through the community
 228.10 health assessment and community health improvement planning process.

228.11 (b) Funding for foundational public health responsibilities as outlined in subdivision 1,
 228.12 paragraph (f), must be used to fulfill foundational public health responsibilities as defined
 228.13 by the commissioner in consultation with the State Community Health Services Advisory
 228.14 Committee unless a community health board demonstrates fulfillment of foundational public
 228.15 health responsibilities. If a community health board demonstrates foundational public health
 228.16 responsibilities are fulfilled, funds may be used for local priorities developed through the
 228.17 community health assessment and community health improvement planning process.

228.18 (c) By July 1, 2028, all local public health grant funds must be used first to fulfill
 228.19 foundational public health responsibilities. Once a community health board demonstrates

220.6 Sec. 65. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision
220.7 to read:

220.8 Subd. 2b. Grants to tribes. The commissioner must distribute grants to Tribal
220.9 governments for foundational public health responsibilities as defined by each Tribal
220.10 government.

228.20 foundational public health responsibilities are fulfilled, funds may be used for local priorities
228.21 developed through the community health assessment and community health improvement
228.22 planning process.

220.6 Sec. 65. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision
220.7 to read:

220.8 Subd. 2b. Grants to tribes. The commissioner shall distribute grants to Tribal
220.9 governments for foundational public health responsibilities as defined by each Tribal
220.10 government.

228.23 Sec. 128. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision
228.24 to read:

228.25 Subd. 2b. Grants to Tribes. The commissioner shall distribute grants to Tribal
228.26 governments for foundational public health responsibilities as defined by each Tribal
228.27 government.

FOR SECTION 129, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

229.11 Sec. 130. Minnesota Statutes 2022, section 148.261, subdivision 1, is amended to read:

229.12 Subdivision 1. Grounds listed. The board may deny, revoke, suspend, limit, or condition
229.13 the license and registration of any person to practice advanced practice, professional, or
229.14 practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee
229.15 or applicant as described in section 148.262. The following are grounds for disciplinary
229.16 action:

229.17 (1) Failure to demonstrate the qualifications or satisfy the requirements for a license
229.18 contained in sections 148.171 to 148.285 or rules of the board. In the case of a person
229.19 applying for a license, the burden of proof is upon the applicant to demonstrate the
229.20 qualifications or satisfaction of the requirements.

229.21 (2) Employing fraud or deceit in procuring or attempting to procure a permit, license,
229.22 or registration certificate to practice advanced practice, professional, or practical nursing
229.23 or attempting to subvert the licensing examination process. Conduct that subverts or attempts
229.24 to subvert the licensing examination process includes, but is not limited to:

229.25 (i) conduct that violates the security of the examination materials, such as removing
229.26 examination materials from the examination room or having unauthorized possession of
229.27 any portion of a future, current, or previously administered licensing examination;

229.28 (ii) conduct that violates the standard of test administration, such as communicating with
229.29 another examinee during administration of the examination, copying another examinee's
229.30 answers, permitting another examinee to copy one's answers, or possessing unauthorized
229.31 materials; or

230.1 (iii) impersonating an examinee or permitting an impersonator to take the examination
230.2 on one's own behalf.

230.3 (3) Conviction of a felony or gross misdemeanor reasonably related to the practice of
230.4 professional, advanced practice registered, or practical nursing. Conviction as used in this
230.5 subdivision includes a conviction of an offense that if committed in this state would be
230.6 considered a felony or gross misdemeanor without regard to its designation elsewhere, or

230.7 a criminal proceeding where a finding or verdict of guilt is made or returned but the
230.8 adjudication of guilt is either withheld or not entered.

230.9 (4) Revocation, suspension, limitation, conditioning, or other disciplinary action against
230.10 the person's professional or practical nursing license or advanced practice registered nursing
230.11 credential, in another state, territory, or country; failure to report to the board that charges
230.12 regarding the person's nursing license or other credential are pending in another state,
230.13 territory, or country; or having been refused a license or other credential by another state,
230.14 territory, or country.

230.15 (5) Failure to or inability to perform professional or practical nursing as defined in section
230.16 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a
230.17 registered nurse to supervise or a licensed practical nurse to monitor adequately the
230.18 performance of acts by any person working at the nurse's direction.

230.19 (6) Engaging in unprofessional conduct, including, but not limited to, a departure from
230.20 or failure to conform to board rules of professional or practical nursing practice that interpret
230.21 the statutory definition of professional or practical nursing as well as provide criteria for
230.22 violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and
230.23 prevailing professional or practical nursing practice, or any nursing practice that may create
230.24 unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not
230.25 be established under this clause.

230.26 (7) Failure of an advanced practice registered nurse to practice with reasonable skill and
230.27 safety or departure from or failure to conform to standards of acceptable and prevailing
230.28 advanced practice registered nursing.

230.29 (8) Delegating or accepting the delegation of a nursing function or a prescribed health
230.30 care function when the delegation or acceptance could reasonably be expected to result in
230.31 unsafe or ineffective patient care.

230.32 (9) Actual or potential inability to practice nursing with reasonable skill and safety to
230.33 patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as
230.34 a result of any mental or physical condition.

231.1 (10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person,
231.2 or a person dangerous to the public by a court of competent jurisdiction, within or without
231.3 this state.

231.4 (11) Engaging in any unethical conduct, including, but not limited to, conduct likely to
231.5 deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for
231.6 the health, welfare, or safety of a patient. Actual injury need not be established under this
231.7 clause.

231.8 (12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted
231.9 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
231.10 to a patient, or engaging in sexual exploitation of a patient or former patient.

231.11 (13) Obtaining money, property, or services from a patient, other than reasonable fees
231.12 for services provided to the patient, through the use of undue influence, harassment, duress,
231.13 deception, or fraud.

231.14 (14) Revealing a privileged communication from or relating to a patient except when
231.15 otherwise required or permitted by law.

231.16 (15) Engaging in abusive or fraudulent billing practices, including violations of federal
231.17 Medicare and Medicaid laws or state medical assistance laws.

231.18 (16) Improper management of patient records, including failure to maintain adequate
231.19 patient records, to comply with a patient's request made pursuant to sections 144.291 to
231.20 144.298, or to furnish a patient record or report required by law.

231.21 (17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage
231.22 in the unlawful practice of advanced practice, professional, or practical nursing.

231.23 (18) Violating a rule adopted by the board, an order of the board, or a state or federal
231.24 law relating to the practice of advanced practice, professional, or practical nursing, or a
231.25 state or federal narcotics or controlled substance law.

231.26 (19) Knowingly providing false or misleading information that is directly related to the
231.27 care of that patient unless done for an accepted therapeutic purpose such as the administration
231.28 of a placebo.

231.29 (20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as
231.30 established by any of the following:

231.31 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
231.32 of section 609.215, subdivision 1 or 2;

232.1 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
232.2 issued under section 609.215, subdivision 4;

232.3 (iii) a copy of the record of a judgment assessing damages under section 609.215,
232.4 subdivision 5; or

232.5 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
232.6 The board shall investigate any complaint of a violation of section 609.215, subdivision 1
232.7 or 2.

232.8 (21) Practicing outside the scope of practice authorized by section 148.171, subdivision
232.9 5, 10, 11, 13, 14, 15, or 21.

232.10 (22) Making a false statement or knowingly providing false information to the board,
232.11 failing to make reports as required by section 148.263, or failing to cooperate with an
232.12 investigation of the board as required by section 148.265.

232.13 (23) Engaging in false, fraudulent, deceptive, or misleading advertising.

232.14 (24) Failure to inform the board of the person's certification or recertification status as
232.15 a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner,
232.16 or certified clinical nurse specialist.

232.17 (25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse
232.18 practitioner practice, or registered nurse anesthetist practice without a license and current
232.19 certification or recertification by a national nurse certification organization acceptable to
232.20 the board.

232.21 (26) Engaging in conduct that is prohibited under section 145.412.

232.22 (27) (26) Failing to report employment to the board as required by section 148.211,
232.23 subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report
232.24 as required by section 148.211, subdivision 2a.

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

232.26 Sec. 131. Minnesota Statutes 2022, section 148.512, subdivision 10a, is amended to read:

232.27 Subd. 10a. **Hearing aid.** "Hearing aid" means an instrument a prescribed aid, or any of
232.28 its parts, worn in the ear canal and designed to or represented as being able to aid or enhance
232.29 human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including,
232.30 but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold.
232.31 Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically
232.32 implanted hearing aids, and assistive listening devices not worn within the ear canal, are
232.33 not hearing aids.

233.3 Sec. 132. Minnesota Statutes 2022, section 148.512, subdivision 10b, is amended to read:

233.4 Subd. 10b. **Hearing aid dispensing.** "Hearing aid dispensing" means making ear mold
233.5 impressions, prescribing, or recommending a hearing aid, assisting the consumer in
233.6 prescription aid selection, selling hearing aids at retail, or testing human hearing in connection
233.7 with these activities regardless of whether the person conducting these activities has a
233.8 monetary interest in the dispensing of prescription hearing aids to the consumer. Hearing
233.9 aid dispensing does not include selling over-the-counter hearing aids.

233.10 Sec. 133. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision
233.11 to read:

233.12 Subd. 10c. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter
233.13 hearing aid" or "OTC hearing aid" has the meaning given to that term in Code of Federal
233.14 Regulations, title 21, section 800.30(b).

233.15 Sec. 134. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision
233.16 to read:

233.17 Subd. 13a. **Prescription hearing aid.** "Prescription hearing aid" means a hearing aid
233.18 requiring a prescription from a certified hearing aid dispenser or licensed audiologist that
233.19 is not an OTC hearing aid.

233.20 Sec. 135. Minnesota Statutes 2022, section 148.513, is amended by adding a subdivision
233.21 to read:

233.22 Subd. 4. **Over-the-counter hearing aids.** Nothing in sections 148.511 to 148.5198 shall
233.23 preclude licensed audiologists from dispensing or selling over-the-counter hearing aids.

233.24 Sec. 136. Minnesota Statutes 2022, section 148.515, subdivision 6, is amended to read:

233.25 Subd. 6. **Dispensing audiologist examination requirements.** (a) Audiologists are
233.26 exempt from the written examination requirement in section 153A.14, subdivision 2h,
233.27 paragraph (a), clause (1).

233.28 (b) After July 31, 2005, all applicants for audiologist licensure under sections 148.512
233.29 to 148.5198 must achieve a passing score on the practical tests of proficiency described in
234.1 section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described
234.2 in section 153A.14, subdivision 2h, paragraph (c).

234.3 (c) In order to dispense prescription hearing aids as a sole proprietor, member of a
234.4 partnership, or for a limited liability company, corporation, or any other entity organized
234.5 for profit, a licensee who obtained audiologist licensure under sections 148.512 to 148.5198,
234.6 before August 1, 2005, and who is not certified to dispense prescription hearing aids under
234.7 chapter 153A, must achieve a passing score on the practical tests of proficiency described
234.8 in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described
234.9 in section 153A.14, subdivision 2h, paragraph (c). All other audiologist licensees who
234.10 obtained licensure before August 1, 2005, are exempt from the practical tests.

234.11 (d) An applicant for an audiology license who obtains a temporary license under section
234.12 148.5175 may dispense prescription hearing aids only under supervision of a licensed
234.13 audiologist who dispenses prescription hearing aids.

234.14 Sec. 137. Minnesota Statutes 2022, section 148.5175, is amended to read:

234.15 **148.5175 TEMPORARY LICENSURE.**

234.16 (a) The commissioner shall issue temporary licensure as a speech-language pathologist,
234.17 an audiologist, or both, to an applicant who:

234.18 (1) submits a signed and dated affidavit stating that the applicant is not the subject of a
234.19 disciplinary action or past disciplinary action in this or another jurisdiction and is not
234.20 disqualified on the basis of section 148.5195, subdivision 3; and

234.21 (2) either:

234.22 (i) provides a copy of a current credential as a speech-language pathologist, an audiologist,
234.23 or both, held in the District of Columbia or a state or territory of the United States; or

234.24 (ii) provides a copy of a current certificate of clinical competence issued by the American
234.25 Speech-Language-Hearing Association or board certification in audiology by the American
234.26 Board of Audiology.

234.27 (b) A temporary license issued to a person under this subdivision expires 90 days after
234.28 it is issued or on the date the commissioner grants or denies licensure, whichever occurs
234.29 first.

234.30 (c) Upon application, a temporary license shall be renewed twice to a person who is able
234.31 to demonstrate good cause for failure to meet the requirements for licensure within the
234.32 initial temporary licensure period and who is not the subject of a disciplinary action or
235.1 disqualified on the basis of section 148.5195, subdivision 3. Good cause includes but is not
235.2 limited to inability to take and complete the required practical exam for dispensing
235.3 prescription hearing instruments aids.

235.4 (d) Upon application, a temporary license shall be issued to a person who meets the
235.5 requirements of section 148.515, subdivisions 2a and 4, but has not completed the
235.6 requirement in section 148.515, subdivision 6.

235.7 Sec. 138. Minnesota Statutes 2022, section 148.5195, subdivision 3, is amended to read:

235.8 Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may
235.9 take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

235.10 (1) intentionally submitted false or misleading information to the commissioner or the
235.11 advisory council;

235.12 (2) failed, within 30 days, to provide information in response to a written request by the
235.13 commissioner or advisory council;

235.14 (3) performed services of a speech-language pathologist or audiologist in an incompetent
235.15 or negligent manner;

235.16 (4) violated sections 148.511 to 148.5198;

235.17 (5) failed to perform services with reasonable judgment, skill, or safety due to the use
235.18 of alcohol or drugs, or other physical or mental impairment;

235.19 (6) violated any state or federal law, rule, or regulation, and the violation is a felony or
235.20 misdemeanor, an essential element of which is dishonesty, or which relates directly or
235.21 indirectly to the practice of speech-language pathology or audiology. Conviction for violating
235.22 any state or federal law which relates to speech-language pathology or audiology is
235.23 necessarily considered to constitute a violation, except as provided in chapter 364;

235.24 (7) aided or abetted another person in violating any provision of sections 148.511 to
235.25 148.5198;

235.26 (8) been or is being disciplined by another jurisdiction, if any of the grounds for the
235.27 discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

235.28 (9) not cooperated with the commissioner or advisory council in an investigation
235.29 conducted according to subdivision 1;

235.30 (10) advertised in a manner that is false or misleading;

236.1 (11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated
236.2 a willful or careless disregard for the health, welfare, or safety of a client;

236.3 (12) failed to disclose to the consumer any fee splitting or any promise to pay a portion
236.4 of a fee to any other professional other than a fee for services rendered by the other
236.5 professional to the client;

236.6 (13) engaged in abusive or fraudulent billing practices, including violations of federal
236.7 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
236.8 assistance laws;

236.9 (14) obtained money, property, or services from a consumer through the use of undue
236.10 influence, high pressure sales tactics, harassment, duress, deception, or fraud;

236.11 (15) performed services for a client who had no possibility of benefiting from the services;

236.12 (16) failed to refer a client for medical evaluation or to other health care professionals
236.13 when appropriate or when a client indicated symptoms associated with diseases that could
236.14 be medically or surgically treated;

236.15 (17) had the certification required by chapter 153A denied, suspended, or revoked
236.16 according to chapter 153A;

236.17 (18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or
236.18 SLPD without having obtained the degree from an institution accredited by the North Central
236.19 Association of Colleges and Secondary Schools, the Council on Academic Accreditation
236.20 in Audiology and Speech-Language Pathology, the United States Department of Education,
236.21 or an equivalent;

236.22 (19) failed to comply with the requirements of section 148.5192 regarding supervision
236.23 of speech-language pathology assistants; or

236.24 (20) if the individual is an audiologist or certified hearing instrument aid dispenser:
236.25 (i) prescribed or otherwise recommended to a consumer or potential consumer the use
236.26 of a prescription hearing instrument aid, unless the prescription from a physician or
236.27 recommendation from, an audiologist, or a certified dispenser is in writing, is based on an
236.28 audiogram that is delivered to the consumer or potential consumer when the prescription
236.29 or recommendation is made, and bears the following information in all capital letters of
236.30 12-point or larger boldface type: "THIS PRESCRIPTION OR RECOMMENDATION
236.31 MAY BE FILLED BY, AND PRESCRIPTION HEARING INSTRUMENTS AIDS MAY

236.32 **BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER**
236.33 **OF YOUR CHOICE";**

237.1 (ii) failed to give a copy of the audiogram, upon which the prescription ~~or~~
237.2 ~~recommendation~~ is based, to the consumer when the consumer requests a copy;

237.3 (iii) failed to provide the consumer rights brochure required by section 148.5197,
237.4 subdivision 3;

237.5 (iv) failed to comply with restrictions on sales of prescription hearing instruments aids
237.6 in sections 148.5197, subdivision 3, and 148.5198;

237.7 (v) failed to return a consumer's prescription hearing instrument aid used as a trade-in
237.8 or for a discount in the price of a new prescription hearing instrument aid when requested
237.9 by the consumer upon cancellation of the purchase agreement;

237.10 (vi) failed to follow Food and Drug Administration or Federal Trade Commission
237.11 regulations relating to dispensing prescription hearing instruments aids;

237.12 (vii) failed to dispense a prescription hearing instrument aid in a competent manner or
237.13 without appropriate training;

237.14 (viii) delegated prescription hearing instrument aid dispensing authority to a person not
237.15 authorized to dispense a prescription hearing instrument aid under this chapter or chapter
237.16 153A;

237.17 (ix) failed to comply with the requirements of an employer or supervisor of a hearing
237.18 instrument aid dispenser trainee;

237.19 (x) violated a state or federal court order or judgment, including a conciliation court
237.20 judgment, relating to the activities of the individual's prescription hearing instrument aid
237.21 dispensing; or

237.22 (xi) failed to include on the audiogram the practitioner's printed name, credential type,
237.23 credential number, signature, and date.

237.24 Sec. 139. Minnesota Statutes 2022, section 148.5196, subdivision 1, is amended to read:

237.25 Subdivision 1. **Membership.** The commissioner shall appoint 12 persons to a
237.26 Speech-Language Pathologist and Audiologist Advisory Council. The 12 persons must
237.27 include:

237.28 (1) three public members, as defined in section 214.02. Two of the public members shall
237.29 be either persons receiving services of a speech-language pathologist or audiologist, or
237.30 family members of or caregivers to such persons, and at least one of the public members
237.31 shall be either a hearing instrument aid user or an advocate of one;

238.1 (2) three speech-language pathologists licensed under sections 148.511 to 148.5198,
238.2 one of whom is currently and has been, for the five years immediately preceding the

238.3 appointment, engaged in the practice of speech-language pathology in Minnesota and each
238.4 of whom is employed in a different employment setting including, but not limited to, private
238.5 practice, hospitals, rehabilitation settings, educational settings, and government agencies;

238.6 (3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who
238.7 is currently and has been, for the five years immediately preceding the appointment,
238.8 employed by a Minnesota public school district or a Minnesota public school district
238.9 consortium that is authorized by Minnesota Statutes and who is licensed in speech-language
238.10 pathology by the Professional Educator Licensing and Standards Board;

238.11 (4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are
238.12 currently and have been, for the five years immediately preceding the appointment, engaged
238.13 in the practice of audiology and the dispensing of prescription hearing instruments aids in
238.14 Minnesota and each of whom is employed in a different employment setting including, but
238.15 not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry,
238.16 and government agencies;

238.17 (5) one nonaudiologist hearing instrument aid dispenser recommended by a professional
238.18 association representing hearing instrument aid dispensers; and

238.19 (6) one physician licensed under chapter 147 and certified by the American Board of
238.20 Otolaryngology, Head and Neck Surgery.

238.21 Sec. 140. Minnesota Statutes 2022, section 148.5197, is amended to read:

238.22 **148.5197 HEARING AID DISPENSING.**

238.23 Subdivision 1. **Content of contracts.** Oral statements made by an audiologist or certified
238.24 dispenser regarding the provision of warranties, refunds, and service on the prescription
238.25 hearing aid or aids dispensed must be written on, and become part of, the contract of sale,
238.26 specify the item or items covered, and indicate the person or business entity obligated to
238.27 provide the warranty, refund, or service.

238.28 Subd. 2. **Required use of license number.** The audiologist's license number or certified
238.29 dispenser's certificate number must appear on all contracts, bills of sale, and receipts used
238.30 in the sale of prescription hearing aids.

238.31 Subd. 3. **Consumer rights information.** An audiologist or certified dispenser shall, at
238.32 the time of the recommendation or prescription, give a consumer rights brochure, prepared
238.33 by the commissioner and containing information about legal requirements pertaining to
239.1 dispensing of prescription hearing aids, to each potential consumer of a prescription hearing
239.2 aid. The brochure must contain information about the consumer information center described
239.3 in section 153A.18. A contract for a prescription hearing aid must note the receipt of the
239.4 brochure by the consumer, along with the consumer's signature or initials.

239.5 Subd. 4. **Liability for contracts.** Owners of entities in the business of dispensing
239.6 prescription hearing aids, employers of audiologists or persons who dispense prescription
239.7 hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers

239.8 conducting the transaction at issue are liable for satisfying all terms of contracts, written or
239.9 oral, made by their agents, employees, assignees, affiliates, or trainees, including terms
239.10 relating to products, repairs, warranties, service, and refunds. The commissioner may enforce
239.11 the terms of prescription hearing aid contracts against the principal, employer, supervisor,
239.12 or dispenser who conducted the transaction and may impose any remedy provided for in
239.13 this chapter.

239.14 Sec. 141. Minnesota Statutes 2022, section 148.5198, is amended to read:

239.15 **148.5198 RESTRICTION ON SALE OF PRESCRIPTION HEARING AIDS.**

239.16 Subdivision 1. **45-calendar-day guarantee and buyer right to cancel.** (a) An audiologist
239.17 or certified dispenser dispensing a prescription hearing aid in this state must comply with
239.18 paragraphs (b) and (c).

239.19 (b) The audiologist or certified dispenser must provide the buyer with a 45-calendar-day
239.20 written money-back guarantee. The guarantee must permit the buyer to cancel the purchase
239.21 for any reason within 45 calendar days after receiving the prescription hearing aid by giving
239.22 or mailing written notice of cancellation to the audiologist or certified dispenser. If the buyer
239.23 mails the notice of cancellation, the 45-calendar-day period is counted using the postmark
239.24 date, to the date of receipt by the audiologist or certified dispenser. If the prescription hearing
239.25 aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee
239.26 period, the running of the 45-calendar-day period is suspended one day for each 24-hour
239.27 period that the prescription hearing aid is not in the buyer's possession. A repaired, remade,
239.28 or adjusted prescription hearing aid must be claimed by the buyer within three business
239.29 days after notification of availability, after which time the running of the 45-calendar-day
239.30 period resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund
239.31 of payment within 30 days of return of the prescription hearing aid to the audiologist or
239.32 certified dispenser. The audiologist or certified dispenser may retain as a cancellation fee
239.33 no more than \$250 of the buyer's total purchase price of the prescription hearing aid.

240.1 (c) The audiologist or certified dispenser shall provide the buyer with a contract written
240.2 in plain English, that contains uniform language and provisions that meet the requirements
240.3 under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must
240.4 include, but is not limited to, the following: in immediate proximity to the space reserved
240.5 for the signature of the buyer, or on the first page if there is no space reserved for the
240.6 signature of the buyer, a clear and conspicuous disclosure of the following specific statement
240.7 in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW
240.8 GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON
240.9 AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER
240.10 RECEIPT OF THE PRESCRIPTION HEARING AID(S). THIS CANCELLATION MUST
240.11 BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR
240.12 CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE PRESCRIPTION
240.13 HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL
240.14 RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM

240.15 WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A
240.16 CANCELLATION FEE NO MORE THAN \$250."

240.17 Subd. 2. **Itemized repair bill.** Any audiologist, certified dispenser, or company who
240.18 agrees to repair a prescription hearing aid must provide the owner of the prescription hearing
240.19 aid, or the owner's representative, with a bill that describes the repair and services rendered.
240.20 The bill must also include the repairing audiologist's, certified dispenser's, or company's
240.21 name, address, and telephone number.

240.22 This subdivision does not apply to an audiologist, certified dispenser, or company that
240.23 repairs a prescription hearing aid pursuant to an express warranty covering the entire
240.24 prescription hearing aid and the warranty covers the entire cost, both parts and labor, of the
240.25 repair.

240.26 Subd. 3. **Repair warranty.** Any guarantee of prescription hearing aid repairs must be
240.27 in writing and delivered to the owner of the prescription hearing aid, or the owner's
240.28 representative, stating the repairing audiologist's, certified dispenser's, or company's name,
240.29 address, telephone number, length of guarantee, model, and serial number of the prescription
240.30 hearing aid and all other terms and conditions of the guarantee.

240.31 Subd. 4. **Misdemeanor.** A person found to have violated this section is guilty of a
240.32 misdemeanor.

241.1 Subd. 5. **Additional.** In addition to the penalty provided in subdivision 4, a person found
241.2 to have violated this section is subject to the penalties and remedies provided in section
241.3 325F.69, subdivision 1.

241.4 Subd. 6. **Estimates.** Upon the request of the owner of a prescription hearing aid or the
241.5 owner's representative for a written estimate and prior to the commencement of repairs, a
241.6 repairing audiologist, certified dispenser, or company shall provide the customer with a
241.7 written estimate of the price of repairs. If a repairing audiologist, certified dispenser, or
241.8 company provides a written estimate of the price of repairs, it must not charge more than
241.9 the total price stated in the estimate for the repairs. If the repairing audiologist, certified
241.10 dispenser, or company after commencing repairs determines that additional work is necessary
241.11 to accomplish repairs that are the subject of a written estimate and if the repairing audiologist,
241.12 certified dispenser, or company did not unreasonably fail to disclose the possible need for
241.13 the additional work when the estimate was made, the repairing audiologist, certified
241.14 dispenser, or company may charge more than the estimate for the repairs if the repairing
241.15 audiologist, certified dispenser, or company immediately provides the owner or owner's
241.16 representative a revised written estimate pursuant to this section and receives authorization
241.17 to continue with the repairs. If continuation of the repairs is not authorized, the repairing
241.18 audiologist, certified dispenser, or company shall return the prescription hearing aid as close
241.19 as possible to its former condition and shall release the prescription hearing aid to the owner
241.20 or owner's representative upon payment of charges for repairs actually performed and not
241.21 in excess of the original estimate.

241.22 Sec. 142. Minnesota Statutes 2022, section 151.37, subdivision 12, is amended to read:

241.23 Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed

241.24 physician, a licensed advanced practice registered nurse authorized to prescribe drugs

241.25 pursuant to section 148.235, or a licensed physician assistant may authorize the following

241.26 individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

241.27 (1) an emergency medical responder registered pursuant to section 144E.27;

241.28 (2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);

241.29 (3) correctional employees of a state or local political subdivision;

241.30 (4) staff of community-based health disease prevention or social service programs;

241.31 (5) a volunteer firefighter; and

242.1 (6) a licensed school nurse or certified public health nurse any other personnel employed

242.2 by, or under contract with, a school board under section 121A.21 charter, public, or private

242.3 school.

242.4 (b) For the purposes of this subdivision, opiate antagonists may be administered by one
242.5 of these individuals only if:

242.6 (1) the licensed physician, licensed physician assistant, or licensed advanced practice
242.7 registered nurse has issued a standing order to, or entered into a protocol with, the individual;
242.8 and

242.9 (2) the individual has training in the recognition of signs of opiate overdose and the use
242.10 of opiate antagonists as part of the emergency response to opiate overdose.

242.11 (c) Nothing in this section prohibits the possession and administration of naloxone
242.12 pursuant to section 604A.04.

242.13 (d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is
242.14 authorized to possess and administer according to this subdivision an opiate antagonist in
242.15 a school setting.

242.16 Sec. 143. Minnesota Statutes 2022, section 153A.13, subdivision 3, is amended to read:

242.17 Subd. 3. **Hearing instrument aid.** "Hearing instrument aid" means an instrument, or

242.18 any of its parts, worn in the ear canal and designed to or represented as being able to aid or

242.19 enhance human hearing. "Hearing instrument" includes the instrument's parts, attachments,

242.20 or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices

242.21 with or without an ear mold. Batteries and cords are not parts, attachments, or accessories

242.22 of a hearing instrument. Surgically implanted hearing instruments, and assistive listening

242.23 devices not worn within the ear canal, are not hearing instruments, as defined in section

242.24 148.512, subdivision 10a.

242.25 Sec. 144. Minnesota Statutes 2022, section 153A.13, subdivision 4, is amended to read:

242.26 Subd. 4. **Hearing instrument aid dispensing.** "Hearing instrument aid dispensing" means making ear mold impressions, prescribing, or recommending a hearing instrument, assisting the consumer in instrument selection, selling hearing instruments at retail, or testing human hearing in connection with these activities regardless of whether the person conducting these activities has a monetary interest in the sale of hearing instruments to the consumer. 242.31 has the meaning given in section 148.512, subdivision 10b.

243.1 Sec. 145. Minnesota Statutes 2022, section 153A.13, subdivision 5, is amended to read:

243.2 Subd. 5. **Dispenser of hearing instruments aids.** "Dispenser of hearing instruments aids" means a natural person who engages in prescription hearing instrument aid dispensing, whether or not certified by the commissioner of health or licensed by an existing health-related board, except that a person described as follows is not a dispenser of hearing instruments aids:

243.7 (1) a student participating in supervised field work that is necessary to meet requirements of an accredited educational program if the student is designated by a title which clearly indicates the student's status as a student trainee; or

243.10 (2) a person who helps a dispenser of hearing instruments aids in an administrative or clerical manner and does not engage in prescription hearing instrument aid dispensing.

243.12 A person who offers to dispense a prescription hearing instrument aid, or a person who advertises, holds out to the public, or otherwise represents that the person is authorized to dispense prescription hearing instruments aids, must be certified by the commissioner except when the person is an audiologist as defined in section 148.512.

243.16 Sec. 146. Minnesota Statutes 2022, section 153A.13, subdivision 6, is amended to read:

243.17 Subd. 6. **Advisory council.** "Advisory council" means the Minnesota Hearing Instrument Aid Dispenser Advisory Council, or a committee of ~~it~~ the council, established under section 153A.20.

243.20 Sec. 147. Minnesota Statutes 2022, section 153A.13, subdivision 7, is amended to read:

243.21 Subd. 7. **ANSI.** "ANSI" means ANSI S3.6-1989, American National Standard Specification for Audiometers from the American National Standards Institute. This document is available through the Minitex interlibrary loan system as defined in the United States Food and Drug Administration, Code of Federal Regulations, title 21, section 874.1050.

243.26 Sec. 148. Minnesota Statutes 2022, section 153A.13, subdivision 9, is amended to read:

243.27 Subd. 9. **Supervision.** "Supervision" means monitoring activities of, and accepting responsibility for, the prescription hearing instrument aid dispensing activities of a trainee.

244.1 Sec. 149. Minnesota Statutes 2022, section 153A.13, subdivision 10, is amended to read:

244.2 Subd. 10. **Direct supervision or directly supervised.** "Direct supervision" or "directly supervised" means the on-site and contemporaneous location of a supervisor and trainee, when the supervisor observes the trainee engaging in prescription hearing instrument aid dispensing with a consumer.

244.6 Sec. 150. Minnesota Statutes 2022, section 153A.13, subdivision 11, is amended to read:

244.7 Subd. 11. **Indirect supervision or indirectly supervised.** "Indirect supervision" or "indirectly supervised" means the remote and independent performance of prescription hearing instrument aid dispensing by a trainee when authorized under section 153A.14, subdivision 4a, paragraph (b).

244.11 Sec. 151. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

244.13 Subd. 12. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter hearing aid" or "OTC hearing aid" has the meaning given in section 148.512, subdivision 10c.

244.16 Sec. 152. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

244.18 Subd. 13. **Prescription hearing aid.** "Prescription hearing aid" has the meaning given in section 148.512, subdivision 13a.

244.20 Sec. 153. Minnesota Statutes 2022, section 153A.14, subdivision 1, is amended to read:

244.21 Subdivision 1. **Application for certificate.** An applicant must:

244.22 (1) be 21 years of age or older;

244.23 (2) apply to the commissioner for a certificate to dispense prescription hearing instruments aids on application forms provided by the commissioner;

244.25 (3) at a minimum, provide the applicant's name, Social Security number, business address and phone number, employer, and information about the applicant's education, training, and experience in testing human hearing and fitting prescription hearing instruments aids;

244.28 (4) include with the application a statement that the statements in the application are true and correct to the best of the applicant's knowledge and belief;

245.1 (5) include with the application a written and signed authorization that authorizes the commissioner to make inquiries to appropriate regulatory agencies in this or any other state where the applicant has sold prescription hearing instruments aids;

245.4 (6) submit certification to the commissioner that the applicant's audiometric equipment has been calibrated to meet current ANSI standards within 12 months of the date of the application;

245.7 (7) submit evidence of continuing education credits, if required;

245.8 (8) submit all fees as required under section 153A.17; and

245.9 (9) consent to a fingerprint-based criminal history records check required under section

245.10 144.0572, pay all required fees, and cooperate with all requests for information. An applicant

245.11 must complete a new criminal background check if more than one year has elapsed since

245.12 the applicant last applied for a license.

245.13 Sec. 154. Minnesota Statutes 2022, section 153A.14, subdivision 2, is amended to read:

245.14 Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each

245.15 dispenser of hearing instruments aids who applies under subdivision 1 if the commissioner

245.16 determines that the applicant is in compliance with this chapter, has passed an examination

245.17 administered by the commissioner, has met the continuing education requirements, if

245.18 required, and has paid the fee set by the commissioner. The commissioner may reject or

245.19 deny an application for a certificate if there is evidence of a violation or failure to comply

245.20 with this chapter.

245.21 (b) The commissioner shall not issue a certificate to an applicant who refuses to consent

245.22 to a criminal history background check as required by section 144.0572 within 90 days after

245.23 submission of an application or fails to submit fingerprints to the Department of Human

245.24 Services. Any fees paid by the applicant to the Department of Health shall be forfeited if

245.25 the applicant refuses to consent to the background study.

245.26 Sec. 155. Minnesota Statutes 2022, section 153A.14, subdivision 2h, is amended to read:

245.27 Subd. 2h. **Certification by examination.** An applicant must achieve a passing score,

245.28 as determined by the commissioner, on an examination according to paragraphs (a) to (c).

245.29 (a) The examination must include, but is not limited to:

245.30 (1) A written examination approved by the commissioner covering the following areas

245.31 as they pertain to prescription hearing instrument aid selling:

246.1 (i) basic physics of sound;

246.2 (ii) the anatomy and physiology of the ear;

246.3 (iii) the function of prescription hearing instruments aids; and

246.4 (iv) the principles of prescription hearing instrument aid selection.

246.5 (2) Practical tests of proficiency in the following techniques as they pertain to prescription

246.6 hearing instrument aid selling:

246.7 (i) pure tone audiometry, including air conduction testing and bone conduction testing;

246.8 (ii) live voice or recorded voice speech audiometry including speech recognition
246.9 (discrimination) testing, most comfortable loudness level, and uncomfortable loudness
246.10 measurements of tolerance thresholds;

246.11 (iii) masking when indicated;

246.12 (iv) recording and evaluation of audiograms and speech audiometry to determine proper
246.13 selection and fitting of a prescription hearing instrument aid;

246.14 (v) taking ear mold impressions;

246.15 (vi) using an otoscope for the visual observation of the entire ear canal; and

246.16 (vii) state and federal laws, rules, and regulations.

246.17 (b) The practical examination shall be administered by the commissioner at least twice
246.18 a year.

246.19 (c) An applicant must achieve a passing score on all portions of the examination within
246.20 a two-year period. An applicant who does not achieve a passing score on all portions of the
246.21 examination within a two-year period must retake the entire examination and achieve a
246.22 passing score on each portion of the examination. An applicant who does not apply for
246.23 certification within one year of successful completion of the examination must retake the
246.24 examination and achieve a passing score on each portion of the examination. An applicant
246.25 may not take any part of the practical examination more than three times in a two-year
246.26 period.

246.27 Sec. 156. Minnesota Statutes 2022, section 153A.14, subdivision 2i, is amended to read:

246.28 Subd. 2i. **Continuing education requirement.** On forms provided by the commissioner,
246.29 each certified dispenser must submit with the application for renewal of certification evidence
246.30 of completion of ten course hours of continuing education earned within the 12-month
246.31 period of November 1 to October 31, between the effective and expiration dates of
247.1 certification. Continuing education courses must be directly related to prescription hearing
247.2 instrument aid dispensing and approved by the International Hearing Society, the American
247.3 Speech-Language-Hearing Association, or the American Academy of Audiology. Evidence
247.4 of completion of the ten course hours of continuing education must be submitted by
247.5 December 1 of each year. This requirement does not apply to dispensers certified for less
247.6 than one year.

247.7 Sec. 157. Minnesota Statutes 2022, section 153A.14, subdivision 2j, is amended to read:

247.8 Subd. 2j. **Required use of certification number.** The certification holder must use the
247.9 certification number on all contracts, bills of sale, and receipts used in the sale of prescription
247.10 hearing instruments aids.

247.11 Sec. 158. Minnesota Statutes 2022, section 153A.14, subdivision 4, is amended to read:

247.12 Subd. 4. **Dispensing of prescription hearing instruments aids without**

247.13 **certificate.** Except as provided in subdivisions 4a and 4c, and in sections 148.512 to

247.14 148.5198, it is unlawful for any person not holding a valid certificate to dispense a

247.15 **prescription hearing instrument aid** as defined in section 153A.13, subdivision 3. A person

247.16 **who dispenses a prescription hearing instrument aid without the certificate required by this**

247.17 **section is guilty of a gross misdemeanor.**

247.18 Sec. 159. Minnesota Statutes 2022, section 153A.14, subdivision 4a, is amended to read:

247.19 Subd. 4a. **Trainees.** (a) A person who is not certified under this section may dispense

247.20 **prescription hearing instruments aids** as a trainee for a period not to exceed 12 months if

247.21 **the person:**

247.22 (1) submits an application on forms provided by the commissioner;

247.23 (2) is under the supervision of a certified dispenser meeting the requirements of this

247.24 **subdivision;**

247.25 (3) meets all requirements for certification except passage of the examination required

247.26 **by this section; and**

247.27 (4) uses the title "dispenser trainee" in contacts with the patients, clients, or consumers.

247.28 (b) A certified hearing **instrument aid** dispenser may not supervise more than two trainees

247.29 **at the same time and may not directly supervise more than one trainee at a time. The certified**

247.30 **dispenser is responsible for all actions or omissions of a trainee in connection with the**

247.31 **dispensing of prescription hearing instruments aids.** A certified dispenser may not supervise

248.1 **a trainee if there are any commissioner, court, or other orders, currently in effect or issued**

248.2 **within the last five years, that were issued with respect to an action or omission of a certified**

248.3 **dispenser or a trainee under the certified dispenser's supervision.**

248.4 Until taking and passing the practical examination testing the techniques described in

248.5 subdivision 2h, paragraph (a), clause (2), trainees must be directly supervised in all areas

248.6 described in subdivision 4b, and the activities tested by the practical examination. Thereafter,

248.7 trainees may dispense **prescription hearing instruments aids** under indirect supervision until

248.8 expiration of the trainee period. Under indirect supervision, the trainee must complete two

248.9 monitored activities a week. Monitored activities may be executed by correspondence,

248.10 telephone, or other telephonic devices, and include, but are not limited to, evaluation of

248.11 audiograms, written reports, and contracts. The time spent in supervision must be recorded

248.12 **and the record retained by the supervisor.**

248.13 Sec. 160. Minnesota Statutes 2022, section 153A.14, subdivision 4b, is amended to read:

248.14 Subd. 4b. **Prescription hearing testing protocol.** A dispenser when conducting a hearing

248.15 **test for the purpose of prescription hearing instrument aid dispensing must:**

248.16 (1) comply with the United States Food and Drug Administration warning regarding
248.17 potential medical conditions required by Code of Federal Regulations, title 21, section
248.18 ~~801.420~~ 801.422;

248.19 (2) complete a case history of the client's hearing;

248.20 (3) inspect the client's ears with an otoscope; and

248.21 (4) conduct the following tests on both ears of the client and document the results, and
248.22 if for any reason one of the following tests cannot be performed pursuant to the United
248.23 States Food and Drug Administration guidelines, an audiologist shall evaluate the hearing
248.24 and the need for a prescription hearing instrument aid:

248.25 (i) air conduction at 250, 500, 1,000, 2,000, 4,000, and 8,000 Hertz. When a difference
248.26 of 20 dB or more occurs between adjacent octave frequencies the interoctave frequency
248.27 must be tested;

248.28 (ii) bone conduction at 500, 1,000, 2,000, and 4,000 Hertz for any frequency where the
248.29 air conduction threshold is greater than 15 dB HL;

248.30 (iii) monaural word recognition (discrimination), with a minimum of 25 words presented
248.31 for each ear; and

249.1 (iv) loudness discomfort level, monaural, for setting a prescription hearing instrument's
249.2 aid's maximum power output; and

249.3 (5) include masking in all tests whenever necessary to ensure accurate results.

249.4 Sec. 161. Minnesota Statutes 2022, section 153A.14, subdivision 4c, is amended to read:

249.5 Subd. 4c. **Reciprocity.** (a) A person who has dispensed prescription hearing instruments
249.6 aids in another jurisdiction may dispense prescription hearing instruments aids as a trainee
249.7 under indirect supervision if the person:

249.8 (1) satisfies the provisions of subdivision 4a, paragraph (a);

249.9 (2) submits a signed and dated affidavit stating that the applicant is not the subject of a
249.10 disciplinary action or past disciplinary action in this or another jurisdiction and is not
249.11 disqualified on the basis of section 153A.15, subdivision 1; and

249.12 (3) provides a copy of a current credential as a hearing instrument aid dispenser held in
249.13 the District of Columbia or a state or territory of the United States.

249.14 (b) A person becoming a trainee under this subdivision who fails to take and pass the
249.15 practical examination described in subdivision 2h, paragraph (a), clause (2), when next
249.16 offered must cease dispensing prescription hearing instruments aids unless under direct
249.17 supervision.

249.18 Sec. 162. Minnesota Statutes 2022, section 153A.14, subdivision 4e, is amended to read:

249.19 Subd. 4e. **Prescription hearing aids; enforcement.** Costs incurred by the Minnesota
249.20 Department of Health for conducting investigations of unlicensed prescription hearing aid
249.21 dispensers dispensing shall be apportioned between all licensed or credentialed professions
249.22 that dispense prescription hearing aids.

249.23 Sec. 163. Minnesota Statutes 2022, section 153A.14, subdivision 6, is amended to read:

249.24 Subd. 6. **Prescription hearing instruments aids to comply with federal and state**
249.25 **requirements.** The commissioner shall ensure that prescription hearing instruments aids
249.26 are dispensed in compliance with state requirements and the requirements of the United
249.27 States Food and Drug Administration. Failure to comply with state or federal regulations
249.28 may be grounds for enforcement actions under section 153A.15, subdivision 2.

250.1 Sec. 164. Minnesota Statutes 2022, section 153A.14, subdivision 9, is amended to read:

250.2 Subd. 9. **Consumer rights.** A hearing instrument aid dispenser shall comply with the
250.3 requirements of sections 148.5195, subdivision 3, clause (20); 148.5197; and 148.5198.

250.4 Sec. 165. Minnesota Statutes 2022, section 153A.14, subdivision 11, is amended to read:

250.5 Subd. 11. **Requirement to maintain current information.** A dispenser must notify the
250.6 commissioner in writing within 30 days of the occurrence of any of the following:

250.7 (1) a change of name, address, home or business telephone number, or business name;

250.8 (2) the occurrence of conduct prohibited by section 153A.15;

250.9 (3) a settlement, conciliation court judgment, or award based on negligence, intentional
250.10 acts, or contractual violations committed in the dispensing of prescription hearing instruments
250.11 aids by the dispenser; and

250.12 (4) the cessation of prescription hearing instrument aid dispensing activities as an
250.13 individual or a business.

250.14 Sec. 166. Minnesota Statutes 2022, section 153A.14, is amended by adding a subdivision
250.15 to read:

250.16 Subd. 12. **Over-the-counter hearing aids.** Nothing in this chapter shall preclude certified
250.17 hearing aid dispensers from dispensing or selling over-the-counter hearing aids.

250.18 Sec. 167. Minnesota Statutes 2022, section 153A.15, subdivision 1, is amended to read:

250.19 Subdivision 1. **Prohibited acts.** The commissioner may take enforcement action as
250.20 provided under subdivision 2 against a dispenser of prescription hearing instruments aids
250.21 for the following acts and conduct:

250.22 (1) dispensing a prescription hearing instrument aid to a minor person 18 years or younger
250.23 unless evaluated by an audiologist for hearing evaluation and prescription hearing aid
250.24 evaluation;

250.25 (2) being disciplined through a revocation, suspension, restriction, or limitation by
250.26 another state for conduct subject to action under this chapter;

250.27 (3) presenting advertising that is false or misleading;

250.28 (4) providing the commissioner with false or misleading statements of credentials,
250.29 training, or experience;

251.1 (5) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating
251.2 a willful or careless disregard for the health, welfare, or safety of a consumer;

251.3 (6) splitting fees or promising to pay a portion of a fee to any other professional other
251.4 than a fee for services rendered by the other professional to the client;

251.5 (7) engaging in abusive or fraudulent billing practices, including violations of federal
251.6 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
251.7 assistance laws;

251.8 (8) obtaining money, property, or services from a consumer through the use of undue
251.9 influence, high pressure sales tactics, harassment, duress, deception, or fraud;

251.10 (9) performing the services of a certified hearing instrument aid dispenser in an
251.11 incompetent or negligent manner;

251.12 (10) failing to comply with the requirements of this chapter as an employer, supervisor,
251.13 or trainee;

251.14 (11) failing to provide information in a timely manner in response to a request by the
251.15 commissioner, commissioner's designee, or the advisory council;

251.16 (12) being convicted within the past five years of violating any laws of the United States,
251.17 or any state or territory of the United States, and the violation is a felony, gross misdemeanor,
251.18 or misdemeanor, an essential element of which relates to prescription hearing instrument
251.19 aid dispensing, except as provided in chapter 364;

251.20 (13) failing to cooperate with the commissioner, the commissioner's designee, or the
251.21 advisory council in any investigation;

251.22 (14) failing to perform prescription hearing instrument aid dispensing with reasonable
251.23 judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental
251.24 impairment;

251.25 (15) failing to fully disclose actions taken against the applicant or the applicant's legal
251.26 authorization to dispense prescription hearing instruments aids in this or another state;

251.27 (16) violating a state or federal court order or judgment, including a conciliation court
251.28 judgment, relating to the activities of the applicant in prescription hearing instrument aid
251.29 dispensing;

251.30 (17) having been or being disciplined by the commissioner of the Department of Health,
251.31 or other authority, in this or another jurisdiction, if any of the grounds for the discipline are
251.32 the same or substantially equivalent to those in sections 153A.13 to 153A.18;

252.1 (18) misrepresenting the purpose of hearing tests, or in any way communicating that the
252.2 hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a medical
252.3 evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a
252.4 test to select a prescription hearing instrument aid, except that the hearing instrument aid
252.5 dispenser can determine the need for or recommend the consumer obtain a medical evaluation
252.6 consistent with requirements of the United States Food and Drug Administration;

252.7 (19) violating any of the provisions of sections 148.5195, subdivision 3, clause (20);
252.8 148.5197; 148.5198; and 153A.13 to 153A.18; and

252.9 (20) aiding or abetting another person in violating any of the provisions of sections
252.10 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18.

252.11 Sec. 168. Minnesota Statutes 2022, section 153A.15, subdivision 2, is amended to read:

252.12 Subd. 2. **Enforcement actions.** When the commissioner finds that a dispenser of
252.13 prescription hearing instruments aids has violated one or more provisions of this chapter,
252.14 the commissioner may do one or more of the following:

252.15 (1) deny or reject the application for a certificate;

252.16 (2) revoke the certificate;

252.17 (3) suspend the certificate;

252.18 (4) impose, for each violation, a civil penalty that deprives the dispenser of any economic
252.19 advantage gained by the violation and that reimburses the Department of Health for costs
252.20 of the investigation and proceeding resulting in disciplinary action, including the amount
252.21 paid for services of the Office of Administrative Hearings, the amount paid for services of
252.22 the Office of the Attorney General, attorney fees, court reporters, witnesses, reproduction
252.23 of records, advisory council members' per diem compensation, department staff time, and
252.24 expenses incurred by advisory council members and department staff;

252.25 (5) censure or reprimand the dispenser;

252.26 (6) revoke or suspend the right to supervise trainees;

252.27 (7) revoke or suspend the right to be a trainee;

252.28 (8) impose a civil penalty not to exceed \$10,000 for each separate violation; or

252.29 (9) any other action reasonably justified by the individual case.

253.1 Sec. 169. Minnesota Statutes 2022, section 153A.15, subdivision 4, is amended to read:

253.2 Subd. 4. **Penalties.** Except as provided in section 153A.14, subdivision 4, a person
253.3 violating this chapter is guilty of a misdemeanor. The commissioner may impose an automatic
253.4 civil penalty equal to one-fourth the renewal fee on each hearing instrument seller aid
253.5 dispenser who fails to renew the certificate required in section 153A.14 by the renewal
253.6 deadline.

253.7 Sec. 170. Minnesota Statutes 2022, section 153A.17, is amended to read:

253.8 **153A.17 EXPENSES; FEES.**

253.9 (a) The expenses for administering the certification requirements, including the complaint
253.10 handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the
253.11 Consumer Information Center under section 153A.18, must be paid from initial application
253.12 and examination fees, renewal fees, penalties, and fines. The commissioner shall only use
253.13 fees collected under this section for the purposes of administering this chapter. The legislature
253.14 must not transfer money generated by these fees from the state government special revenue
253.15 fund to the general fund. Surcharges collected by the commissioner of health under section
253.16 16E.22 are not subject to this paragraph.

253.17 (b) The fees are as follows:

253.18 (1) the initial certification application fee is \$772.50;
253.19 (2) the annual renewal certification application fee is \$750;
253.20 (3) the initial examination fee for the practical portion is \$1,200, and \$600 for each time
253.21 it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision
253.22 2, the fee for the practical portion of the prescription hearing instrument aid dispensing
253.23 examination is \$600 each time it is taken;

253.24 (4) the trainee application fee is \$230;

253.25 (5) the penalty fee for late submission of a renewal application is \$260; and

253.26 (6) the fee for verification of certification to other jurisdictions or entities is \$25.

253.27 (c) The commissioner may prorate the certification fee for new applicants based on the
253.28 number of quarters remaining in the annual certification period.

253.29 (d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited
253.30 in the state government special revenue fund.

254.1 (e) Hearing instrument dispensers who were certified before January 1, 2018, shall pay
254.2 a onetime surcharge of \$22.50 to renew their certification when it expires after October 31,
254.3 2020. The surcharge shall cover the commissioner's costs associated with criminal
254.4 background checks.

254.5 Sec. 171. Minnesota Statutes 2022, section 153A.175, is amended to read:

254.6 **153A.175 PENALTY FEES.**

254.7 (a) The penalty fee for holding oneself out as a hearing instrument aid dispenser without
254.8 a current certificate after the credential has expired and before it is renewed is one-half the
254.9 amount of the certificate renewal fee for any part of the first day, plus one-half the certificate
254.10 renewal fee for any part of any subsequent days up to 30 days.

254.11 (b) The penalty fee for applicants who hold themselves out as hearing instrument aid
254.12 dispensers after expiration of the trainee period and before being issued a certificate is
254.13 one-half the amount of the certificate application fee for any part of the first day, plus
254.14 one-half the certificate application fee for any part of any subsequent days up to 30 days.
254.15 This paragraph does not apply to applicants not qualifying for a certificate who hold
254.16 themselves out as hearing instrument aid dispensers.

254.17 (c) The penalty fee for practicing prescription hearing instrument aid dispensing and
254.18 failing to submit a continuing education report by the due date with the correct number or
254.19 type of hours in the correct time period is \$200 plus \$200 for each missing clock hour.
254.20 "Missing" means not obtained between the effective and expiration dates of the certificate,
254.21 the one-month period following the certificate expiration date, or the 30 days following
254.22 notice of a penalty fee for failing to report all continuing education hours. The certificate
254.23 holder must obtain the missing number of continuing education hours by the next reporting
254.24 due date.

254.25 (d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005,
254.26 for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty
254.27 fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified
254.28 by the individual case.

254.29 Sec. 172. Minnesota Statutes 2022, section 153A.18, is amended to read:

254.30 **153A.18 CONSUMER INFORMATION CENTER.**

254.31 The commissioner shall establish a Consumer Information Center to assist actual and
254.32 potential purchasers of prescription hearing aids by providing them with information
255.1 regarding prescription hearing instrument aid sales. The Consumer Information Center shall
255.2 disseminate information about consumers' legal rights related to prescription hearing
255.3 instrument aid sales, provide information relating to complaints about dispensers of
255.4 prescription hearing instruments aids, and provide information about outreach and advocacy
255.5 services for consumers of prescription hearing instruments aids. In establishing the center
255.6 and developing the information, the commissioner shall consult with representatives of
255.7 hearing instrument aid dispensers, audiologists, physicians, and consumers.

255.8 Sec. 173. Minnesota Statutes 2022, section 153A.20, is amended to read:

255.9 **153A.20 HEARING INSTRUMENT AID DISPENSER ADVISORY COUNCIL.**

255.10 Subdivision 1. **Membership.** (a) The commissioner shall appoint seven persons to a
255.11 Hearing Instrument Aid Dispenser Advisory Council.

255.12 (b) The seven persons must include:

255.13 (1) three public members, as defined in section 214.02. At least one of the public members
255.14 shall be a prescription hearing instrument aid user and one of the public members shall be
255.15 either a prescription hearing instrument aid user or an advocate of one;

255.16 (2) three hearing instrument aid dispensers certified under sections 153A.14 to 153A.20,
255.17 each of whom is currently, and has been for the five years immediately preceding their
255.18 appointment, engaged in prescription hearing instrument aid dispensing in Minnesota and
255.19 who represent the occupation of prescription hearing instrument aid dispensing and who
255.20 are not audiologists; and

255.21 (3) one audiologist licensed as an audiologist under chapter 148 who dispenses
255.22 prescription hearing instruments aids, recommended by a professional association
255.23 representing audiologists and speech-language pathologists.

255.24 (c) The factors the commissioner may consider when appointing advisory council
255.25 members include, but are not limited to, professional affiliation, geographical location, and
255.26 type of practice.

255.27 (d) No two members of the advisory council shall be employees of, or have binding
255.28 contracts requiring sales exclusively for, the same prescription hearing instrument aid
255.29 manufacturer or the same employer.

255.30 Subd. 2. **Organization.** The advisory council shall be organized and administered
255.31 according to section 15.059. The council may form committees to carry out its duties.

255.32 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall:

256.1 (1) advise the commissioner regarding hearing instrument aid dispenser certification
256.2 standards;

256.3 (2) provide for distribution of information regarding hearing instrument aid dispenser
256.4 certification standards;

256.5 (3) review investigation summaries of competency violations and make recommendations
256.6 to the commissioner as to whether the allegations of incompetency are substantiated; and

256.7 (4) perform other duties as directed by the commissioner.

220.11 Sec. 66. Minnesota Statutes 2022, section 256B.0625, subdivision 49, is amended to read:

220.12 Subd. 49. **Community health worker.** (a) Medical assistance covers the care

220.13 coordination and patient education services provided by a community health worker if the
220.14 community health worker has received a certificate from the Minnesota State Colleges and
220.15 Universities System approved community health worker curriculum.

220.16 (b) Community health workers must work under the supervision of a medical assistance
220.17 enrolled physician, registered nurse, advanced practice registered nurse, physician assistant,
220.18 mental health professional, or dentist, or work under the supervision of a certified public
220.19 health nurse operating under the direct authority of an enrolled unit of government.

220.20 (c) Effective January 1, 2026, community health workers who are eligible for payment
220.21 under this subdivision who are providing care coordination or patient education services in
220.22 an adult day care, respite care, or in-home care setting must complete a training program
220.23 in Alzheimer's disease and dementia care that has been developed or approved by the
220.24 commissioner of health, in accordance with section 144.6504, to remain eligible for payment.

220.25 (d) Care coordination and patient education services covered under this subdivision
220.26 include, but are not limited to, services relating to oral health and dental care.

256.8 Sec. 174. Minnesota Statutes 2022, section 256B.434, subdivision 4f, is amended to read:

256.9 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)

256.10 Effective October 1, 2006, facilities reimbursed under this section may receive a property
256.11 rate adjustment for construction projects exceeding the threshold in section 256B.431,
256.12 subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a)
256.13 paragraph (c), clause (1). For these projects, capital assets purchased shall be counted as
256.14 construction project costs for a rate adjustment request made by a facility if they are: (1)
256.15 purchased within 24 months of the completion of the construction project; (2) purchased
256.16 after the completion date of any prior construction project; and (3) are not purchased prior
256.17 to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate
256.18 calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota
256.19 Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable
256.20 construction projects under this subdivision and section 144A.073. Facilities completing
256.21 construction projects between October 1, 2005, and October 1, 2006, are eligible to have a
256.22 property rate adjustment effective October 1, 2006. Facilities completing projects after
256.23 October 1, 2006, are eligible for a property rate adjustment effective on the first day of the
256.24 month following the completion date. Facilities completing projects after January 1, 2018,
256.25 are eligible for a property rate adjustment effective on the first day of the month of January
256.26 or July, whichever occurs immediately following the completion date.

256.27 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under

256.28 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
256.29 construction project on or after October 1, 2004, and do not have a contract under subdivision

256.30 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,
256.31 subdivision 10, through September 30, 2006. If the request results in the commissioner
256.32 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
256.33 the month following project completion. These facilities shall be allowed to accumulate
256.34 construction project costs for the period October 1, 2004, to September 30, 2006.

257.1 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
257.2 months after completing a previous construction project. Facilities must request the rate
257.3 adjustment according to section 256B.431, subdivision 10.

257.4 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
257.5 subpart 11. For rate calculations under this section, the number of licensed beds in the
257.6 nursing facility shall be the number existing after the construction project is completed and
257.7 the number of days in the nursing facility's reporting period shall be 365.

257.8 (e) The value of assets to be recognized for a total replacement project as defined in
257.9 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
257.10 of assets to be recognized for all other projects shall be computed as described in clause
257.11 (2).

257.12 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
257.13 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
257.14 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
257.15 current request for a rate adjustment results from the completion of a construction project
257.16 that was previously approved under section 144A.073, the assets to be used in the rate
257.17 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
257.18 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
257.19 project. A current request that is not the result of a project under section 144A.073 cannot
257.20 exceed the limit under section 144A.071, subdivision 2, paragraph (a), clause (1).
257.21 Applicable credits must be deducted from the cost of the construction project.

257.22 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
257.23 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
257.24 used to compute the maximum amount of assets allowable in a facility's property rate
257.25 calculation.

257.26 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
257.27 the total appraised value from the last rate notice a facility received when its rates were set
257.28 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
257.29 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
257.30 rate year the facility received an inflation factor on its property-related rate when its rates
257.31 were set under this section. The value of assets listed as previous capital additions, capital
257.32 additions, and special projects on the facility's base year rate notice and the value of assets
257.33 related to a construction project for which the facility received a rate adjustment when its
257.34 rates were determined under this section shall be added to the indexed appraised value.

258.1 (iii) The maximum amount of assets to be recognized in computing a facility's rate
258.2 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
258.3 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
258.4 construction project.

258.5 (iv) If a facility's current request for a rate adjustment results from the completion of a
258.6 construction project that was previously approved under section 144A.073, the assets to be
258.7 added to the rate calculation cannot exceed the lesser of the amount determined under
258.8 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
258.9 costs of the construction project. A current request that is not the result of a project under
258.10 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
258.11 paragraph (a) (c), clause (1). Assets disposed of as a result of a construction project and
258.12 applicable credits must be deducted from the cost of the construction project.

258.13 (f) For construction projects approved under section 144A.073, allowable debt may
258.14 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
258.15 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
258.16 debt.

258.17 (g) For construction projects that were not approved under section 144A.073, allowable
258.18 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
258.19 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
258.20 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
258.21 project shall not be allowed regardless of the use of the funds.

258.22 For all construction projects being recognized, interest expense and average debt shall
258.23 be computed based on the first 12 months following project completion. "Previously existing
258.24 capital debt" means capital debt recognized on the last rate determined under section
258.25 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
258.26 recognized for a construction project for which the facility received a rate adjustment when
258.27 its rates were determined under this section.

258.28 For a total replacement project as defined in section 256B.431, subdivision 17d, the
258.29 value of previously existing capital debt shall be zero.

258.30 (h) In addition to the interest expense allowed from the application of paragraph (f), the
258.31 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
258.32 (3), will be added to interest expense.

258.33 (i) The equity portion of the construction project shall be computed as the allowable
258.34 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be
259.1 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
259.2 This sum must be divided by 95 percent of capacity days to compute the construction project
259.3 rate adjustment.

259.4 (j) For projects that are not a total replacement of a nursing facility, the amount in
259.5 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
259.6 payment rate of the facility.

259.7 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
259.8 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
259.9 Any amounts existing in a facility's rate before the effective date of the construction project
259.10 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
259.11 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
259.12 subdivision 19, shall be removed from the facility's rates.

259.13 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
259.14 subpart 10, as the result of construction projects under this section. Allowable equipment
259.15 shall be included in the construction project costs.

259.16 (m) Capital assets purchased after the completion date of a construction project shall be
259.17 counted as construction project costs for any future rate adjustment request made by a facility
259.18 under section 144A.071, subdivision 2, clause (a) paragraph (c), clause (1), if they are
259.19 purchased within 24 months of the completion of the future construction project.

259.20 (n) In subsequent rate years, the property payment rate for a facility that results from
259.21 the application of this subdivision shall be the amount inflated in subdivision 4.

259.22 (o) Construction projects are eligible for an equity incentive under section 256B.431,
259.23 subdivision 16. When computing the equity incentive for a construction project under this
259.24 subdivision, only the allowable costs and allowable debt related to the construction project
259.25 shall be used. The equity incentive shall not be a part of the property payment rate and not
259.26 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
259.27 facilities reimbursed under this section shall be allowed for a duration determined under
259.28 section 256B.431, subdivision 16, paragraph (c).

259.29 Sec. 175. Minnesota Statutes 2022, section 256B.692, subdivision 2, is amended to read:

259.30 Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N,
259.31 a county that elects to purchase medical assistance in return for a fixed sum without regard
259.32 to the frequency or extent of services furnished to any particular enrollee is not required to
259.33 obtain a certificate of authority under chapter 62D or 62N. The county board of
260.1 commissioners is the governing body of a county-based purchasing program. In a multicounty
260.2 arrangement, the governing body is a joint powers board established under section 471.59.

260.3 (b) A county that elects to purchase medical assistance services under this section must
260.4 satisfy the commissioner of health that the requirements for assurance of consumer protection,
260.5 provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance
260.6 organizations will be met according to the following schedule:

260.7 (1) for a county-based purchasing plan approved on or before June 30, 2008, the plan
260.8 must have in reserve:

260.9 (i) at least 50 percent of the minimum amount required under chapter 62D as of January
260.10 1, 2010;
260.11 (ii) at least 75 percent of the minimum amount required under chapter 62D as of January
260.12 1, 2011;
260.13 (iii) at least 87.5 percent of the minimum amount required under chapter 62D as of
260.14 January 1, 2012; and
260.15 (iv) at least 100 percent of the minimum amount required under chapter 62D as of January
260.16 1, 2013; and
260.17 (2) for a county-based purchasing plan first approved after June 30, 2008, the plan must
260.18 have in reserve:
260.19 (i) at least 50 percent of the minimum amount required under chapter 62D at the time
260.20 the plan begins enrolling enrollees;
260.21 (ii) at least 75 percent of the minimum amount required under chapter 62D after the first
260.22 full calendar year;
260.23 (iii) at least 87.5 percent of the minimum amount required under chapter 62D after the
260.24 second full calendar year; and
260.25 (iv) at least 100 percent of the minimum amount required under chapter 62D after the
260.26 third full calendar year.
260.27 (c) Until a plan is required to have reserves equaling at least 100 percent of the minimum
260.28 amount required under chapter 62D, the plan may demonstrate its ability to cover any losses
260.29 by satisfying the requirements of chapter 62N. A county-based purchasing plan must also
260.30 assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71
260.31 to 62J.73; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055;
261.1 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43;
261.2 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.
261.3 (d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62N,
261.4 and 62Q are hereby granted to the commissioner of health with respect to counties that
261.5 purchase medical assistance services under this section.
261.6 (e) The commissioner, in consultation with county government, shall develop
261.7 administrative and financial reporting requirements for county-based purchasing programs
261.8 relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31,
261.9 and other sections as necessary, that are specific to county administrative, accounting, and
261.10 reporting systems and consistent with other statutory requirements of counties.
261.11 (f) The commissioner shall collect from a county-based purchasing plan under this
261.12 section the following fees:

220.27 Sec. 67. Minnesota Statutes 2022, section 259.83, subdivision 1, is amended to read:

220.28 Subdivision 1. **Services provided.** (a) Agencies shall provide assistance and counseling
220.29 services upon receiving a request for current information from adoptive parents, birth parents,
220.30 or adopted persons aged ~~19~~ 18 years of age and ~~ever~~ older. The agency shall contact the
220.31 other adult persons or the adoptive parents of a minor child in a personal and confidential
220.32 manner to determine whether there is a desire to receive or share information or to have
221.1 contact. If there is such a desire, the agency shall provide the services requested. The agency
221.2 shall provide services to adult genetic siblings if there is no known violation of the
221.3 confidentiality of a birth parent or if the birth parent gives written consent.

221.4 (b) Upon a request for assistance or services from an adoptive parent, birth parent, or
221.5 an adopted person 18 years of age or older, the agency must inform the person:

221.6 (1) about the right of an adopted person to request and obtain a copy of the adopted
221.7 person's original birth record at the age and circumstances specified in section 144.2253;
221.8 and

221.9 (2) about the right of the birth parent named on the adopted person's original birth record
221.10 to file a contact preference form with the state registrar pursuant to section 144.2253.

221.11 In adoptive placements, the agency must provide in writing to the birth parents listed on
221.12 the original birth record the information required under this section.

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

221.14 Sec. 68. Minnesota Statutes 2022, section 259.83, subdivision 1a, is amended to read:

221.15 Subd. 1a. **Social and medical history.** (a) If a person aged ~~19~~ 18 years of age and ~~ever~~
221.16 older who was adopted on or after August 1, 1994, or the adoptive parent requests the
221.17 detailed nonidentifying social and medical history of the adopted person's birth family that
221.18 was provided at the time of the adoption, agencies must provide the information to the
221.19 adopted person or adoptive parent on the applicable form required under sections 259.43
221.20 and 260C.212, subdivision 15.

221.21 (b) If an adopted person aged ~~19~~ 18 years of age and ~~ever~~ older or the adoptive parent
221.22 requests the agency to contact the adopted person's birth parents to request current
221.23 nonidentifying social and medical history of the adopted person's birth family, agencies

261.13 (1) fees attributable to the costs of audits and other examinations of plan financial
261.14 operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800,
261.15 subpart 1, item F; and

261.16 (2) an annual fee of \$21,500, to be paid by June 15 of each calendar year.

261.17 All fees collected under this paragraph shall be deposited in the state government special
261.18 revenue fund.

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

221.24 must use the applicable form required under sections 259.43 and 260C.212, subdivision 15,
221.25 when obtaining the information for the adopted person or adoptive parent.

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

221.27 Sec. 69. Minnesota Statutes 2022, section 259.83, subdivision 1b, is amended to read:

221.28 Subd. 1b. **Genetic siblings.** (a) A person who is at least 19 18 years old of age who was
221.29 adopted or, because of a termination of parental rights, was committed to the guardianship
221.30 of the commissioner of human services, whether adopted or not, must upon request be
222.1 advised of other siblings who were adopted or who were committed to the guardianship of
222.2 the commissioner of human services and not adopted.

222.3 (b) Assistance must be provided by the county or placing agency of the person requesting
222.4 information to the extent that information is available in the existing records at the
222.5 Department of Human Services. If the sibling received services from another agency, the
222.6 agencies must share necessary information in order to locate the other siblings and to offer
222.7 services, as requested. Upon the determination that parental rights with respect to another
222.8 sibling were terminated, identifying information and contact must be provided only upon
222.9 mutual consent. A reasonable fee may be imposed by the county or placing agency.

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

222.11 Sec. 70. Minnesota Statutes 2022, section 259.83, is amended by adding a subdivision to
222.12 read:

222.13 Subd. 3a. **Birth parent identifying information.** (a) This subdivision applies to adoptive
222.14 placements where an adopted person does not have a record of live birth registered in this
222.15 state. Upon written request by an adopted person 18 years of age or older, the agency
222.16 responsible for or supervising the placement must provide to the requester the following
222.17 identifying information related to the birth parents listed on that adopted person's original
222.18 birth record:

222.19 (1) each of the birth parent's names; and

222.20 (2) each of the birth parent's birthdate and birthplace.

222.21 (b) The agency may charge a reasonable fee to the requester for providing the required
222.22 information under paragraph (a).

222.23 (c) The agency, acting in good faith and in a lawful manner in disclosing the identifying
222.24 information under this subdivision, is not civilly liable for such disclosure.

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

222.26 Sec. 71. Minnesota Statutes 2022, section 260C.317, subdivision 4, is amended to read:

222.27 Subd. 4. **Rights of terminated parent.** (a) Upon entry of an order terminating the
222.28 parental rights of any person who is identified as a parent on the original birth record of the

222.29 child as to whom the parental rights are terminated, the court shall cause written notice to
222.30 be made to that person setting forth:

223.1 (1) the right of the person to file at any time with the state registrar of vital records a
223.2 consent to disclosure, as defined in section 144.212, subdivision 11;

223.3 (2) the right of the person to file at any time with the state registrar of vital records an
223.4 affidavit stating that the information on the original birth record shall not be disclosed as
223.5 provided in section 144.2252, and a contact preference form under section 144.2253.

223.6 (3) the effect of a failure to file either a consent to disclosure, as defined in section
223.7 144.212, subdivision 11, or an affidavit stating that the information on the original birth
223.8 record shall not be disclosed.

223.9 (b) A parent whose rights are terminated under this section shall retain the ability to
223.10 enter into a contact or communication agreement under section 260C.619 if an agreement
223.11 is determined by the court to be in the best interests of the child. The agreement shall be
223.12 filed with the court at or prior to the time the child is adopted. An order for termination of
223.13 parental rights shall not be conditioned on an agreement under section 260C.619.

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

223.15 Sec. 72. Minnesota Statutes 2022, section 403.161, subdivision 1, is amended to read:

223.16 Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail
223.17 transaction is imposed on prepaid wireless telecommunications service until the fee is
223.18 adjusted as an amount per retail transaction under subdivision 7.

223.19 (b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the
223.20 monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail
223.21 transaction for prepaid wireless telecommunications service until the fee is adjusted as an
223.22 amount per retail transaction under subdivision 7.

223.23 (c) A prepaid wireless 988 fee, in the amount of the monthly charge provided for in
223.24 section 145.561, subdivision 4, paragraph (b), is imposed on each retail transaction for
223.25 prepaid wireless telecommunications service until the fee is adjusted as an amount per retail
223.26 transaction under subdivision 7.

223.27 Sec. 73. Minnesota Statutes 2022, section 403.161, subdivision 3, is amended to read:

223.28 Subd. 3. **Fee collected.** The prepaid wireless E911 and telecommunications access
223.29 Minnesota, and 988 fees must be collected by the seller from the consumer for each retail
223.30 transaction occurring in this state. The amount of each fee must be combined into one
223.31 amount, which must be separately stated on an invoice, receipt, or other similar document
223.32 that is provided to the consumer by the seller.

224.1 Sec. 74. Minnesota Statutes 2022, section 403.161, subdivision 5, is amended to read:

224.2 Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access
224.3 Minnesota, ~~and~~ 988 fees are the liability of the consumer and not of the seller or of any
224.4 provider, except that the seller is liable to remit all fees as provided in section 403.162.

224.5 Sec. 75. Minnesota Statutes 2022, section 403.161, subdivision 6, is amended to read:

224.6 Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid
224.7 wireless E911 ~~and~~, telecommunications access Minnesota, ~~and~~ 988 fees collected by a seller
224.8 from a consumer must not be included in the base for measuring any tax, fee, surcharge, or
224.9 other charge that is imposed by this state, any political subdivision of this state, or any
224.10 intergovernmental agency.

224.11 Sec. 76. Minnesota Statutes 2022, section 403.161, subdivision 7, is amended to read:

224.12 Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access
224.13 Minnesota ~~fee~~, ~~and~~ 988 fees must be proportionately increased or reduced upon any change
224.14 to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013,
224.15 or the fee imposed under section 237.52, subdivision 2, ~~or the fee imposed under section~~
224.16 ~~145.561~~, subdivision 4, as applicable.

224.17 (b) The department shall post notice of any fee changes on its website at least 30 days
224.18 in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor
224.19 the department's website for notice of fee changes.

224.20 (c) Fee changes are effective 60 days after the first day of the first calendar month after
224.21 the commissioner of public safety or the Public Utilities Commission, as applicable, changes
224.22 the fee.

224.23 Sec. 77. Minnesota Statutes 2022, section 403.162, subdivision 1, is amended to read:

224.24 Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~, telecommunications access
224.25 Minnesota, ~~and~~ 988 fees collected by sellers must be remitted to the commissioner of revenue
224.26 at the times and in the manner provided by chapter 297A with respect to the general sales
224.27 and use tax. The commissioner of revenue shall establish registration and payment procedures
224.28 that substantially coincide with the registration and payment procedures that apply in chapter
224.29 ~~297A~~.

225.1 Sec. 78. Minnesota Statutes 2022, section 403.162, subdivision 2, is amended to read:

225.2 Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid
225.3 wireless E911 ~~and~~, telecommunications access Minnesota, ~~and~~ 988 fees collected by the
225.4 seller from consumers.

225.5 Sec. 79. Minnesota Statutes 2022, section 403.162, subdivision 5, is amended to read:

225.6 Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative
225.7 proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications

225.8 access Minnesota fee, and the prepaid wireless 988 fee imposed per retail transaction, divide
225.9 the fees collected in corresponding proportions. Within 30 days of receipt of the collected
225.10 fees, the commissioner shall:

225.11 (1) deposit the proportion of the collected fees attributable to the prepaid wireless E911
225.12 fee in the 911 emergency telecommunications service account in the special revenue fund;
225.13 and

225.14 (2) deposit the proportion of collected fees attributable to the prepaid wireless
225.15 telecommunications access Minnesota fee in the telecommunications access fund established
225.16 in section 237.52, subdivision 1-; and

225.17 (3) deposit the proportion of the collected fees attributable to the prepaid wireless 988
225.18 fee in the 988 special revenue account established in section 145.561, subdivision 3.

225.19 (b) The commissioner of revenue may deduct and deposit in a special revenue account
225.20 an amount not to exceed two percent of collected fees. Money in the account is annually
225.21 appropriated to the commissioner of revenue to reimburse its direct costs of administering
225.22 the collection and remittance of prepaid wireless E911 fees and, prepaid wireless
225.23 telecommunications access Minnesota fees, and prepaid wireless 988 fees.

261.20 Sec. 176. Minnesota Statutes 2022, section 518A.39, subdivision 2, is amended to read:

261.21 Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support
261.22 may be modified upon a showing of one or more of the following, any of which makes the
261.23 terms unreasonable and unfair: (1) substantially increased or decreased gross income of an
261.24 obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or
261.25 the child or children that are the subject of these proceedings; (3) receipt of assistance under
261.26 the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to 256B.40
261.27 256B.39, or chapter 256J or 256K; (4) a change in the cost of living for either party as
261.28 measured by the federal Bureau of Labor Statistics; (5) extraordinary medical expenses of
261.29 the child not provided for under section 518A.41; (6) a change in the availability of
261.30 appropriate health care coverage or a substantial increase or decrease in health care coverage
261.31 costs; (7) the addition of work-related or education-related child care expenses of the obligee
261.32 or a substantial increase or decrease in existing work-related or education-related child care
261.33 expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

262.1 (b) It is presumed that there has been a substantial change in circumstances under
262.2 paragraph (a) and the terms of a current support order shall be rebuttably presumed to be
262.3 unreasonable and unfair if:

262.4 (1) the application of the child support guidelines in section 518A.35, to the current
262.5 circumstances of the parties results in a calculated court order that is at least 20 percent and
262.6 at least \$75 per month higher or lower than the current support order or, if the current support

262.7 order is less than \$75, it results in a calculated court order that is at least 20 percent per
262.8 month higher or lower;

262.9 (2) the medical support provisions of the order established under section 518A.41 are
262.10 not enforceable by the public authority or the obligee;

262.11 (3) health coverage ordered under section 518A.41 is not available to the child for whom
262.12 the order is established by the parent ordered to provide;

262.13 (4) the existing support obligation is in the form of a statement of percentage and not a
262.14 specific dollar amount;

262.15 (5) the gross income of an obligor or obligee has decreased by at least 20 percent through
262.16 no fault or choice of the party; or

262.17 (6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause
262.18 (4), and the child no longer resides in a foreign country or the factor is otherwise no longer
262.19 applicable.

262.20 (c) A child support order is not presumptively modifiable solely because an obligor or
262.21 obligee becomes responsible for the support of an additional nonjoint child, which is born
262.22 after an existing order. Section 518A.33 shall be considered if other grounds are alleged
262.23 which allow a modification of support.

262.24 (d) If child support was established by applying a parenting expense adjustment or
262.25 presumed equal parenting time calculation under previously existing child support guidelines
262.26 and there is no parenting plan or order from which overnights or overnight equivalents can
262.27 be determined, there is a rebuttable presumption that the established adjustment or calculation
262.28 will continue after modification so long as the modification is not based on a change in
262.29 parenting time. In determining an obligation under previously existing child support
262.30 guidelines, it is presumed that the court shall:

262.31 (1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's
262.32 share of the combined basic support obligation calculated under section 518A.34, paragraph
262.33 (b), clause (5), by 0.88; or

263.1 (2) if the parenting time was presumed equal but the parents' parental incomes for
263.2 determining child support were not equal:

263.3 (i) multiply the combined basic support obligation under section 518A.34, paragraph
263.4 (b), clause (5), by 0.75;

263.5 (ii) prorate the amount under item (i) between the parents based on each parent's
263.6 proportionate share of the combined PICS; and

263.7 (iii) subtract the lower amount from the higher amount.

263.8 (e) On a motion for modification of maintenance, including a motion for the extension
263.9 of the duration of a maintenance award, the court shall apply, in addition to all other relevant

263.10 factors, the factors for an award of maintenance under section 518.552 that exist at the time
263.11 of the motion. On a motion for modification of support, the court:

263.12 (1) shall apply section 518A.35, and shall not consider the financial circumstances of
263.13 each party's spouse, if any; and

263.14 (2) shall not consider compensation received by a party for employment in excess of a
263.15 40-hour work week, provided that the party demonstrates, and the court finds, that:

263.16 (i) the excess employment began after entry of the existing support order;

263.17 (ii) the excess employment is voluntary and not a condition of employment;

263.18 (iii) the excess employment is in the nature of additional, part-time employment, or
263.19 overtime employment compensable by the hour or fractions of an hour;

263.20 (iv) the party's compensation structure has not been changed for the purpose of affecting
263.21 a support or maintenance obligation;

263.22 (v) in the case of an obligor, current child support payments are at least equal to the
263.23 guidelines amount based on income not excluded under this clause; and

263.24 (vi) in the case of an obligor who is in arrears in child support payments to the obligee,
263.25 any net income from excess employment must be used to pay the arrearages until the
263.26 arrearages are paid in full.

263.27 (f) A modification of support or maintenance, including interest that accrued pursuant
263.28 to section 548.091, may be made retroactive only with respect to any period during which
263.29 the petitioning party has pending a motion for modification but only from the date of service
263.30 of notice of the motion on the responding party and on the public authority if public assistance
263.31 is being furnished or the county attorney is the attorney of record, unless the court adopts
263.32 an alternative effective date under paragraph (l). The court's adoption of an alternative
264.1 effective date under paragraph (l) shall not be considered a retroactive modification of
264.2 maintenance or support.

264.3 (g) Except for an award of the right of occupancy of the homestead, provided in section
264.4 518.63, all divisions of real and personal property provided by section 518.58 shall be final,
264.5 and may be revoked or modified only where the court finds the existence of conditions that
264.6 justify reopening a judgment under the laws of this state, including motions under section
264.7 518.145, subdivision 2. The court may impose a lien or charge on the divided property at
264.8 any time while the property, or subsequently acquired property, is owned by the parties or
264.9 either of them, for the payment of maintenance or support money, or may sequester the
264.10 property as is provided by section 518A.71.

264.11 (h) The court need not hold an evidentiary hearing on a motion for modification of
264.12 maintenance or support.

225.24 Sec. 80. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by
225.25 Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:
225.26 **Sec. 11. MORATORIUM ON CONVERSION TRANSACTIONS.**

225.27 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan
225.28 corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health
225.29 maintenance organization operating under Minnesota Statutes, chapter 62D, as of January
225.30 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single
225.31 transaction or a series of transactions within a 24-month period, all or a material amount of
226.1 its assets to an entity that is a corporation organized under Minnesota Statutes, chapter
226.2 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the
226.3 health maintenance organization. For purposes of this section, "material amount" means
226.4 the lesser of ten percent of such an entity's total admitted net assets as of December 31 of
226.5 the previous year, or \$50,000,000.

226.6 (b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit
226.7 health maintenance organization files an intent to dissolve due to insolvency of the
226.8 corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings
226.9 are commenced under Minnesota Statutes, chapter 60B.

226.10 (c) Nothing in this section shall be construed to authorize a nonprofit health maintenance
226.11 organization or a nonprofit service plan corporation to engage in any transaction or activities
226.12 not otherwise permitted under state law.

226.13 (d) This section expires July 1, ~~2023~~ 2026.

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

264.13 (i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions
264.14 brought under this subdivision.

264.15 (j) An enactment, amendment, or repeal of law constitutes a substantial change in the
264.16 circumstances for purposes of modifying a child support order when it meets the standards
264.17 for modification in this section.

264.18 (k) On the first modification following implementation of amended child support
264.19 guidelines, the modification of basic support may be limited if the amount of the full variance
264.20 would create hardship for either the obligor or the obligee. Hardship includes, but is not
264.21 limited to, eligibility for assistance under chapter 256J.

264.22 (l) The court may select an alternative effective date for a maintenance or support order
264.23 if the parties enter into a binding agreement for an alternative effective date.

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

264.25 Sec. 177. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended
264.26 by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:
264.27 **Sec. 11. MORATORIUM ON CONVERSION TRANSACTIONS.**

264.28 (a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan
264.29 corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health
264.30 maintenance organization operating under Minnesota Statutes, chapter 62D, as of January
264.31 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single
264.32 transaction or a series of transactions within a 24-month period, all or a material amount of
265.1 its assets to an entity that is a corporation organized under Minnesota Statutes, chapter
265.2 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the
265.3 health maintenance organization. For purposes of this section, "material amount" means
265.4 the lesser of ten percent of such an entity's total admitted net assets as of December 31 of
265.5 the previous year, or \$50,000,000.

265.6 (b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit
265.7 health maintenance organization files an intent to dissolve due to insolvency of the
265.8 corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings
265.9 are commenced under Minnesota Statutes, chapter 60B.

265.10 (c) Nothing in this section shall be construed to authorize a nonprofit health maintenance
265.11 organization or a nonprofit service plan corporation to engage in any transaction or activities
265.12 not otherwise permitted under state law.

265.13 (d) This section expires July 1, ~~2023~~ 2026.

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

265.15 Sec. 178. Laws 2022, chapter 99, article 1, section 46, is amended to read:
265.16 Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

265.17 Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant
265.18 program to award grants to health care entities, including but not limited to health care
265.19 systems, hospitals, nursing facilities, community health clinics or consortium of clinics,
265.20 federally qualified health centers, rural health clinics, or health professional associations
265.21 for the purpose of establishing or expanding programs focused on improving the mental
265.22 health of health care professionals.

265.23 (b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed
265.24 and are focused on addressing the mental health of health care professionals by:

265.25 (1) identifying and addressing the barriers to and stigma among health care professionals
265.26 associated with seeking self-care, including mental health and substance use disorder services;

265.27 (2) encouraging health care professionals to seek support and care for mental health and
265.28 substance use disorder concerns;

265.29 (3) identifying risk factors associated with suicide and other mental health conditions;
265.30 ~~or~~

266.1 (4) developing and making available resources to support health care professionals with
266.2 self-care and resiliency; or

266.3 (5) identifying and modifying structural barriers in health care delivery that create
266.4 unnecessary stress in the workplace.

266.5 Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit
266.6 an application to the commissioner by the deadline established by the commissioner. An
266.7 application must be on a form and contain information as specified by the commissioner
266.8 and at a minimum must contain:

266.9 (1) a description of the purpose of the program for which the grant funds will be used;
266.10 (2) a description of the achievable objectives of the program and how these objectives
266.11 will be met; and

266.12 (3) a process for documenting and evaluating the results of the program.

266.13 (b) The commissioner shall give priority to programs that involve peer-to-peer support.

266.14 Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision
266.15 6, encumbrances for grants under this section issued by June 30 of each year may be certified
266.16 for a period of up to three years beyond the year in which the funds were originally
266.17 appropriated.

266.18 Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the
266.19 grant program by conducting a periodic evaluation of the impact and outcomes of the grant

266.20 program on health care professional burnout and retention. The commissioner shall submit
266.21 the results of the evaluation and any recommendations for improving the grant program to
266.22 the chairs and ranking minority members of the legislative committees with jurisdiction
266.23 over health care policy and finance by October 15, 2024.

266.24 Sec. 179. Laws 2022, chapter 99, article 3, section 9, is amended to read:
266.25 Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE
266.26 PROFESSIONALS.**

266.27 \$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner
266.28 of health for the health care professionals mental health grant program. This is a onetime
266.29 appropriation and is available until June 30, 2027.

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

267.1 Sec. 180. **ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS
267.2 AUTHORIZED.**

267.3 Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective
267.4 factors for mental well-being and decrease disparities in rates of mental health issues among
267.5 adolescent populations. The commissioner of health shall administer grants to
267.6 community-based organizations to facilitate mental health promotion programs for
267.7 adolescents, particularly those from populations that report higher rates of specific mental
267.8 health needs.

267.9 (b) The commissioner of health shall coordinate with other efforts at the local, state, or
267.10 national level to avoid duplication and promote complementary efforts in mental health
267.11 promotion among adolescents.

267.12 Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to
267.13 eligible community organizations, including nonprofit organizations, community health
267.14 boards, and Tribal public health entities, to implement community-based mental health
267.15 promotion programs for adolescents in community settings to improve adolescent mental
267.16 health and reduce disparities between adolescent populations in reported rates of mental
267.17 health needs.

267.18 (b) The commissioner of health, in collaboration with community and professional
267.19 stakeholders, shall establish criteria for review of applications received under this subdivision
267.20 to ensure funded programs operate using best practices such as trauma-informed care and
267.21 positive youth development principles.

267.22 (c) Grant funds distributed under this subdivision shall be used to support new or existing
267.23 community-based mental health promotion programs that include but are not limited to:

267.24 (1) training community-based members to facilitate discussions or courses on adolescent
267.25 mental health promotion skills;

267.26 (2) training trusted community members to model positive mental health skills and
267.27 practices in their existing roles;
267.28 (3) training and supporting adolescents to provide peer support; and
267.29 (4) supporting community dialogue on mental health promotion and collective stress or
267.30 trauma.
267.31 Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the
267.32 community-based grant programs funded under this section. Grant recipients shall cooperate
268.1 with the commissioner in the evaluation, and at the direction of the commissioner, shall
268.2 provide the commissioner with the information needed to conduct the evaluation.

270.22 Sec. 183. **CRITICAL ACCESS DENTAL INFRASTRUCTURE PROGRAM.**

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

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

270.26 (c) "Critical access dental provider" means a critical access dental provider as defined
270.27 in Minnesota Statutes, section 256B.76, subdivision 4.

270.28 (d) "Dental infrastructure" means:

270.29 (1) physical infrastructure of a dental setting, including but not limited to the operations
270.30 and clinical spaces in a dental clinic; associated heating, ventilation, and air conditioning
271.1 infrastructure and other mechanical infrastructure; and dental equipment needed to operate
271.2 a dental clinic; or

271.3 (2) mobile dental equipment or other equipment needed to provide dental services via
271.4 a hub-and-spoke service delivery model or via teledentistry.

271.5 Subd. 2. **Grant and loan program established.** The commissioner shall make grants
271.6 and forgivable loans to critical access dental providers for eligible dental infrastructure
271.7 projects.

271.8 Subd. 3. **Eligible projects.** In order to be eligible for a grant or forgivable loan under
271.9 this section, a dental infrastructure project must be proposed by a critical access dental
271.10 provider and must allow the provider to maintain or expand the provider's capacity to serve
271.11 Minnesota health care program enrollees.

271.12 Subd. 4. **Application.** (a) The commissioner must develop forms and procedures for
271.13 soliciting and reviewing applications for grants and forgivable loans under this section and
271.14 for awarding grants and forgivable loans. Critical access dental providers seeking a grant
271.15 or forgivable loan under this section must apply to the commissioner in a time and manner
271.16 specified by the commissioner. In evaluating applications for grants or forgivable loans for

226.15 Sec. 81. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**
226.16 Notwithstanding the terms of office specified to the members upon their appointment,
226.17 the terms for members appointed to the Palliative Care Advisory Council under Minnesota
226.18 Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in
226.19 Minnesota Statutes, section 144.059, subdivision 3.

271.17 eligible projects, the commissioner must review applications for completeness and must
271.18 determine the extent to which:

271.19 (1) the project would ensure that the critical access dental provider is able to continue
271.20 to serve Minnesota health care program enrollees in a manner that would not be possible
271.21 but for the project; or
271.22 (2) the project would increase the number of Minnesota health care program enrollees
271.23 served by the provider or the clinical complexity of the Minnesota health care program
271.24 enrollees served by the provider.

271.25 (b) The commissioner must award grants and forgivable loans based on the information
271.26 provided in the grant application.

271.27 Subd. 5. **Program oversight.** The commissioner may require and collect from grant and
271.28 loan recipients any information needed to evaluate the program.

FOR SECTION 185, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE
FOR SECTION 189, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

281.25 Sec. 191. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**
281.26 Notwithstanding the terms of office specified to the members upon their appointment,
281.27 the terms for members appointed to the Palliative Care Advisory Council under Minnesota
281.28 Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in
281.29 Minnesota Statutes, section 144.059, subdivision 3.

281.30 Sec. 192. **PSYCHEDELIC MEDICINE TASK FORCE.**

281.31 Subdivision 1. **Establishment; purpose.** The Psychedelic Medicine Task Force is
281.32 established to advise the legislature on the legal, medical, and policy issues associated with
282.1 the legalization of psychedelic medicine in the state. For purposes of this section,
282.2 "psychedelic medicine" means 3,4-methylenedioxymethamphetamine (MDMA), psilocybin,
282.3 and LSD.

282.4 Subd. 2. **Membership; compensation.** (a) The Psychedelic Medicine Task Force shall
282.5 consist of:

282.6 (1) the governor or a designee;

282.7 (2) two members of the house of representatives, one appointed by the speaker of the
282.8 house and one appointed by the minority leader of the house of representatives, and two
282.9 members of the senate, one appointed by the senate majority leader and one appointed by
282.10 the senate minority leader;

282.11 (3) the commissioner of health or a designee;

282.12 (4) the commissioner of public safety or a designee;

282.13 (5) the commissioner of human services or a designee;
282.14 (6) the attorney general or a designee;
282.15 (7) the executive director of the Board of Pharmacy or a designee;
282.16 (8) the commissioner of commerce or a designee; and
282.17 (9) members of the public, appointed by the governor, who have relevant knowledge
282.18 and expertise, including:
282.19 (i) two members representing Indian Tribes within the boundaries of Minnesota, one
282.20 representing the Ojibwe Tribes and one representing the Dakota Tribes;
282.21 (ii) one member with expertise in the treatment of substance use disorders;
282.22 (iii) one member with experience working in public health policy;
282.23 (iv) two veterans with treatment-resistant mental health conditions;
282.24 (v) two patients with treatment-resistant mental health conditions;
282.25 (vi) one psychiatrist with experience treating treatment-resistant mental health conditions,
282.26 including post-traumatic stress disorder;
282.27 (vii) one health care practitioner with experience in integrative medicine;
282.28 (viii) one psychologist with experience treating treatment-resistant mental health
282.29 conditions, including post-traumatic stress disorder; and
283.1 (ix) one member with demonstrable experience in the medical use of psychedelic
283.2 medicine.
283.3 (b) Members listed in paragraph (a), clauses (1) and (3) to (8), and members appointed
283.4 under paragraph (a), clause (9), may be reimbursed for expenses under Minnesota Statutes,
283.5 section 15.059, subdivision 6. Members appointed under paragraph (a), clause (2), may
283.6 receive per diem compensation from their respective bodies according to the rules of their
283.7 respective bodies.
283.8 (c) Members shall be designated or appointed to the task force by July 15, 2023.
283.9 Subd. 3. **Organization.** (a) The commissioner of health or the commissioner's designee
283.10 shall convene the first meeting of the task force.
283.11 (b) At the first meeting, the members of the task force shall elect a chairperson and other
283.12 officers as the members deem necessary.
283.13 (c) The first meeting of the task force shall occur by August 1, 2023. The task force shall
283.14 meet monthly or as determined by the chairperson.

283.15 Subd. 4. **Staff.** The commissioner of health shall provide support staff, office and meeting
283.16 space, and administrative services for the task force.

283.17 Subd. 5. **Duties.** The task force shall:

283.18 (1) survey existing studies in the scientific literature on the therapeutic efficacy of
283.19 psychedelic medicine in the treatment of mental health conditions, including depression,
283.20 anxiety, post-traumatic stress disorder, bipolar disorder, and any other mental health
283.21 conditions and medical conditions for which a psychedelic medicine may provide an effective
283.22 treatment option;

283.23 (2) compare the efficacy of psychedelic medicine in treating the conditions described
283.24 in clause (1) with the efficacy of treatments currently used for these conditions; and

283.25 (3) develop a comprehensive plan that covers:

283.26 (i) statutory changes necessary for the legalization of psychedelic medicine;

283.27 (ii) state and local regulation of psychedelic medicine;

283.28 (iii) federal law, policy, and regulation of psychedelic medicine, with a focus on retaining
283.29 state autonomy to act without conflicting with federal law, including methods to resolve
283.30 conflicts such as seeking an administrative exemption to the federal Controlled Substances
283.31 Act under United States Code, title 21, section 822(d), and Code of Federal Regulations,
283.32 title 21, part 1307.03; seeking a judicially created exemption to the federal Controlled
284.1 Substances Act; petitioning the United States Attorney General to establish a research
284.2 program under United States Code, title 21, section 872(e); using the Food and Drug
284.3 Administration's expanded access program; and using authority under the federal Right to
284.4 Try Act; and

284.5 (iv) education of the public on recommendations made to the legislature and others about
284.6 necessary and appropriate actions related to the legalization of psychedelic medicine in the
284.7 state.

284.8 Subd. 6. **Reports.** The task force shall submit two reports to the chairs and ranking
284.9 minority members of the legislative committees with jurisdiction over health and human
284.10 services that detail the task force's findings regarding the legalization of psychedelic medicine
284.11 in the state, including the comprehensive plan developed under subdivision 5. The first
284.12 report must be submitted by February 1, 2024, and the second report must be submitted by
284.13 January 1, 2025.

FOR SECTION 193, SEE ARTICLE 2, HEALTH INSURANCE

286.4 Sec. 194. **RETURN OF CHARITABLE ASSETS.**

286.5 If a health system that is organized as a charitable organization, and that includes M
286.6 Health Fairview University of Minnesota Medical Center, sells or transfers control to an

286.7 out-of-state nonprofit entity or to any for-profit entity, the health system must return to the
286.8 general fund any charitable assets the health system received from the state.

286.9 **EFFECTIVE DATE.** This section is effective the day following final enactment and
286.10 applies to transactions completed on or after that date.

FOR SECTION 196, SEE ARTICLE 2, HEALTH INSURANCE

287.22 Sec. 197. **STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH**
287.23 **MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER**
287.24 **TRANSACTIONS.**

287.25 (a) The commissioner of health shall study and develop recommendations on the
287.26 regulation of conversions, mergers, transfers of assets, and other transactions affecting
287.27 Minnesota-domiciled nonprofit health maintenance organizations and for-profit health
287.28 maintenance organizations. The recommendations must at least address:

287.29 (1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance
287.30 organizations;

287.31 (2) issues related to public benefit assets held by a nonprofit health maintenance
287.32 organization, including identifying the portion of the organization's assets that are considered
288.1 public benefit assets to be protected, establishing a fair and independent process to value
288.2 to the assets, and how public benefit assets should be stewarded for the public good;

288.3 (3) designating a state agency or executive branch office with authority to review and
288.4 approve or disapprove a nonprofit health maintenance organization's plan to convert to a
288.5 for-profit organization; and

288.6 (4) establishing a process for the public to learn about and provide input on a nonprofit
288.7 health maintenance organization's proposed conversion to a for-profit organization.

288.8 (b) To fulfill the requirements under this section, the commissioner:

288.9 (1) may consult with the commissioners of human services and commerce;

288.10 (2) may enter into one or more contracts for professional or technical services;

288.11 (3) notwithstanding any law to the contrary, may use data submitted under Minnesota
288.12 Statutes, sections 62U.04 and 144.695 to 144.705, and other data held by the commissioner
288.13 for purposes of regulating health maintenance organizations or already submitted to the
288.14 commissioner by health carriers; and

288.15 (4) may collect from health maintenance organizations and their parent or affiliated
288.16 companies, financial data and other information, including nonpublic data and trade secret
288.17 data, that are deemed necessary by the commissioner to conduct the study and develop the
288.18 recommendations under this section. Health maintenance organizations must provide the
288.19 commissioner with any information requested by the commissioner under this clause, in
288.20 the form and manner specified by the commissioner. Any data collected by the commissioner

226.20 **Sec. 82. STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
 226.21 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

226.25 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
 226.26 medical device, or medical intervention that maintains life by sustaining, restoring, or
 226.27 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
 226.28 to sustain patient cleanliness and comfort.

226.29 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
 226.30 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
 227.1 preferences of a patient with an advanced serious illness who is nearing the end of the their
 227.2 life are honored.

227.3 (e) "POLST form" means a portable medical form used to communicate a physician's
 227.4 order to help ensure that a patient's medical treatment preferences are conveyed to emergency
 227.5 medical service personnel and other health care providers.

227.6 **Subd. 2. Establishment.** (a) The commissioner, in consultation with the advisory
 227.7 committee established in paragraph (c), shall develop recommendations for a statewide
 227.8 registry of POLST forms to ensure that a patient's medical treatment preferences are followed
 227.9 by all health care providers. The registry must allow for the submission of completed POLST
 227.10 forms and for the forms to be accessed by health care providers and emergency medical
 227.11 service personnel in a timely manner for the provision of care or services.

227.12 (b) The commissioner shall develop recommendations on the following:

288.21 **under this clause is classified as confidential data as defined in Minnesota Statutes, section**
 288.22 **13.02, subdivision 3 or protected nonpublic data as defined in Minnesota Statutes, section**
 288.23 **13.02, subdivision 13.**

288.24 (c) No later than October 1, 2023, the commissioner must seek public comments on the
 288.25 regulation of conversion transactions involving nonprofit health maintenance organizations.

288.26 (d) The commissioner may use the enforcement authority in Minnesota Statutes, section
 288.27 62D.17, if a health maintenance organization fails to comply with a request for information
 288.28 under paragraph (b), clause (4).

288.29 (e) The commissioner shall submit preliminary findings from this study to the chairs of
 288.30 the legislative committees with jurisdiction over health and human services by January 15,
 288.31 2024, and shall submit a final report and recommendations to the legislature by June 30,
 288.32 2024.

289.1 **Sec. 198. STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR**
 289.2 **PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

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

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

289.6 (c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug,
 289.7 medical device, or medical intervention that maintains life by sustaining, restoring, or
 289.8 supplanting a vital function. Life-sustaining treatment does not include routine care necessary
 289.9 to sustain patient cleanliness and comfort.

289.10 (d) "POLST" means a provider order for life-sustaining treatment, signed by a physician,
 289.11 advanced practice registered nurse, or physician assistant, to ensure that the medical treatment
 289.12 preferences of a patient with an advanced serious illness who is nearing the end of life are
 289.13 honored.

289.14 (e) "POLST form" means a portable medical form used to communicate a physician's,
 289.15 advanced practice registered nurse's, or physician assistant's order to help ensure that a
 289.16 patient's medical treatment preferences are conveyed to emergency medical service personnel
 289.17 and other health care providers.

289.18 **Subd. 2. Establishment.** (a) The commissioner, in consultation with the advisory
 289.19 committee established in paragraph (c), shall develop recommendations for a statewide
 289.20 registry of POLST forms to ensure that a patient's medical treatment preferences are followed
 289.21 by all health care providers. The registry must allow for the submission of completed POLST
 289.22 forms and for the forms to be accessed by health care providers and emergency medical
 289.23 service personnel in a timely manner for the provision of care or services.

289.24 (b) The commissioner shall develop recommendations on the following:

227.13 (1) electronic capture, storage, and security of information in the registry;

227.14 (2) procedures to protect the accuracy and confidentiality of information submitted to

227.15 the registry;

227.16 (3) limits as to who can access the registry;

227.17 (4) where the registry should be housed;

227.18 (5) ongoing funding models for the registry; and

227.19 (6) any other action needed to ensure that patients' rights are protected and that their

227.20 health care decisions are followed.

227.21 (c) The commissioner shall create an advisory committee with members representing

227.22 physicians, physician assistants, advanced practice registered nurses, registered nurses,

227.23 nursing homes, emergency medical system providers, hospice and palliative care providers,

227.24 the disability community, attorneys, medical ethicists, and the religious community.

227.25 Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a

227.26 statewide registry of POLST forms to the chairs and ranking minority members of the

227.27 legislative committees with jurisdiction over health and human services policy and finance

227.28 by February 1, 2024.

228.1 Sec. 83. **DIRECTION TO THE COMMISSIONER; ALZHEIMER'S PUBLIC**

228.2 **INFORMATION PROGRAM.**

228.3 (a) The commissioner of health shall design and make publicly available materials for

228.4 a statewide public information program that:

228.5 (1) promotes the benefits of early detection and the importance of discussing cognition

228.6 with a health care provider;

228.7 (2) outlines the benefits of cognitive testing, the early warning signs of cognitive

228.8 impairment, and the difference between normal cognitive aging and dementia; and

228.9 (3) provides awareness of Alzheimer's disease and other dementias.

228.10 (b) The commissioner shall include in the program materials messages directed at the

228.11 general population, as well as messages designed to reach underserved communities including

228.12 but not limited to rural populations, Native and Indigenous communities, and communities

228.13 of color. The program materials shall include culturally specific messages developed in

228.14 consultation with leaders of targeted cultural communities who have experience with

228.15 Alzheimer's disease and other dementias. The commissioner shall develop the materials for

228.16 the program by June 30, 2024, and make them available online to local and county public

228.17 health agencies and other interested parties.

228.18 (c) To the extent funds remain available for this purpose, the commissioner shall

228.19 implement an initial statewide public information campaign using the developed program

289.25 (1) electronic capture, storage, and security of information in the registry;

289.26 (2) procedures to protect the accuracy and confidentiality of information submitted to

289.27 the registry;

289.28 (3) limits as to who can access the registry;

289.29 (4) where the registry should be housed;

289.30 (5) ongoing funding models for the registry; and

289.31 (6) any other action needed to ensure that patients' rights are protected and that their

289.32 health care decisions are followed.

290.1 (c) The commissioner shall create an advisory committee with members representing

290.2 physicians, physician assistants, advanced practice registered nurses, nursing homes,

290.3 emergency medical system providers, hospice and palliative care providers, the disability

290.4 community, attorneys, medical ethicists, and the religious community.

290.5 Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a

290.6 statewide registry of POLST forms to the chairs and ranking minority members of the

290.7 legislative committees with jurisdiction over health and human services policy and finance

290.8 by February 1, 2024, and implement the registry no later than December 1, 2024.

228.20 materials. The campaign must include culturally specific messages and the development of
228.21 a community digital public forum. These messages may be disseminated by television and
228.22 radio public service announcements, social media and digital advertising, print materials,
228.23 or other means.

228.24 (d) The commissioner may contract with one or more third parties to initially implement
228.25 some or all of the public information campaign, provided the contracted third party has
228.26 prior experience promoting Alzheimer's awareness and the contract is awarded through a
228.27 competitive process. The public information campaign must be implemented by July 1,
228.28 2025.

228.29 (e) By June 30, 2026, the commissioner shall report to the chairs and ranking minority
228.30 members of the legislative committees and divisions with jurisdiction over public health or
228.31 aging on the development of the program materials and initial implementation of the public
228.32 information campaign, including how and where the funds appropriated for this purpose
228.33 were spent.

229.1 Sec. 84. **MORATORIUM ON GREEN BURIALS; STUDY.**

229.2 Subdivision 1. **Definition.** For purposes of this section, "green burial" means a burial
229.3 of a dead human body in a manner that minimizes environmental impact and does not inhibit
229.4 decomposition of the body by using practices that include at least the following:

229.5 (1) the human body is not embalmed prior to burial or is embalmed only with nontoxic
229.6 chemicals;

229.7 (2) a biodegradable casket or shroud is used for burial; and

229.8 (3) the casket or shroud holding the human body is not placed in an outer burial container
229.9 when buried.

229.10 Subd. 2. **Moratorium.** Between July 1, 2023, and July 1, 2025, a green burial shall not
229.11 be performed in this state unless the green burial is performed in a cemetery that permits
229.12 green burials and at which green burials are permitted by any applicable ordinances or
229.13 regulations.

229.14 Subd. 3. **Study and report.** (a) The commissioner of health shall study the environmental
229.15 and health impacts of green burials and develop recommendations for the performance of
229.16 green burials to prevent environmental harm, including contamination of groundwater and
229.17 surface water, and to protect the health of workers performing green burials, mourners, and
229.18 the public. The study and recommendations may address topics that include:

229.19 (1) the siting of locations where green burials are permitted;

229.20 (2) the minimum distance a green burial location must have from groundwater, surface
229.21 water, and drinking water;

229.22 (3) the minimum depth at which a body buried via green burial must be buried, the
229.23 minimum soil depth below the body, and the minimum soil depth covering the body;

229.24 (4) the maximum density of green burial interments in a green burial location;

229.25 (5) procedures used by individuals who come in direct contact with a body awaiting
229.26 green burial to minimize the risk of infectious disease transmission from the body;

229.27 (6) methods to temporarily inhibit decomposition of an unembalmed body awaiting
229.28 green burial; and

229.29 (7) the time period within which an unembalmed body awaiting green burial must be
229.30 buried or held in a manner that delays decomposition.

230.1 (b) The commissioner shall submit the study and recommendations, including any
230.2 statutory changes needed to implement the recommendations, to the chairs and ranking
230.3 minority members of the legislative committees with jurisdiction over health and the
230.4 environment by February 1, 2025.

230.5 Sec. 85. **ADOPTION LAW CHANGES; PUBLIC AWARENESS CAMPAIGN.**

230.6 (a) The commissioner of human services must, in consultation with licensed child-placing
230.7 agencies, provide information and educational materials to adopted persons and birth parents
230.8 about the changes in law made by this article affecting access to birth records.

230.9 (b) The commissioner of human services must provide notice on the department's website
230.10 about the changes in the law. The commissioner or the commissioner's designee, in
230.11 consultation with licensed child-placement agencies, must coordinate a public awareness
230.12 campaign to advise the public about the changes in law made by this article.

230.13 **EFFECTIVE DATE.** This section is effective August 1, 2023.

230.14 Sec. 86. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

230.15 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
230.16 Recovery Program.

230.17 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
230.18 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
230.19 of:

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

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

272.24 Sec. 186. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

272.25 Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims
272.26 Recovery Program.

272.27 Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish
272.28 the Emmett Louis Till Victims Recovery Program to address the health and wellness needs
272.29 of:

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

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

230.26 (b) The commissioner, in consultation with victims, families, and heirs described in
 230.27 paragraph (a), shall award competitive grants to applicants for projects to provide the
 230.28 following services to victims, families, and heirs described in paragraph (a):

230.29 (1) health and wellness services, which may include services and support to address
 230.30 physical health, mental health, cultural needs, and spiritual or faith-based needs;

230.31 (2) remembrance and legacy preservation activities;

231.1 (3) cultural awareness services;

231.2 (4) spiritual and faith-based support; and

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

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

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

231.11 Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024,
 231.12 and an additional report by January 15, 2025, on the operation and results of the grant
 231.13 program, to the extent available. These reports must be submitted to the chairs and ranking
 231.14 minority members of the legislative committees with jurisdiction over health care. The
 231.15 report due January 15, 2024, must include information on grant program activities to date
 231.16 and an assessment of the need to continue to offer services provided by grant recipients to
 231.17 victims, families, and heirs who experienced trauma as described in subdivision 2, paragraph
 231.18 (a). The report due January 15, 2025, must include a summary of the services offered by
 231.19 grant recipients; an assessment of the need to continue to offer services provided by grant
 231.20 recipients to victims, families, and heirs described in subdivision 2, paragraph (a); and an
 231.21 evaluation of the grant program's goals and outcomes.

231.22 Sec. 87. **EMPLOYEE SAFETY AND SECURITY GRANTS.**

231.23 Subdivision 1. **Establishment.** The commissioner of health must establish a competitive
 231.24 grant program for workplace safety grants for eligible health care entities to increase the
 231.25 employee safety or security. Each grant award must be for at least \$5,000, but no more than
 231.26 \$100,000.

231.27 Subd. 2. **Eligible applicants.** A health care entity located in this state is eligible to apply
 231.28 for a grant. For purposes of this section, a health care entity includes but is not limited to

273.5 (b) The commissioner, in consultation with victims, families, and heirs described in
 273.6 paragraph (a), shall award competitive grants to applicants for projects to provide the
 273.7 following services to victims, families, and heirs described in paragraph (a):

273.8 (1) health and wellness services, which may include services and support to address
 273.9 physical health, mental health, and cultural needs;

273.10 (2) remembrance and legacy preservation activities;

273.11 (3) cultural awareness services; and

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

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

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

273.20 Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024,
 273.21 and an additional report by January 15, 2025, on the operation and results of the grant
 273.22 program, to the extent available. These reports must be submitted to the chairs and ranking
 273.23 minority members of the legislative committees with jurisdiction over health care. The
 273.24 report due January 15, 2024, must include information on grant program activities to date
 273.25 and an assessment of the need to continue to offer services provided by grant recipients to
 273.26 victims, families, and heirs who experienced trauma resulting from government-sponsored
 273.27 activities. The report due January 15, 2025, must include a summary of the services offered
 273.28 by grant recipients; an assessment of the need to continue to offer services provided by
 273.29 grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a);
 273.30 and an evaluation of the grant program's goals and outcomes.

290.17 Sec. 200. **WORKPLACE SAFETY GRANTS; HEALTH CARE ENTITIES AND
 290.18 HUMAN SERVICES PROVIDERS.**

290.19 Subdivision 1. **Grant program established.** The commissioner of health shall administer
 290.20 a program to award workplace safety grants to health care entities and human services
 290.21 providers to increase safety measures at health care settings and at human services workplaces
 290.22 providing behavioral health care; services for children, families, and vulnerable adults;
 290.23 services for older adults and people with disabilities; and other social services or related
 290.24 care.

290.25 Subd. 2. **Eligible applicants; application.** (a) Entities eligible for a grant under this
 290.26 section shall include health systems, hospitals, medical clinics, dental clinics, ambulance

231.29 the following: health care systems, long-term care facilities, hospitals, nursing facilities,
231.30 medical clinics, dental clinics, community health clinics, and ambulance services.

290.27 services, community health clinics, county human services agencies, Tribal human services
290.28 agencies, and other human services provider organizations.

290.29 (b) An entity seeking a grant under this section must submit an application to the
290.30 commissioner in a form and manner prescribed by the commissioner. An application must
290.31 include information about:

290.32 (1) the type of entity or organization seeking grant funding;
291.1 (2) the specific safety measures or activities for which the applicant will use the grant
291.2 funding;

291.3 (3) the specific policies that will be implemented or upheld to ensure that individuals'
291.4 rights to privacy and data protection are protected during the use of safety equipment obtained
291.5 or operated through grant funding;

291.6 (4) a proposed budget for each of the specific activities for which the applicant will use
291.7 the grant funding;

291.8 (5) an outline of efforts to enhance or improve existing safety measures or proposed
291.9 new measures to improve the safety of staff at the entity, agency, or organization;

291.10 (6) sample consent forms for any safety equipment that has capacity to record, store, or
291.11 share audio or video that will be collected from patients or clients prior to implementation
291.12 of grant-funded safety measures, excluding equipment located in public spaces in
291.13 provider-controlled, licensed settings;

291.14 (7) how the grant-funded measures will lead to long-term improvements in safety and
291.15 stability for staff and for patients and clients accessing health care or services from the
291.16 applicant; and

291.17 (8) methods the applicant will use to evaluate effectiveness of the safety measures and
291.18 changes that will be made if the measures are deemed ineffective.

231.31 Subd. 3. Applications. An entity seeking a grant under this section must apply to the
231.32 commissioner in a form and manner prescribed by the commissioner. The grant applicant,
231.33 in its application, must include:

232.1 (1) a proposed plan for how the grant funds will be used to improve employee safety or
232.2 security;

232.3 (2) a description of the achievable objectives the applicant plans to achieve through the
232.4 use of the grant funds; and

232.5 (3) a process for documenting and evaluating the results achieved through the use of the
232.6 grant funds.

291.19 Subd. 3. Grant awards. Grants must be awarded to eligible applicants that meet
291.20 application requirements on a first-come, first-served basis. Forty percent of grant funds
291.21 must be awarded to eligible applicants located outside of the seven-county metropolitan
291.22 area. Each grant award must be for at least \$5,000, but no more than \$100,000.

232.7 Subd. 4. **Eligible uses.** Grant funds must be used for the following purposes:

232.8 (1) training for employees on self-defense;

232.9 (2) training for employees on de-escalation methods;

232.10 (3) creating and implementing a health care-based violence intervention programs

232.11 (HBVI); or

232.12 (4) technology system improvements designed to improve employee safety or security.

291.23 Subd. 4. **Allowable uses of grant funds.** (a) Grant funds may be used for one or more

291.24 of the following:

291.25 (1) the procurement and installation of safety equipment, including but not limited to

291.26 cellular telephones; personal radios; wearable tracking devices for staff to share their location

291.27 with supervisors, subject to the federal Health Insurance Portability and Accountability Act

291.28 of 1996 (HIPAA) data privacy requirements outlined in Code of Federal Regulations, title

291.29 45, parts 160 and 164, subparts A and E; security systems and cameras in public spaces of

291.30 provider-controlled, licensed settings or of health care settings; and panic buttons;

291.31 (2) training for staff, which may include:

292.1 (i) sessions and exercises for crisis management, strategies for de-escalating conflict

292.2 situations, safety planning, and self-defense in accordance with positive support strategies

292.3 under Minnesota Rules, chapter 9544, and person-centered planning and service delivery

292.4 according to Minnesota Statutes, section 245D.07, subdivision 1a;

292.5 (ii) training in culturally informed and culturally affirming practices, including linguistic

292.6 training;

292.7 (iii) training in trauma-informed social, emotional, and behavioral support; and

292.8 (iv) other training topics, sessions, and exercises the commissioner determines to be

292.9 appropriate;

292.10 (3) facility safety improvements, including but not limited to a threat and vulnerability

292.11 review and barrier protection;

292.12 (4) support services, counseling, and additional resources for staff who have experienced

292.13 safety concerns or trauma-related incidents in the workplace;

292.14 (5) installation and implementation of an internal data incident tracking system to track

292.15 and prevent workplace safety incidents; and

292.16 (6) other prevention and mitigation measures and safety training, resources, and support

292.17 services the commissioner determines to be appropriate.

292.18 (b) The following restrictions apply to the eligible uses of grant funds under paragraph

292.19 (a):

292.20 (1) safety equipment must not include:
292.21 (i) tools or devices that facilitate physical or chemical restraint;
292.22 (ii) barriers, environmental modifications, or other tools or devices that facilitate
292.23 individual seclusion, except plexiglass barriers in office settings are allowed;
292.24 (iii) wearable body cameras; or
292.25 (iv) wearable tracking devices that have the capacity to store location data;
292.26 (2) security cameras must only be used in staff spaces and entry points of buildings and
292.27 may not be used in common areas, bedrooms, and bathrooms;
292.28 (3) in settings that are required to comply with the positive supports rule, all safety
292.29 equipment or measures must comply with Minnesota Rules, chapter 9544;
292.30 (4) settings licensed under Minnesota Statutes, section 245D, must follow person-centered
292.31 practices according to Minnesota Statutes, section 245D.07;
293.1 (5) any safety equipment purchased with grant funding that has electronic monitoring
293.2 capacity must be used according to Minnesota Statutes, section 144.6502, or the brain injury,
293.3 community alternative care, community access for disability inclusion, and developmental
293.4 disabilities federal waiver plan language that outlines monitoring technology use;
293.5 (6) prior to the use of safety equipment that has capacity to record, store, and share audio,
293.6 video, or a combination thereof, the grant recipient must:
293.7 (i) provide patients or clients with information about electronic monitoring in a way that
293.8 is most accessible to the patients or clients, including the definition of electronic monitoring,
293.9 the type of device that will be in use, how the footage captured will be used, with whom
293.10 the footage captured will be shared, and a statement that a patient or client has the right to
293.11 decline use of safety equipment that has capacity to record, store, and share audio, video,
293.12 or a combination thereof;
293.13 (ii) provide notice every time electronic monitoring devices are in use; and
293.14 (iii) obtain written consent from anyone whose audio or video may be recorded during
293.15 the time the device is in use and, if applicable, from guardians of individuals whose audio
293.16 or video may be recorded during the time the device is in use; and
293.17 (7) in settings that provide home and community-based services, if at any point a client
293.18 or their guardian declines the use of safety equipment that has capacity to record, store, or
293.19 share audio, video, or a combination thereof or revokes prior consent to such use, the provider
293.20 must cease using the safety equipment immediately and indefinitely. A provider may not
293.21 deny or delay the provision of services as a result of an individual's decision to decline the
293.22 use of safety equipment that has capacity to record, store, or share audio, video, or a
293.23 combination thereof.

232.13 Subd. 5. **Grant allocations.** For grants awarded prior to January 1, 2025, the
232.14 commissioner must ensure that approximately 60 percent of awards are to health care entities
232.15 in the seven-county metropolitan area and 40 percent are to health care entities outside of
232.16 the seven-county metropolitan area. If funds remain on January 1, 2025, the commissioner
232.17 may award grants to health care entities regardless of where the entity is located.

232.18 Subd. 6. **Report.** By January 15, 2026, the commissioner of health must report to the
232.19 legislative committees with jurisdiction over health policy and finance on the grants awarded
232.20 by this section. The report must include the following information:

232.21 (1) the name of each grantee, the amount awarded to the grantee, and how the grantee
232.22 used the funds; and
232.23 (2) the percentage of awards made to entities outside of the seven-county metropolitan
232.24 area.

293.24 (c) All video, audio, or other personally identifiable information collected through safety
293.25 equipment paid for by grant funds under this section must:
293.26 (1) be treated consistently with the federal Health Insurance Portability and Accountability
293.27 Act of 1996 (HIPAA) requirements outlined in Code of Federal Regulations, title 45, parts
293.28 160 and 164, subparts A and E;
293.29 (2) be subject to applicable rules of evidence and procedure if admitted into evidence
293.30 in a civil, criminal, or administrative proceeding; and
293.31 (3) not result in the denial or delay of services provided to an individual.

293.32 Subd. 5. **Report.** Within two years after receiving grant funds under this section, each
293.33 grant recipient must submit a report to the commissioner. The commissioner must submit
294.1 a compilation of the reports to the chairs and ranking minority members of the legislative
294.2 committees with jurisdiction over health and human services, the Office of Ombudsman
294.3 for Long-Term Care, and Office of Ombudsman for Mental Health and Developmental
294.4 Disabilities. Grant recipient reports to the commissioner must include:

294.5 (1) the number of workplace safety incidents that occurred over the course of the grant
294.6 period;
294.7 (2) the number and type of safety measures funded by the grants, and how those safety
294.8 measures helped alleviate or de-escalate workplace safety incidents;
294.9 (3) the number of staff benefiting from safety measures implemented through grant
294.10 funding;
294.11 (4) the number of patients or clients benefiting from safety measures implemented
294.12 through grant funding;
294.13 (5) practices implemented concurrently with the use of safety equipment that ensured
294.14 that the rights of patients or clients served were upheld;
294.15 (6) the number of patients or clients who declined to consent to the use of any safety
294.16 equipment that had capacity to record, store, or share audio, video, or a combination thereof;
294.17 (7) an evaluation of the effectiveness of the safety measures, including assessment of
294.18 whether and how the grant funding has led or will lead to improved safety and service
294.19 provisions for staff, patients, and clients; and

294.20 (8) changes to policy or practice that were made if safety measures implemented using
294.21 grant funds were deemed ineffective.

294.22 Subd. 6. **Technical assistance.** The commissioner must provide technical assistance to
294.23 grant applicants throughout the application process and to applicants and grant recipients
294.24 regarding grant distribution and required grant recipient reporting

232.25 Sec. 88. **EQUITABLE HEALTH CARE TASK FORCE.**

232.26 Subdivision 1. **Establishment; composition of task force.** The equitable health care
232.27 task force consists of up to 20 members appointed by the commissioner of health from both
232.28 metropolitan and greater Minnesota. Members must include representatives of:

232.29 (1) African American and African heritage communities;

232.30 (2) Asian American and Pacific Islander communities;

233.1 (3) Latina/o/x/ communities;

233.2 (4) American Indian communities and Tribal Nations;

233.3 (5) disability communities;

233.4 (6) lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+)
233.5 communities;

233.6 (7) organizations that advocate for the rights of individuals using the health care system;

233.7 (8) health care providers of primary care and specialty care; and

233.8 (9) organizations that provide health coverage in Minnesota.

233.9 Subd. 2. **Organization and meetings.** The task force shall be organized and administered
233.10 under Minnesota Statutes, section 15.059. The commissioner of health must convene meetings
233.11 of the task force at least quarterly. Subcommittees or workgroups may be established as
233.12 necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task
233.13 force shall expire on June 30, 2025.

233.14 Subd. 3. **Duties of task force.** The task force shall examine inequities in how people
233.15 access and receive health care based on race, religion, culture, sexual orientation, gender
233.16 identity, age, or disability and identify strategies to ensure that all Minnesotans can receive
233.17 care and coverage that is respectful and ensures optimal health outcomes, to include:

233.18 (1) identifying inequities experienced by Minnesotans in interacting with the health care
233.19 system that originate from or can be attributed to their race, religion, culture, sexual
233.20 orientation, gender identity, age, or disability status;

233.21 (2) conducting community engagement across multiple systems, sectors, and communities
233.22 to identify barriers for these population groups that result in diminished standards of care
233.23 and foregone care;

233.24 (3) identifying promising practices to improve the experience of care and health outcomes
233.25 for individuals in these population groups; and

233.26 (4) making recommendations to the commissioner of health and to the chairs and ranking
233.27 minority members of the legislative with primary jurisdiction over health policy and finance
233.28 for changes in health care system practices or health insurance regulations that would address
233.29 identified issues.

234.1 Sec. 89. **RULEMAKING AUTHORITY.**

234.2 The commissioner of health must adopt rules using the expedited rulemaking process
234.3 under Minnesota Statutes, section 14.389, to implement the installation of submerged closed
234.4 loop heat exchanger systems according to Minnesota Statutes, sections 103I.209 and
234.5 103I.210. The rules must incorporate, and are limited to, the provisions in those sections.

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

234.7 Sec. 90. **REPORT; CLOSED LOOP HEAT EXCHANGER SYSTEM.**

234.8 By December 31, 2024, the commissioner of health must submit a report to the chairs
234.9 and ranking minority members of the legislative committees with jurisdiction over health
234.10 finance and policy. The report must include a recommendation on whether additional
234.11 requirements are necessary to ensure that the construction and operation of submerged
234.12 closed loop heat exchangers do not create the risk of material adverse impacts on the state's
234.13 groundwater caused by the chemical or biological composition of the circulating fluids by
234.14 operation of the well as part of the submerged closed loop heat exchanger. Unless specifically
234.15 authorized by subsequent act of the legislature, the commissioner must not adopt any rules
234.16 or requirements to implement the recommendations included in the report.

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

234.18 Sec. 91. **CLOSED LOOP HEAT EXCHANGER SYSTEM MONITORING AND**
234.19 **REPORTING.**

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

234.22 (b) "Accredited laboratory" means a laboratory that is certified under Minnesota Rules,
234.23 chapter 4740.

234.24 (c) "Permit holder" means persons who receive a permit under this section and includes
234.25 the property owner and licensed well contractor.

234.26 Subd. 2. **Monitoring and reporting requirements.** (a) The system owner is responsible
234.27 for monitoring and reporting to the commissioner for permitted submerged closed loop heat

234.28 exchanger systems installed under the provisional program. The commissioner must identify
234.29 projects subject to reporting by including a permit condition.

234.30 (b) The closed loop heat exchanger owner must implement a closed loop water monitoring
234.31 plan.

235.1 (c) The system owner must analyze the closed loop water for:

235.2 (1) aluminum;

235.3 (2) arsenic;

235.4 (3) copper;

235.5 (4) iron;

235.6 (5) lead;

235.7 (6) manganese;

235.8 (7) zinc;

235.9 (8) total coliform;

235.10 (9) escherichia coli (E. coli);

235.11 (10) heterotrophic plate count;

235.12 (11) legionella;

235.13 (12) pH;

235.14 (13) electrical conductivity;

235.15 (14) dissolved oxygen; and

235.16 (15) temperature.

235.17 (d) The system owner must provide the results for the sampling event, including the
235.18 parameters in paragraph (c), clauses (1) to (11), to the commissioner within 30 days of the
235.19 date of the report provided by an accredited laboratory. Paragraph (c), clauses (12) to (15),
235.20 may be measured in the field and reported along with the laboratory results.

235.21 Subd. 3. **Evaluation of permit conditions.** (a) In order to determine whether additional
235.22 permit conditions are necessary and appropriate to ensure that the construction and operation
235.23 of a submerged closed loop heat exchanger does not create the risk of material adverse
235.24 impacts on the state's groundwater, the commissioner shall require semiannual sampling of
235.25 the circulating fluids in accordance with subdivision 2 to determine whether there have been
235.26 any material changes in the chemical or biological composition of the circulating fluids.

235.27 (b) The information required by this section shall be collected from each submerged
235.28 closed loop heat exchanger system installed after June 30, 2023, under this provisional

235.29 program. The commissioner shall identify up to ten systems for which report submission
235.30 is required, and this requirement shall be included in the permit conditions. The information
236.1 shall be provided to the commissioner on a semiannual basis and the final semiannual
236.2 submission shall include information from the period from January 1, 2024, through July
236.3 1, 2024.

236.4 Subd. 4. **Report requirements.** Every closed loop heat exchanger owner that holds a
236.5 permit issued under this section must provide a report to the commissioner for each permit
236.6 by September 30, 2024. The report must describe the status, operation, and performance of
236.7 each submerged closed loop heat exchanger system. The report may be in a format
236.8 determined by the system owner and must include:

236.9 (1) date of the report;
236.10 (2) a narrative description of system installation, operation, and status, including dates;
236.11 (3) mean monthly temperature of the water entering the building;
236.12 (4) mean monthly temperature of the water leaving the building;
236.13 (5) maintenance performed on the system, including dates, identification of heat
236.14 exchangers or components that were addressed, and descriptions of actions that occurred;
236.15 and
236.16 (6) any maintenance issues, material failures, leaks, and repairs, including dates and
236.17 descriptions of the heat exchangers or components involved, issues, failures, leaks, and
236.18 repairs.

236.19 **EFFECTIVE DATE.** This section is effective the day following final enactment and
236.20 expires on December 31, 2024.

290.9 Sec. 199. **VACCINES FOR UNINSURED AND UNDERINSURED ADULTS.**

290.10 The commissioner of health shall administer a program to provide vaccines to uninsured
290.11 and underinsured adults. The commissioner shall determine adult eligibility for free or
290.12 low-cost vaccines under this program and shall enroll clinics to participate in the program
290.13 and administer vaccines recommended by the Centers for Disease Control and Prevention.
290.14 In administering the program, the commissioner shall address racial and ethnic disparities
290.15 in vaccine coverage rates. State money appropriated for purposes of this section shall be
290.16 used to supplement, but not supplant, available federal funding for purposes of this section.

294.25 Sec. 201. **TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE**
294.26 **DISORDERS.**

294.27 Subdivision 1. **Establishment.** The Task Force on Pregnancy Health and Substance Use
294.28 Disorders is established to recommend protocols for when physicians, advanced practice

294.29 registered nurses, and physician assistants should administer a toxicology test and
294.30 requirements for reporting for prenatal exposure to a controlled substance.

294.31 Subd. 2. **Membership.** (a) The task force shall consist of the following members:

295.1 (1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides
295.2 care primarily to medical assistance enrollees during pregnancy appointed by the American
295.3 College of Obstetricians and Gynecologists;

295.4 (2) a physician licensed in Minnesota to practice pediatrics or family medicine who
295.5 provides care primarily to medical assistance enrollees with substance use disorders or who
295.6 provides addiction medicine care during pregnancy appointed by the Minnesota Medical
295.7 Association;

295.8 (3) a certified nurse-midwife licensed as an advanced practice registered nurse in
295.9 Minnesota who provides care primarily to medical assistance enrollees with substance use
295.10 disorders or provides addiction medicine care during pregnancy appointed by the Minnesota
295.11 Advanced Practice Registered Nurses Coalition;

295.12 (4) two representatives of county social services agencies, one from a county outside
295.13 the seven-county metropolitan area and one from a county within the seven-county
295.14 metropolitan area, appointed by the Minnesota Association of County Social Service
295.15 Administrators;

295.16 (5) one representative from the Board of Social Work;

295.17 (6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

295.18 (7) two members who identify as Black or African American and who have lived
295.19 experience with the child welfare system and substance use disorders appointed by the
295.20 Cultural and Ethnic Communities Leadership Council;

295.21 (8) two members who are licensed substance use disorder treatment providers appointed
295.22 by the Minnesota Association of Resources for Recovery and Chemical Health;

295.23 (9) one member representing hospitals appointed by the Minnesota Hospital Association;

295.24 (10) one designee of the commissioner of health with expertise in substance use disorders
295.25 and treatment;

295.26 (11) two members who identify as Native American or American Indian and who have
295.27 lived experience with the child welfare system and substance use disorders appointed by
295.28 the Minnesota Indian Affairs Council;

295.29 (12) two members from the Council for Minnesotans of African Heritage; and

295.30 (13) one member of the Minnesota Perinatal Quality Collaborative.

295.31 (b) Appointments to the task force must be made by October 1, 2023.

296.1 Subd. 3. **Chairs; meetings.** (a) The task force shall elect a chair and cochair at the first
296.2 meeting, which shall be convened no later than October 15, 2023.

296.3 (b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota
296.4 Statutes, chapter 13D.

296.5 Subd. 4. **Administrative support.** The Department of Health must provide administrative
296.6 support and meeting space for the task force.

296.7 Subd. 5. **Duties; reports.** (a) The task force shall develop recommended protocols for
296.8 when a toxicology test for prenatal exposure to a controlled substance should be administered
296.9 to a birthing parent and a newborn infant. The task force must also recommend protocols
296.10 for providing notice or reporting of prenatal exposure to a controlled substance to local
296.11 welfare agencies under Minnesota Statutes, chapter 260E.

296.12 (b) No later than December 1, 2024, the task force must submit a written report to the
296.13 chairs and ranking minority members of the legislative committees and divisions with
296.14 jurisdiction over health and human services on the task force's activities and recommendations
296.15 on the protocols developed under paragraph (a).

296.16 Subd. 6. **Expiration.** The task force shall expire upon submission of the report required
296.17 under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

296.18 Sec. 202. **REVISOR INSTRUCTION.**

296.19 (a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer
296.20 reporting system" wherever it appears in the next edition of Minnesota Statutes and Minnesota
296.21 Rules and in the online publication.

296.22 (b) The revisor of statutes shall amend the headnote for Minnesota Statutes, section
296.23 145.423, to read "RECOGNITION OF INFANT WHO IS BORN ALIVE."

FOR PARAGRAPH (C), SEE ARTICLE 3, KEEPING NURSES AT THE
BEDSIDE

236.21 Sec. 92. **REPEALER.**

236.22 (a) Minnesota Statutes 2022, section 144.059, subdivision 10, is repealed.

297.1 Sec. 203. **REPEALER.**

297.2 (a) Minnesota Rules, parts 4640.1500; 4640.1600; 4640.1700; 4640.1800; 4640.1900;
297.3 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500; 4640.2600;
297.4 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200; 4640.3300;
297.5 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900; 4640.4000;
297.6 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300; 4640.6400;
297.7 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800; 4645.0900;
297.8 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500; 4645.1600;
297.9 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200; 4645.2300;
297.10 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900; 4645.3000;
297.11 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600; 4645.3700;
297.12 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200; 4645.4300;

236.23 (b) Minnesota Statutes 2022, sections 144.212, subdivision 11; 259.83, subdivision 3;
236.24 259.89; and 260C.637, are repealed.

236.25 **EFFECTIVE DATE.** Paragraph (b) is effective July 1, 2024.

297.13 4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900; 4645.5100; and
297.14 4645.5200, are repealed effective January 1, 2024.

297.15 (b) Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7,
297.16 and 8; 144.059, subdivision 10; 144.9505, subdivision 3; 145.4235; and 153A.14, subdivision
297.17 5, are repealed.

297.18 (c) Minnesota Rules, part 4615.3600, is repealed effective the day following final
297.19 enactment.

297.20 (d) Minnesota Rules, parts 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300,
297.21 subparts 1, 3, 4, 4a, and 5; 4700.2410; 4700.2420; and 4700.2500, are repealed.

297.22 (e) Minnesota Statutes 2022, sections 62Q.145; 145.1621; 145.411, subdivisions 2 and
297.23 4; 145.412; 145.413, subdivisions 2 and 3; 145.4131; 145.4132; 145.4133; 145.4134;
297.24 145.4135; 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, and 9;
297.25 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248;
297.26 145.4249; 256B.011; 256B.40; 261.28; and 393.07, subdivision 11, are repealed effective
297.27 the day following final enactment.