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ARTICLE 4

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2022, section 13.10, subdivision 5, is amended to read:

Subd. 5. **Adoption records.** Notwithstanding any provision of this or any other chapter, adoption records shall be treated as provided in sections 259.53, 259.61, 259.79, and 259.83 to ~~259.89~~ 259.88.

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

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ARTICLE 3

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2022, section 12A.08, subdivision 3, is amended to read:

Subd. 3. **Implementation.** To implement the requirements of this section, the commissioner may cooperate with private health care providers and facilities, Tribal nations, and community health boards as defined in section 145A.02~~,~~; provide grants to assist community health boards~~,~~ and Tribal nations; use volunteer services of individuals qualified to provide public health services~~,~~; and enter into cooperative or mutual aid agreements to provide public health services.

Sec. 2. Minnesota Statutes 2022, section 13.3805, subdivision 1, is amended to read:

Subdivision 1. **Health data generally.** (a) **Definitions.** As used in this subdivision:

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

(2) "Health data" are data on individuals created, collected, received, or maintained by the Department of Health, political subdivisions, or statewide systems relating to the identification, description, prevention, and control of disease or as part of an epidemiologic investigation the commissioner designates as necessary to analyze, describe, or protect the public health.

(b) **Data on individuals.** (1) Health data are private data on individuals. Notwithstanding section 13.05, subdivision 9, health data may not be disclosed except as provided in this subdivision and section 13.04.

(2) The commissioner or a community health board as defined in section 145A.02, subdivision 5, may disclose health data to the data subject's physician as necessary to locate or identify a case, carrier, or suspect case, to establish a diagnosis, to provide treatment, to identify persons at risk of illness, or to conduct an epidemiologic investigation.

(3) With the approval of the commissioner, health data may be disclosed to the extent necessary to assist the commissioner to locate or identify a case, carrier, or suspect case, to alert persons who may be threatened by illness as evidenced by epidemiologic data, to control or prevent the spread of serious disease, or to diminish an imminent threat to the public health.

(c) **Health summary data.** Summary data derived from data collected under section 145.413 may be provided under section 13.05, subdivision 7.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2022, section 103I.005, subdivision 17a, is amended to read:

Subd. 17a. ~~**Temporary boring**~~ **Submerged closed-loop heat exchanger.** ~~"Temporary boring"~~ "Submerged closed-loop heat exchanger" means ~~an excavation that is 15 feet or~~

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

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

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

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

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

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

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

~~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:

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

(2) ~~monitor or measure physical, chemical, radiological, or biological parameters of earth materials or earth fluids, including hydraulic conductivity, bearing capacity, or resistance~~ utilizes the convective flow of groundwater as the primary medium of heat exchange;

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

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

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

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

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

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

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

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

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

(4) determine groundwater flow direction or velocity.

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

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

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

(1) for potable water supply;

(2) for irrigation;

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

(4) for heating or cooling; ~~and~~

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

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

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

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

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

(1) for a water supply well that is not in use under a maintenance permit, $175 annually;

(2) for an environmental well that is unsealed under a maintenance permit, $175 annually except no fee is required for an environmental well owned by a federal agency, state agency, or local unit of government that is unsealed under a maintenance permit. "Local unit of government" means a statutory or home rule charter city, town, county, or soil and water conservation district, watershed district, an organization formed for the joint exercise of powers under section 471.59, a community health board, or other special purpose district or authority with local jurisdiction in water and related land resources management;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the name, license number, and signature of the well contractor installing the closed loop heat exchangers;

(2) the name, address, and signature of the owner of the property on which the device will be installed;

(3) the township number, range number, section, and one quartile, and the property street address if assigned, of the proposed device location;

(4) a description of existing wells to be utilized or any wells proposed to be constructed including, the unique well numbers, locations, well depth, diameters of bore holes and casing, depth of casing, grouting methods and materials, and dates of construction;

(5) the specifications for piping including the materials to be used for piping, the closed loop water treatment protocol, and the provisions for pressure testing the system; and

(6) a diagram of the proposed system.

(b) The fees collected under this subdivision must be deposited in the state government special revenue fund.

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

(d) If a permit application contains all of the information required in paragraph (a) and for which the technical specifications are consistent with the requirements of paragraph (a), the commissioner may only deny the permit if the commissioner determines that the proposed submerged closed loop heat exchanger system creates a new material risk to human health and the environment by adversely affecting the migration of an existing groundwater contamination plume.

(e) Within 30 days of submission of a complete permit application, the commissioner must either issue the permit or notify the applicant that the commissioner has determined that the proposed submerged closed loop heat exchanger system may create a material risk to human health and the environment by adversely affecting the migration of an existing groundwater plume. If the commissioner determines the system may create a material risk, the commissioner must make a final determination as to whether the proposed system poses such material risk within 30 days after initial notice is provided to the applicant. The commissioner may extend this 30-day period with the consent of the applicant. An application is deemed to have been granted if the commissioner fails to notify the applicant that the commissioner has determined that the proposed submerged closed loop heat exchanger system may create a material risk to human health and the environment by adversely affecting the migration of an existing groundwater within 30 days of submission of a complete

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

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

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

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

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

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

(2) material and design specifications and standards;

(3) heat exchange fluid requirements;

(4) signage requirements;

(5) backflow prevention requirements;

(6) pressure tests of the system;

(7) documentation of the system construction;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

121A.335 LEAD IN SCHOOL DRINKING WATER.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the number of grant programs administered by the commissioner that required a full-time equivalent staff appropriation or administrative appropriation in order to implement;

(2) the total amount of funds appropriated to the commissioner for full-time equivalent staff or administration for all the grant programs; and

(3) for each grant program administered by the commissioner:

(i) the amount of funds appropriated to the commissioner for full-time equivalent staff or administration to administer that particular grant program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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:

(1) advance access to evidence-based nonnarcotic pain management services;

(2) implement culturally specific interventions and prevention programs with population and community groups in greatest need, including those who are pregnant and their infants;

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

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

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

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

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

(i) promote medication-assisted treatment options;

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

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

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

(8) design a system to assess, address, and prevent the impacts of drug overdose and morbidity on those who are pregnant, their infants, and children. Specifically, the commissioner of health may:

(i) inform health care providers and the public of the prevalence, risks, conditions, and treatments associated with substance use disorders involving or affecting pregnancies, infants, and children; and

(ii) identify communities, families, infants, and children affected by substance use disorder in order to recommend focused interventions, prevention, and services.

Subd. 3. **Partnerships.** The commissioner of health may consult with sovereign Tribal nations, the Minnesota Departments of Human Services, Corrections, Public Safety, and Education, local public health agencies, care providers and insurers, community organizations that focus on substance abuse risks and recovery, individuals affected by substance use disorders, and any other individuals, entities, and organizations as necessary to carry out the goals of this section.

Subd. 4. **Grants authorized.** (a) The commissioner of health may award grants, as funding allows, to entities and organizations focused on addressing and preventing the negative impacts of drug overdose and morbidity. Examples of activities the commissioner may consider for these grant awards include:

(1) developing, implementing, or promoting drug overdose and morbidity prevention programs and activities;

(2) community outreach and other efforts addressing the root causes of drug overdose and morbidity;

(3) identifying risk and protective factors relating to drug overdose and morbidity that contribute to identification, development, or improvement of prevention strategies and community outreach;

(4) developing or providing trauma-informed drug overdose and morbidity prevention and services;

(5) developing or providing culturally and linguistically appropriate drug overdose and morbidity prevention and services, and programs that target and serve historically underserved communities;

(6) working collaboratively with educational institutions, including school districts, to implement drug overdose and morbidity prevention strategies for students, teachers, and administrators;

(7) working collaboratively with sovereign Tribal nations, care providers, nonprofit organizations, for-profit organizations, government entities, community-based organizations,

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

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

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

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

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

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

(1) the number of organizations receiving grant money under this section;

(2) the number of individuals served by the grant programs;

(3) a description and analysis of the practices implemented by program grantees; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) representatives of community-based organizations serving or advocating for African American citizens;

(2) at-large community leaders or elders, as nominated by other council members;

(3) African American individuals who provide and receive health care services;

(4) African American secondary or college students;

(5) health or human service professionals serving African American communities or clients;

(6) representatives with research or academic expertise in racial equity; and

(7) other members that the commissioner deems appropriate to facilitate the goals and duties of the council.

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

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

Subd. 3. **Duties of commissioner.** The commissioner or commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

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

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

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

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

(1) representatives of community-based organizations serving or advocating for African American citizens;

(2) at-large community leaders or elders, as nominated by other council members;

(3) African American individuals who provide and receive health care services;

(4) African American secondary or college students;

(5) health or human service professionals serving African American communities or clients;

(6) representatives with research or academic expertise in racial equity; and

(7) other members that the commissioner deems appropriate to facilitate the goals and duties of the council.

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

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

Subd. 4. **Duties of commissioner.** The commissioner or commissioner's designee shall:

(1) maintain and actively engage with the council established in this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) maintain open communication channels with respective constituencies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) maintain open communication channels with respective constituencies;

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

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

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

Subd. 6. **Staffing; office space; equipment.** The commissioner shall provide the advisory council with staff support, office space, and access to office equipment and services.

Subd. 7. **Reimbursement.** Compensation or reimbursement for travel and expenses, or both, incurred for council activities is governed in accordance with section 15.059, subdivision 3.

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

Subdivision 1. **Establishment.** The commissioner of health shall establish the African American health special emphasis grant program administered by the Office of African American Health. The purposes of the program are to:

(1) identify disparities impacting African American health arising from cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination; and

(2) develop community-based solutions that incorporate a multisector approach to addressing identified disparities impacting African American health.

Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the commissioner of health, the Office of African American Health shall:

(1) develop a request for proposals for an African American health special emphasis grant program in consultation with community stakeholders;

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

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

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

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

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

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include nonprofit organizations or entities that work with African American communities or are focused on addressing disparities impacting the health of African American communities.

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

Subd. 7. **Staffing; office space; equipment.** The commissioner shall provide the advisory council with staff support, office space, and access to office equipment and services.

Subd. 8. **Reimbursement.** Compensation and reimbursement for travel and expenses incurred for council activities are governed by section 15.059, subdivision 3.

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

Subdivision 1. **Establishment.** The commissioner of health shall establish the African American health special emphasis grant program administered by the Office of African American Health. The purposes of the program are to:

(1) identify disparities impacting African American health arising from cumulative and historical discrimination and disadvantages in multiple systems, including but not limited to housing, education, employment, gun violence, incarceration, environmental factors, and health care discrimination; and

(2) develop community-based solutions that incorporate a multisector approach to addressing identified disparities impacting African American health.

Subd. 2. **Requests for proposals; accountability; data collection.** As directed by the commissioner of health, the Office of African American Health shall:

(1) develop a request for proposals for an African American health special emphasis grant program in consultation with community stakeholders;

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

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

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

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

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

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include nonprofit organizations or entities that work with African American communities or are focused on addressing disparities impacting the health of African American communities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

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

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

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

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

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

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

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

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

Senate Language S2995-3

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

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

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

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

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

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

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$ 1,200
Psychiatric hospitals	$ 1,400
Rural health facilities	$ 1,100
Portable x-ray providers	$ 500

House Language UES2995-2

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

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

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

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

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

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

Prospective payment surveys for hospitals	$ 900
Swing bed surveys for nursing homes	$ 1,200
Psychiatric hospitals	$ 1,400
Rural health facilities	$ 1,100
Portable x-ray providers	$ 500

Senate Language S2995-3

Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
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.	

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.

(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:

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

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

The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a method for determining capacity thresholds in this paragraph in consultation with the commissioner of human services and must coordinate the administration of this paragraph with the commissioner of human services for purposes of verification.

House Language UES2995-2

Home health agencies	$	1,800
Outpatient therapy agencies	$	800
End stage renal dialysis providers	$	2,100
Independent therapists	$	800
Comprehensive rehabilitation outpatient facilities	$	1,200
Hospice providers	$	1,700
Ambulatory surgical providers	$	1,800
Hospitals	$	4,200
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.	

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.

(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:

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

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

The commissioner may annually adjust the percentages in clauses (1) and (2), to ensure this paragraph is implemented in a revenue-neutral manner. The commissioner shall develop a method for determining capacity thresholds in this paragraph in consultation with the commissioner of human services and must coordinate the administration of this paragraph with the commissioner of human services for purposes of verification.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) a dentist licensed under chapter 150A;

(8) an allied dental personnel as defined in Minnesota Rules, part 3100.0100, subpart 5;

~~(8) a midlevel practitioner;~~

(9) an advanced practice professional;

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

~~(10)~~ (11) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(11)~~ (12) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; ~~and~~

(13) a member of a Tribal Nation;

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

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

(16) a representative of a community organization that works with individuals experiencing health disparities;

(17) an individual with expertise in economic development, or an employer working outside the seven-county metropolitan area;

~~(12) three~~ (18) two consumers, at least one of whom must be ~~an advocate for persons who are mentally ill or developmentally disabled.~~ from a community experiencing health disparities; and

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

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

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

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

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

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

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

(i) approved by the Board of Dentistry; or

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

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

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

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

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

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

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

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

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

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

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

(1) establishing or expanding rotations and clinical training ~~for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental health professionals in Minnesota~~;

(2) recruitment, training, and retention of students and faculty;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship activities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand ~~a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional~~ training program; and

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

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, dental, physician, and mental health professional programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of

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

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

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

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

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

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

(1) is located in Minnesota;

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

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

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

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

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

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

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

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

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

(3) establishing new rural residency training programs;

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

(5) travel and lodging for new residents;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) other supporting information the commissioner deems necessary.

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

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

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

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

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

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

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

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

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

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

~~(2) that preparation of the record is optional; and~~

~~(3) how to obtain a certified copy of the record if one is requested and prepared.~~

(1) that the parent or parents may choose to provide a full name or provide only a last name for the record;

(2) that the parent or parents may request a certificate of birth resulting in stillbirth after the fetal death record is established;

(3) that the parent who gave birth may request an informational copy of the fetal death record; and

(4) that the parent or parents named on the fetal death record and the party responsible for reporting the fetal death may correct or amend the record to protect the integrity and accuracy of vital records.

Subd. 3. **~~Preparation~~ Responsibilities of the state registrar.** ~~(a) Within five days after delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record with the state registrar if the parent or parents of the stillbirth, after being advised as provided in subdivision 2, request to have a record of birth resulting in stillbirth prepared.~~

~~(b) If the parent or parents of the stillbirth do not choose to provide a full name for the stillbirth, the parent or parents may choose to file only a last name.~~

~~(c) Either parent of the stillbirth or, if neither parent is available, another person with knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered on the record in time to permit the filing of the record within five days after delivery.~~

The state registrar shall:

(1) prescribe the process to:

(i) register a fetal death;

(ii) request the certificate of birth resulting in stillbirth; and

(iii) request the informational copy of a fetal death record;

(2) prescribe a standardized format for the certificate of birth resulting in stillbirth, which shall integrate security features and be as similar as possible to a birth certificate;

(3) issue a certificate of birth resulting in stillbirth or a statement of no vital record found to the parent or parents named on the fetal death record upon the parent's proper completion of an attestation provided by the commissioner and payment of the required fee;

(4) correct or amend the fetal death record upon a request from the parent who gave birth, parents, or the person who registered the fetal death or filed the report; and

(5) refuse to amend or correct the fetal death record when an applicant does not submit the minimum documentation required to amend the record or when the state registrar has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.222 FETAL DEATH REPORTS ~~OF FETAL OR INFANT DEATH~~ AND REGISTRATION.

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

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

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

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

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House Language UES2995-2

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

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

Subdivision 1. **Fetal death report required.** A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section ~~145.4241~~ 145.411, subdivision 5. A fetal death report must be prepared in a format prescribed by the state registrar and filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) child support enforcement purposes; and

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

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

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

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

144.2252 ACCESS TO ORIGINAL BIRTH RECORD AFTER ADOPTION.

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

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

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

(2) the legal representative of an adopted person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 33. **[144.3832] PUBLIC WATER SYSTEM INFRASTRUCTURE STRENGTHENING GRANTS.**

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

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

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

(1) ensuring the uninterrupted delivery of safe and affordable water to their customers;

(2) anticipating and mitigating potential threats arising from climate change such as flooding and drought;

(3) providing resiliency to maintain drinking water supply capacity in case of a loss of power;

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

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

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

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

Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants must be a nonprofit organization or a nongovernmental organization serving victims of labor trafficking or labor exploitation. An 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.

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.

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

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

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

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

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

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(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.

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

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

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

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

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

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

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

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

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

(2) a public information program under section 144.393;

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

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

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

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

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

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

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

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

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

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

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

(2) a public information program under section 144.393;

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

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

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(5) statewide tobacco cessation services under section 144.397.

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

(1) prioritize preventing persons under the age of 21 from using commercial tobacco, electronic delivery devices, tobacco-related devices, and nicotine delivery products;

(2) promote racial and health equity; and

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

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

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

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

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.

(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.

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.

(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.

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(5) statewide tobacco cessation services under section 144.397.

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

(1) prioritize preventing persons under the age of 21 from using commercial tobacco, electronic delivery devices, tobacco-related devices, and nicotine delivery products;

(2) promote racial and health equity; and

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

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

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

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

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.~~

(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.

(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.

(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.

~~(b)~~ (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.

~~(c)~~ (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.

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

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

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

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

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

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

(e) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

(6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

(7) an entity that owns or exercises control over an entity listed in clauses (1) to (5).

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

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

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

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

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

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

(d) "Health care entity" means:

(1) a hospital;

(2) a hospital system;

(3) a captive professional entity;

(4) a medical foundation;

(5) a health care provider group practice;

(6) an entity organized or controlled by an entity listed in clauses (1) to (5); or

(7) an entity that owns or exercised substantial control over an entity listed in clauses (1) to (5).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the entities involved in the transaction;

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

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

(4) the primary service area for each location;

(5) the proposed service area for each location;

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

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

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

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

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

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

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

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

(1) the entities involved in the transaction;

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

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

(4) the primary service area for each location;

(5) the proposed service area for each location;

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

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

(8) the acquisition price;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) the acquisition price;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) substantially lessen competition; or

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

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

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

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

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

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

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

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

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

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

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

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

(1) substantially lessen competition; or

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(2) tend to create a monopoly or monopsony.

Subd. 4. **Additional requirements for nonprofit health care entities.** A health care entity that is incorporated under chapter 317A or organized under section 322C.1101, or that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

(1) the transaction complies with chapters 317A and 501B and other applicable laws;

(2) the transaction does not involve or constitute a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets, provided that this requirement is waived if application for waiver is made to the attorney general and the attorney general determines a waiver from this requirement is in the public interest;

(4) the value of the public benefit assets to be transferred has not been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the transaction will not result in a breach of fiduciary duty; and

(7) there are procedures and policies in place to prohibit any officer, director, trustee, or other executive of the nonprofit health care entity from directly or indirectly benefiting from the transaction.

Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction:

(1) will harm public health;

(2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience;

(3) will have a detrimental impact on competing health care options within primary and dispersed service areas;

(4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;

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(2) tend to create a monopoly or monopsony.

Subd. 4. **Additional requirements for nonprofit health care entities.** A health care entity that is incorporated under chapter 317A or organized under section 322C.1101, or that is a subsidiary of any such entity, must, before entering into a transaction, ensure that:

(1) the transaction complies with chapters 317A and 501B and other applicable laws;

(2) the transaction does not involve or constitute a breach of charitable trust;

(3) the nonprofit health care entity will receive full and fair value for its public benefit assets;

(4) the value of the public benefit assets to be transferred has not been manipulated in a manner that causes or has caused the value of the assets to decrease;

(5) the proceeds of the transaction will be used in a manner consistent with the public benefit for which the assets are held by the nonprofit health care entity;

(6) the transaction will not result in a breach of fiduciary duty; and

(7) there are procedures and policies in place to prohibit any officer, director, trustee, or other executive of the nonprofit health care entity from directly or indirectly benefiting from the transaction.

Subd. 5. **Attorney general enforcement and supplemental authority.** (a) The attorney general may bring an action in district court to enjoin or unwind a transaction or seek other equitable relief necessary to protect the public interest if a health care entity or transaction violates this section, if the transaction is contrary to the public interest, or if both a health care entity or transaction violates this section and the transaction is contrary to the public interest. Factors informing whether a transaction is contrary to the public interest include but are not limited to whether the transaction:

(1) will harm public health;

(2) will reduce the affected community's continued access to affordable and quality care and to the range of services historically provided by the entities or will prevent members in the affected community from receiving a comparable or better patient experience;

(3) will have a detrimental impact on competing health care options within primary and dispersed service areas;

(4) will reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs;

(5) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;

(6) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers;

(7) will increase health care costs for patients; or

(8) will adversely impact provider cost trends and containment of total health care spending.

(b) The attorney general may enforce this section under section 8.31.

(c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable relief, provided the attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

(d) The attorney general shall consult with the commissioner to determine whether a transaction is contrary to the public interest. Any information exchanged between the attorney general and the commissioner according to this subdivision is confidential data on individuals as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the Department of Health to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (d).

Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to the contrary, the commissioner may use data or information submitted under this section, section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

(b) The commissioner shall issue periodic public reports on the number and types of transactions subject to this section and on the aggregate impact of transactions on health care cost, quality, and competition in Minnesota.

Subd. 7. **Relation to other law.** (a) The powers and authority under this section are in addition to, and do not affect or limit, all other rights, powers, and authority of the attorney general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

(b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309, 317A, 325D, 501B, or other law on the entities involved in a transaction.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date. In determining whether a transaction

(5) will have a substantial negative impact on medical education and teaching programs, health care workforce training, or medical research;

(6) will have a negative impact on the market for health care services, health insurance services, or skilled health care workers;

(7) will increase health care costs for patients; or

(8) will adversely impact provider cost trends and containment of total health care spending.

(b) The attorney general may enforce this section under section 8.31.

(c) Failure of the entities involved in a transaction to provide timely information as required by the attorney general or the commissioner shall be an independent and sufficient ground for a court to enjoin the transaction or provide other equitable relief, provided the attorney general notified the entities of the inadequacy of the information provided and provided the entities with a reasonable opportunity to remedy the inadequacy.

(d) The attorney general shall consult with the commissioner to determine whether a transaction is contrary to the public interest. Any information exchanged between the attorney general and the commissioner according to this subdivision is confidential data on individuals as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in section 13.02, subdivision 13. The commissioner may share with the attorney general, according to section 13.05, subdivision 9, any not public data, as defined in section 13.02, subdivision 8a, held by the Department of Health to aid in the investigation and review of the transaction, and the attorney general must maintain this data with the same classification according to section 13.03, subdivision 4, paragraph (d).

Subd. 6. **Supplemental authority of commissioner.** (a) Notwithstanding any law to the contrary, the commissioner may use data or information submitted under this section, section 62U.04, and sections 144.695 to 144.705 to conduct analyses of the aggregate impact of health care transactions on access to or the cost of health care services, health care market consolidation, and health care quality.

(b) The commissioner shall issue periodic public reports on the number and types of transactions subject to this section and on the aggregate impact of transactions on health care cost, quality, and competition in Minnesota.

Subd. 7. **Relation to other law.** (a) The powers and authority under this section are in addition to, and do not affect or limit, all other rights, powers, and authority of the attorney general or the commissioner under chapter 8, 309, 317A, 325D, 501B, or other law.

(b) Nothing in this section shall suspend any obligation imposed under chapter 8, 309, 317A, 325D, 501B, or other law on the entities involved in a transaction.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date. In determining whether a transaction

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was completed on or after the effective date, any actions or series of actions necessary to the completion of the transaction that occurred prior to the effective date must be considered.

Sec. 38. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR HEALTH COVERAGE OR ASSISTANCE.**

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

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

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

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

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

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

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

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

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

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

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was completed on or after the effective date, any actions or series of actions necessary to 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

Sec. 73. **[144.587] REQUIREMENTS FOR SCREENING FOR ELIGIBILITY FOR HEALTH COVERAGE OR ASSISTANCE.**

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

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

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

(d) "Minnesota attorney general/hospital agreement" means the agreement between the attorney general and certain Minnesota hospitals that is filed in Ramsey County District Court and that establishes requirements for hospital litigation practices, garnishments, use of collection agencies, central billing office practices, and practices for billing uninsured patients.

(e) "Most favored insurer" means the nongovernmental third-party payor that provided the most revenue to the provider during the previous calendar year.

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

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

(g) "Premium tax credit" means a tax credit or premium subsidy under the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to and federal guidance and regulations issued under these acts.

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

(j) "Uninsured service or treatment" means any service or treatment that is not covered by: (1) a health plan, contract, or policy that provides health coverage to a patient; or (2) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage.

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

Subd. 2. **Screening.** (a) A hospital participating in the hospital presumptive eligibility program under section 256B.057, subdivision 12, must determine whether a patient who is uninsured or whose insurance coverage status is not known by the hospital is eligible for hospital presumptive eligibility coverage.

(b) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and for any patient whose insurance coverage status is not known to the hospital, a hospital must:

(1) if it is a certified application counselor organization, schedule an appointment for the patient with a certified application counselor to occur prior to discharge unless the occurrence of the appointment would delay discharge;

(2) if the occurrence of the appointment under clause (1) would delay discharge or if the hospital is not a certified application counselor organization, schedule prior to discharge an appointment for the patient with a MNsure-certified navigator to occur after discharge unless the scheduling of an appointment would delay discharge; or

(3) if the scheduling of an appointment under clause (2) would delay discharge or if the patient declines the scheduling of an appointment under clause (1) or (2), provide the patient with contact information for available MNsure-certified navigators who can meet the needs of the patient.

(c) For any uninsured patient, including any patient the hospital determines is eligible for hospital presumptive eligibility coverage, and any patient whose insurance coverage status is not known to the hospital, a hospital must screen the patient for eligibility for charity care from the hospital. The hospital must attempt to complete the screening process for charity care in person or by telephone within 30 days after the patient receives services at the hospital or at the emergency department associated with the hospital.

Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2, paragraph (c), the hospital must determine whether the patient is ineligible or potentially eligible for charity care. When a hospital evaluates a patient's eligibility for charity care, hospital requests to the responsible party for verification of assets or income shall be limited to:

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

Subd. 2. **Screening.** A hospital must screen a patient who is uninsured or whose insurance coverage status is not known by the hospital for: eligibility for charity care from the hospital; eligibility for state or federal public health care programs using presumptive eligibility or another similar process; and eligibility for a premium tax credit. The hospital must attempt to complete this screening process in person or by telephone within 30 days after the patient receives services at the hospital or at the emergency department associated with the hospital.

Subd. 3. **Charity care.** (a) Upon completion of the screening process in subdivision 2, the hospital must either assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up or make a determination that the patient is ineligible for charity care. A hospital may initiate one or more of the following steps only after the hospital determines that the patient is ineligible for charity care and may not initiate any of the following steps while the patient's application for charity care is pending:

(c) When a hospital evaluates a patient's eligibility for charity care, hospital requests to the responsible party for verification of assets or income shall be limited to:

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(1) information that is reasonably necessary and readily available to determine eligibility; and

(2) facts that are relevant to determine eligibility.

A hospital must not demand duplicate forms of verification of assets.

(b) If the patient is not ineligible for charity care, the hospital must assist the patient with applying for charity care and refer the patient to the appropriate department in the hospital for follow-up. A hospital may not impose application procedures for charity care that place an unreasonable burden on the individual patient, taking into account the individual patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the patient's ability to comply with application procedures.

(c) A hospital may not initiate any of the actions described in subdivision 4 while the patient's application for charity care is pending.

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

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

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

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

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

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

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

Subd. 5. **Notice.** (a) A hospital must post notice of the availability of charity care from the hospital in at least the following locations: (1) areas of the hospital where patients are admitted or registered; (2) emergency departments; and (3) the portion of the hospital's financial services or billing department that is accessible to patients. The posted notice must be in all languages spoken by more than five percent of the population in the hospital's service area.

(b) A hospital must make available on the hospital's website the current version of the hospital's charity care policy, a plain-language summary of the policy, and the hospital's

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(1) information that is reasonably necessary and readily available to determine eligibility; and

(2) facts that are relevant to determine eligibility.

A hospital must not demand duplicate forms of verification of assets.

(b) A hospital may not impose application procedures for charity care that place an unreasonable burden on the individual patient, taking into account the individual patient's physical, mental, intellectual, or sensory deficiencies or language barriers that may hinder the patient's ability to comply with application procedures.

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

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

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

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

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

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

Subd. 6. **Notice.** (a) A hospital must post notice of the availability of charity care from the hospital in at least the following locations: (1) areas of the hospital where patients are admitted or registered; (2) emergency departments; and (3) the portion of the hospital's financial services or billing department that is accessible to patients. The posted notice must be in all languages spoken by more than five percent of the population in the hospital's service area.

(b) A hospital must make available on the hospital's website, the current version of the hospital's charity care policy, a plain-language summary of the policy, and the hospital's

charity care application form. The summary and application form must be available in all languages spoken by more than five percent of the population in the hospital's service area.

charity care application form. The summary and application form must be available in all languages spoken by more than five percent of the population in the hospital's service area.

Subd. 4. **Public health care program; premium tax credit.** (a) If a patient is presumptively eligible for a public health care program, the hospital must assist the patient in completing an insurance affordability program application, help the patient schedule an appointment with a navigator organization, or provide the patient with contact information for the nearest available navigator or certified application counselor services.

(b) If a patient is eligible for a premium tax credit, the hospital may schedule an appointment for the patient with a navigator or a MNsure-certified insurance broker organization or provide the patient with contact information for the nearest available navigator services or a MNsure-certified insurance broker.

Subd. 6. **Patient may decline services.** A patient may decline to complete an insurance affordability program application to schedule an appointment with a certified application counselor, to schedule an appointment with a MNsure-certified navigator, to accept information about navigator services, to participate in the charity care screening process, or to apply for charity care.

Subd. 5. **Patient may decline services.** A patient may decline to participate in the screening process, to apply for charity care, to complete an insurance affordability program application, to schedule an appointment with a navigator organization, or to accept information about navigator services.

Subd. 7. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to services and treatments provided on or after that date.

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

Sec. 39. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

Sec. 74. **[144.588] CERTIFICATION OF EXPERT REVIEW.**

Subdivision 1. **Requirement; action to collect medical debt or garnish wages or bank accounts.** (a) In an action against a patient or guarantor for collection of medical debt owed to a hospital or for garnishment of the patient's or guarantor's wages or bank accounts to collect medical debt owed to a hospital, the hospital must serve on the defendant with the summons and complaint an affidavit of expert review certifying that:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care;

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the

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debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan;

(6) there is no reasonable basis to believe that the patient's or guarantor's wages or funds at a financial institution are likely to be exempt from garnishment; and

(7) in the case of a default judgment proceeding, there is not a reasonable basis to believe:

(i) that the patient may already consider that the patient has adequately answered the complaint by calling or writing to the hospital, its debt collection agency, or its attorney;

(ii) that the patient is potentially unable to answer the complaint due to age, disability, or medical condition; or

(iii) the patient may not have received service of the complaint.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to initiate the action or garnishment.

Subd. 2. **Requirement; referral to third-party debt collection agency.** (a) In order to refer a patient's account to a third-party debt collection agency, a hospital must complete an affidavit of expert review certifying that:

(1) unless the patient declined to participate, the hospital complied with the requirements in section 144.587;

(2) there is a reasonable basis to believe that the patient owes the debt;

(3) all known third-party payors have been properly billed by the hospital, such that any remaining debt is the financial responsibility of the patient, and the hospital will not bill the patient for any amount that an insurance company is obligated to pay;

(4) the patient has been given a reasonable opportunity to apply for charity care, if the facts and circumstances suggest that the patient may be eligible for charity care; and

(5) where the patient has indicated an inability to pay the full amount of the debt in one payment and provided reasonable verification of the inability to pay the full amount of the debt in one payment if requested by the hospital, the hospital has offered the patient a reasonable payment plan.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to refer the patient's account to a third-party debt collection agency.

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Subdivision 1. **Requirement; referral to third-party debt collection agency.** (a) In order to refer a patient's account to a third-party debt collection agency, a hospital must complete an affidavit of expert review certifying that the hospital:

(1) confirmed the information required of the hospital in the most recent version of the Minnesota attorney general/hospital agreement for referral of a specific patient's account to a third-party debt collection agency; and

(2) unless the patient declined to participate, complied with the requirements in section 144.587 to conduct a patient screening and, as applicable, assist the patient in applying for charity care, assist the patient with completing an insurance affordability program application, or refer the patient to a navigator organization.

(b) The affidavit of expert review must be completed by a designated employee of the hospital seeking to refer the patient's account to a third-party debt collection agency.

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Subd. 3. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall result, upon motion, in mandatory dismissal with prejudice of the action to collect the medical debt or to garnish the patient's or guarantor's wages or bank accounts. Failure to comply with subdivision 2 shall subject a hospital to a fine assessed by the commissioner of health. In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

Subd. 4. **Collection agency; immunity.** A collection agency, as defined in section 332.31, subdivision 3, is not liable under section 144.588, subdivision 3, for inaccuracies in an affidavit of expert review completed by a designated employee of the hospital.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to actions and referrals to third-party debt collection agencies stemming from services and treatments provided on or after that date.

Sec. 40. **[144.589] BILLING OF UNINSURED PATIENTS.**

Subdivision 1. **Limits on charges.** A hospital must not charge a patient whose annual household income is less than $125,000 for any uninsured service or treatment in an amount that exceeds the lowest total amount the provider would be reimbursed for that service or treatment from a nongovernmental third-party payor. The lowest total amount the provider would be reimbursed for that service or treatment from a nongovernmental third-party payor includes both the amount the provider would be reimbursed directly from the nongovernmental third-party payor and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance. This statute supersedes the language in the Minnesota Attorney General Hospital Agreement.

Subd. 2. **Enforcement.** In addition to the enforcement of this section by the commissioner, the attorney general may enforce this section under section 8.31.

EFFECTIVE DATE. This section is effective November 1, 2023, and applies to services and treatments provided on or after that date.

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Subd. 2. **Penalty for noncompliance.** Failure to comply with subdivision 1 shall subject a hospital to a fine assessed by the commissioner of health.

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

Sec. 75. **[144.589] BILLING OF UNINSURED PATIENTS.**

A hospital shall not charge a patient whose annual household income is less than $125,000 for any uninsured service or treatment in an amount that exceeds the total amount the provider would be reimbursed for that service or treatment from its most favored insurer. The total amount the provider would be reimbursed for that service or treatment from its most favored insurer includes both the amount the provider would be reimbursed directly from its most favored insurer, and the amount the provider would be reimbursed from the insured's policyholder under any applicable co-payments, deductibles, and coinsurance.

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

FOR SECTION 77, SEE ARTICLE 2, HEALTH INSURANCE

Sec. 78. Minnesota Statutes 2022, section 144.615, subdivision 7, is amended to read:

Subd. 7. **Limitations of services.** (a) The following limitations apply to the services performed at a birth center:

(1) surgical procedures must be limited to those normally accomplished during an uncomplicated birth, including episiotomy and repair; and

~~(2) no abortions may be administered; and~~

~~(3)~~ (2) no general or regional anesthesia may be administered.

(b) Notwithstanding paragraph (a), local anesthesia may be administered at a birth center if the administration of the anesthetic is performed within the scope of practice of a health care professional.

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

Sec. 41. **[144.645] SUPPORTING HEALTHY DEVELOPMENT OF BABIES GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health must establish a grant program to support healthy development of babies. Grant proceeds must be used for community-driven training and education on best practices for supporting healthy development of babies during pregnancy and postpartum. The grant money must be used to build capacity in, train, educate, or improve practices among individuals, from youth to elders, serving families with members who are Black, Indigenous, or People of Color during pregnancy and postpartum.

Subd. 2. **Eligibility; application.** To be eligible for a grant under this section, applicants must be a nonprofit organization. A nonprofit 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 shall review each application to determine if the application is complete, the nonprofit 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.

Sec. 42. **[144.6504] ALZHEIMER'S DISEASE AND DEMENTIA CARE TRAINING PROGRAM.**

(a) The commissioner of health, in collaboration with interested stakeholders, shall develop and provide a training program for community health workers on recognizing and understanding Alzheimer's disease and dementia. The training program may be conducted either virtually or in person and must, at a minimum, include instruction on:

(1) recognizing the common warning signs of Alzheimer's disease and dementia;

(2) understanding how Alzheimer's disease and dementia affect communication and behavior;

(3) recognizing potential safety risks for individuals living with dementia, including the risks of wandering and elder abuse; and

(4) identifying appropriate techniques to communicate with individuals living with dementia and how to appropriately respond to dementia-related behaviors.

(b) The commissioner shall work with the Minnesota State Colleges and University System (MNSCU) to explore the possibility of including a training program that meets the

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requirements of this section to the MNSCU-approved community health worker certification program.

(c) Notwithstanding paragraph (a), if a training program already exists that meets the requirements of this section, the commissioner may approve the existing training program or programs instead of developing a new program, and, in collaboration with interested stakeholders, ensure that the approved training program or programs are available to all community health workers.

Sec. 43. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision to read:

Subd. 10a. **Designated support person for pregnant patient.** (a) Subject to paragraph (c), a health care provider and a health care facility must allow, at a minimum, one designated support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services including during a hospital stay.

(b) For purposes of this subdivision, "designated support person" means any person chosen by the patient to provide comfort to the patient including but not limited to the patient's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

(c) A facility may restrict or prohibit the presence of a designed support person in treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition is strictly necessary to meet the appropriate standard of care. A facility may also restrict or prohibit the presence of a designated support person if the designated support person is acting in a violent or threatening manner towards others. Any restriction or prohibition of a designated support person by the facility is subject to the facility's written internal grievance procedure required by subdivision 20.

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Sec. 79. Minnesota Statutes 2022, section 144.651, is amended by adding a subdivision to read:

Subd. 10a. **Designated support person for pregnant patient.** (a) A health care provider and a health care facility must allow, at a minimum, one designated support person of a pregnant patient's choosing to be physically present while the patient is receiving health care services including during a hospital stay.

(b) For purposes of this subdivision, "designated support person" means any person necessary to provide comfort to the patient including but not limited to the patient's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

FOR SECTION 80, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

Sec. 81. Minnesota Statutes 2022, section 144.6535, subdivision 1, is amended to read:

Subdivision 1. **Request for variance or waiver.** A hospital may request that the commissioner grant a variance or waiver from the provisions of ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b). A request for a variance or waiver must be submitted to the commissioner in writing. Each request must contain:

(1) the specific ~~rule or rules~~ requirement for which the variance or waiver is requested;

(2) the reasons for the request;

(3) the alternative measures that will be taken if a variance or waiver is granted;

(4) the length of time for which the variance or waiver is requested; and

(5) other relevant information deemed necessary by the commissioner to properly evaluate the request for the variance or waiver.

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

Sec. 82. Minnesota Statutes 2022, section 144.6535, subdivision 2, is amended to read:

Subd. 2. **Criteria for evaluation.** The decision to grant or deny a variance or waiver must be based on the commissioner's evaluation of the following criteria:

(1) whether the variance or waiver will adversely affect the health, treatment, comfort, safety, or well-being of a patient;

(2) whether the alternative measures to be taken, if any, are equivalent to or superior to those prescribed in ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b); and

(3) whether compliance with the ~~rule or rules~~ requirements would impose an undue burden upon the applicant.

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

Sec. 83. Minnesota Statutes 2022, section 144.6535, subdivision 4, is amended to read:

Subd. 4. **Effect of alternative measures or conditions.** (a) Alternative measures or conditions attached to a variance or waiver have the same force and effect as the ~~rules~~ requirement under ~~Minnesota Rules, chapter 4640 or 4645~~ section 144.55, subdivision 3, paragraph (b), and are subject to the issuance of correction orders and penalty assessments in accordance with section 144.55.

(b) Fines for a violation of this section shall be in the same amount as that specified for the particular ~~rule~~ requirement for which the variance or waiver was requested.

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

Sec. 84. Minnesota Statutes 2022, section 144.69, is amended to read:

144.69 CLASSIFICATION OF DATA ON INDIVIDUALS.

Subdivision 1. **Data collected by the cancer reporting system.** Notwithstanding any law to the contrary, including section 13.05, subdivision 9, data collected on individuals by the cancer ~~surveillance~~ reporting system, including the names and personal identifiers of persons required in section 144.68 to report, shall be private and may only be used for the purposes set forth in this section and sections 144.671, 144.672, and 144.68. Any disclosure other than is provided for in this section and sections 144.671, 144.672, and 144.68, is declared to be a misdemeanor and punishable as such. Except as provided by rule, and as part of an epidemiologic investigation, an officer or employee of the commissioner of health may interview patients named in any such report, or relatives of any such patient, only after ~~the consent of~~ notifying the attending physician, advanced practice registered nurse, physician

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Sec. 44. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

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

assistant, or surgeon ~~is obtained~~. Research protections for patients must be consistent with section 13.04, subdivision 2, and Code of Federal Regulations, title 45, part 46.

Subd. 2. **Transfers of information to state cancer registries and federal government agencies.** (a) Information containing personal identifiers of a non-Minnesota resident collected by the cancer reporting system may be provided to the statewide cancer registry of the nonresident's home state solely for the purposes consistent with this section and sections 144.671, 144.672, and 144.68, provided that the other state agrees to maintain the classification of the information as provided under subdivision 1.

(b) Information, excluding direct identifiers such as name, Social Security number, telephone number, and street address, collected by the cancer reporting system may be provided to the Centers for Disease Control and Prevention's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results Program registry.

FOR SECTIONS 85 TO 93, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

Sec. 94. Minnesota Statutes 2022, section 144.9501, subdivision 9, is amended to read:

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

Sec. 95. Minnesota Statutes 2022, section 144.9501, subdivision 17, is amended to read:

Subd. 17. **Lead hazard reduction.** (a) "Lead hazard reduction" means abatement, swab team services, or interim controls undertaken to make a residence, child care facility, school, playground, or other location where lead hazards are identified lead-safe by complying with the lead standards and methods adopted under section 144.9508.

(b) Lead hazard reduction does not include renovation activity that is primarily intended to remodel, repair, or restore a given structure or dwelling rather than abate or control lead-based paint hazards.

(c) Lead hazard reduction does not include activities that disturb painted surfaces that total:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than two square feet (0.2 square meters) in an interior room.

Sec. 96. Minnesota Statutes 2022, section 144.9501, subdivision 26a, is amended to read:

Subd. 26a. **Regulated lead work.** ~~(a)~~ "Regulated lead work" means:

(1) abatement;

(2) interim controls;

(3) a clearance inspection;

(4) a lead hazard screen;

(5) a lead inspection;

(6) a lead risk assessment;

(7) lead project designer services;

(8) lead sampling technician services;

(9) swab team services;

(10) renovation activities; ~~or~~

(11) lead hazard reduction; or

~~(11)~~ (12) activities performed to comply with lead orders issued by ~~a community health board~~ an assessing agency.

~~(b) Regulated lead work does not include abatement, interim controls, swab team services, or renovation activities that disturb painted surfaces that total no more than:~~

~~(1) 20 square feet (two square meters) on exterior surfaces; or~~

~~(2) six square feet (0.6 square meters) in an interior room.~~

Sec. 97. Minnesota Statutes 2022, section 144.9501, subdivision 26b, is amended to read:

Subd. 26b. **Renovation.** (a) "Renovation" means the modification of any pre-1978 affected property for compensation that results in the disturbance of known or presumed lead-containing painted surfaces defined under section 144.9508, unless that activity is performed as lead hazard reduction. A renovation performed for the purpose of converting a building or part of a building into an affected property is a renovation under this subdivision.

(b) Renovation does not include minor repair and maintenance activities described in this paragraph. All activities that disturb painted surfaces and are performed within 30 days of other activities that disturb painted surfaces in the same room must be considered a single project when applying the criteria below. Unless the activity involves window replacement or demolition of a painted surface, building component, or portion of a structure, for purposes of this paragraph, "minor repair and maintenance" means activities that disturb painted surfaces totaling:

(1) less than 20 square feet (two square meters) on exterior surfaces; or

(2) less than six square feet (0.6 square meters) in an interior room.

(c) Renovation does not include total demolition of a freestanding structure. For purposes of this paragraph, "total demolition" means demolition and disposal of all interior and exterior painted surfaces, including windows. Unpainted foundation building components remaining after total demolition may be reused.

Sec. 98. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision to read:

Subd. 33. **Compensation.** "Compensation" means money or other mutually agreed upon form of payment given or received for regulated lead work, including rental payments, rental income, or salaries derived from rental payments.

Sec. 99. Minnesota Statutes 2022, section 144.9501, is amended by adding a subdivision to read:

Subd. 34. **Individual.** "Individual" means a natural person.

Sec. 100. Minnesota Statutes 2022, section 144.9505, subdivision 1, is amended to read:

Subdivision 1. **Licensing, certification, and permitting.** (a) Fees collected under this section shall be deposited into the state treasury and credited to the state government special revenue fund.

(b) Persons shall not advertise or otherwise present themselves as lead supervisors, lead workers, lead inspectors, lead risk assessors, lead sampling technicians, lead project designers, renovation firms, or lead firms unless they have licenses or certificates issued by the commissioner under this section.

(c) The fees required in this section for inspectors, risk assessors, and certified lead firms are waived for state or local government employees performing services for or as an assessing agency.

(d) ~~An individual who is the owner of property on which regulated lead work is to be performed or an adult individual who is related to the property owner, as defined under section 245A.02, subdivision 13, is exempt from the requirements to obtain a license and pay a fee according to this section.~~ Individual residential property owners who perform regulated lead work on their own residence are exempt from the licensure and firm certification requirements of this section. Notwithstanding the provisions of paragraphs (a) to (c), this exemption does not apply when the regulated lead work is a renovation performed for compensation, when a child with an elevated blood level has been identified in the residence or the building in which the residence is located, or when the residence is occupied by one or more individuals who are not related to the property owner, as defined under section 245A.02, subdivision 13.

~~(e) A person that employs individuals to perform regulated lead work outside of the person's property must obtain certification as a certified lead firm. An individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessments, clearance inspections, lead project designer services, lead sampling technician services,~~

~~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.~~

Sec. 101. Minnesota Statutes 2022, section 144.9505, subdivision 1g, is amended to read:

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.

Sec. 102. Minnesota Statutes 2022, section 144.9505, subdivision 1h, is amended to read:

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.

Sec. 103. Minnesota Statutes 2022, section 144.9508, subdivision 2, is amended to read:

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.

(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.

The commissioner shall work cooperatively with the commissioner of the Pollution Control Agency to develop disposal procedures. In adopting rules under this section, the commissioner shall require the best available technology for regulated lead work methods, paint stabilization, and repainting.

(c) The commissioner of health shall adopt regulated lead work standards and methods for lead in bare soil in a manner to protect public health and the environment. The commissioner shall adopt a maximum standard of 100 parts of lead per million in bare soil. The commissioner shall set a soil replacement standard not to exceed 25 parts of lead per million. Soil lead hazard reduction methods shall focus on erosion control and covering of bare soil.

(d) The commissioner shall adopt regulated lead work standards and methods for lead in dust in a manner to protect the public health and environment. Dust standards shall use a weight of lead per area measure and include dust on the floor, on the window sills, and on window wells. Lead hazard reduction methods for dust shall focus on dust removal and other practices which minimize the formation of lead dust from paint, soil, or other sources.

(e) The commissioner shall adopt lead hazard reduction standards and methods for lead in drinking water both at the tap and public water supply system or private well in a manner to protect the public health and the environment. The commissioner may adopt the rules for controlling lead in drinking water as contained in Code of Federal Regulations, title 40, part 141. Drinking water lead hazard reduction methods may include an educational approach of minimizing lead exposure from lead in drinking water.

(f) The commissioner of the Pollution Control Agency shall adopt rules to ensure that removal of exterior lead-based coatings from residences and steel structures by abrasive blasting methods is conducted in a manner that protects health and the environment.

(g) All regulated lead work standards shall provide reasonable margins of safety that are consistent with more than a summary review of scientific evidence and an emphasis on overprotection rather than underprotection when the scientific evidence is ambiguous.

(h) No unit of local government shall have an ordinance or regulation governing regulated lead work standards or methods for lead in paint, dust, drinking water, or soil that require a different regulated lead work standard or method than the standards or methods established under this section.

(i) Notwithstanding paragraph (h), the commissioner may approve the use by a unit of local government of an innovative lead hazard reduction method which is consistent in approach with methods established under this section.

(j) The commissioner shall adopt rules for issuing lead orders required under section 144.9504, rules for notification of abatement or interim control activities requirements, and other rules necessary to implement sections 144.9501 to 144.9512.

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Sec. 45. **[144.9821] ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.**

Subdivision 1. **Establishment of grant program.** (a) The commissioner of health shall establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving people of color, American Indians, LGBTQIA+ people, and people with disabilities in Minnesota who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) The commissioner of health shall create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(1) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(2) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

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

(1) in consultation with community stakeholders, community health boards and Tribal nations, develop a request for proposals for infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

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

(k) The commissioner shall adopt rules consistent with section 402(c)(3) of the Toxic Substances Control Act and all regulations adopted thereunder to ensure that renovation in a pre-1978 affected property ~~where a child or pregnant female resides~~ is conducted in a manner that protects health and the environment. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

(l) The commissioner shall adopt rules consistent with sections 406(a) and 406(b) of the Toxic Substances Control Act. Notwithstanding sections 14.125 and 14.128, the authority to adopt these rules does not expire.

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Sec. 181. **ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.**

Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

(1) establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving populations of color, American Indians, LGBTQIA+ communities, and those with disabilities in Minnesota who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities; and

(2) create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(i) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(ii) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

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

(1) in consultation with community stakeholders, community health boards, and Tribal nations, develop a request for proposals for an infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

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

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

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, Minnesota Council on Disability, Minnesota Commission of the Deaf, Deafblind, and Hard of Hearing, and the governor's office on the request for proposal process;

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

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

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such populations of color, American Indian, LGBTQIA+, and those with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color, American Indians and those serving communities of color, American Indians; LGBTQIA+, and disability communities.

Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 46. **[144.9981] CLIMATE RESILIENCY.**

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

(1) increase awareness of climate change;

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

(4) ensure communication with the ethnic councils; Minnesota Indian Affairs Council; Minnesota Council on Disability; Minnesota Commission of the Deaf, Deafblind, and Hard of Hearing; and the governor's office on the request for proposal process;

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

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

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such as populations of color, American Indians, LGBTQIA+ communities, and those with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color or American Indians, and those serving communities of color, American Indians, LGBTQIA+ communities, and disability communities.

Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+, and disability communities to the extent possible.

Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 182. **CLIMATE RESILIENCY.**

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

(1) increase awareness of climate change;

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(2) track the public health impacts of climate change and extreme weather events;

(3) provide technical assistance and tools that support climate resiliency to local public health, Tribal health, soil and water conservation districts, and other local governmental and nongovernmental organizations; and

(4) coordinate with the commissioners of the pollution control agency, natural resources, and agriculture and other state agencies in climate resiliency related planning and implementation.

Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage a grant program for the purpose of climate resiliency planning. The commissioner shall award grants through a request for proposals process to local public health, Tribal health, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Priority shall be given to organizations that serve communities that are disproportionately impacted by climate change.

(b) Grantees must use the funds to develop a plan or implement strategies that will reduce the risk of health impacts from extreme weather events. The grant application must include:

(1) a description of the plan or project for which the grant funds will be used;

(2) a description of the pathway between the plan or project and its impacts on health;

(3) a description of the objectives, a work plan, and a timeline for implementation; and

(4) the community or group the grant proposes to focus on.

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(2) track the public health impacts of climate change and extreme weather events;

(3) provide technical assistance and tools that support climate resiliency to local public health departments, Tribal health departments, soil and water conservation districts, and other local governmental and nongovernmental organizations; and

(4) coordinate with the commissioners of the Pollution Control Agency, natural resources, and agriculture and other state agencies in climate resiliency related planning and implementation.

Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage a grant program for the purpose of climate resiliency planning. The commissioner shall award grants through a request for proposals process to local public health departments, Tribal health departments, soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Priority shall be given to organizations that serve communities that are disproportionately impacted by climate change.

(b) Grantees must use the funds to develop a plan or implement strategies that will reduce the risk of health impacts from extreme weather events. The grant application must include:

(1) a description of the plan or project for which the grant funds will be used;

(2) a description of the pathway between the plan or project and its impacts on health;

(3) a description of the objectives, a work plan, and a timeline for implementation; and

(4) the community or group on which the grant proposes to focus.

Sec. 104. Minnesota Statutes 2022, section 144A.06, subdivision 2, is amended to read:

Subd. 2. **New license required; change of ownership.** (a) The commissioner of health by rule shall prescribe procedures for licensure under this section.

(b) A new license is required and the prospective licensee must apply for a license prior to operating a currently licensed nursing home. The licensee must change whenever one of the following events occur:

(1) the form of the licensee's legal entity structure is converted or changed to a different type of legal entity structure;

(2) the licensee dissolves, consolidates, or merges with another legal organization and the licensee's legal organization does not survive;

(3) within the previous 24 months, 50 percent or more of the licensee's ownership interest is transferred, whether by a single transaction or multiple transactions to:

(i) a different person or multiple different persons; or

(ii) a person or multiple persons who had less than a five percent ownership interest in the facility at the time of the first transaction; or

(4) any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's responsibility for the facility.

Sec. 105. Minnesota Statutes 2022, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** (a) The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

(b) The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

(c) In addition, the commissioner of health must not approve any construction project whose cost exceeds $1,000,000, unless:

~~(a)~~ (1) any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

~~(b)~~ (2) the project:

~~(1)~~ (i) has been approved through the process described in section 144A.073;

~~(2)~~ (ii) meets an exception in subdivision 3 or 4a;

~~(3)~~ (iii) is necessary to correct violations of state or federal law issued by the commissioner of health;

~~(4)~~ (iv) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met; or

~~(5)~~ (v) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

(d) Prior to the final plan approval of any construction project, the commissioners of health and human services shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioners and

shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioners, the total project construction costs for the construction project shall be submitted to the commissioners. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

(e) The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in ~~clauses (1) to (6)~~ paragraph (c), clause (2), items (i) to (v), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under ~~clause (1)~~ paragraph (c), clause (2), item (i), the dollar threshold is the cost estimate submitted with a proposal for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under ~~clauses (2) to (4)~~ paragraph (c), clause (2), items (ii) to (iv), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

(f) The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

(g) All construction projects approved through section 144A.073, subdivision 3, after March 1, 2020, are subject to the fair rental value property rate as described in section 256R.26.

EFFECTIVE DATE. This section is effective retroactively from March 1, 2020.

Sec. 106. Minnesota Statutes 2022, section 144A.073, subdivision 3b, is amended to read:

Subd. 3b. **Amendments to approved projects.** (a) Nursing facilities that have received approval ~~on or after July 1, 1993,~~ for exceptions to the moratorium on nursing homes through the process described in this section may request amendments to the designs of the projects by writing the commissioner within 15 months of receiving approval. Applicants shall submit supporting materials that demonstrate how the amended projects meet the criteria described in paragraph (b).

(b) The commissioner shall approve requests for amendments for projects approved ~~on or after July 1, 1993,~~ according to the following criteria:

(1) the amended project designs must provide solutions to all of the problems addressed by the original application that are at least as effective as the original solutions;

(2) the amended project designs may not reduce the space in each resident's living area or in the total amount of common space devoted to resident and family uses by more than five percent;

(3) the costs ~~recognized for reimbursement~~ of amended project designs shall be ~~the threshold amount of the original proposal as identified according to section 144A.071, subdivision 2~~ the cost estimate associated with the project as originally approved, except under conditions described in clause (4); and

(4) total costs ~~up to ten percent greater than the cost identified in clause (3) may be recognized for reimbursement if~~ of the amendment are no greater than ten percent of the cost estimate associated with the project as initially approved if the proposer can document that one of the following circumstances is true:

(i) changes are needed due to a natural disaster;

(ii) conditions that affect the safety or durability of the project that could not have reasonably been known prior to approval are discovered;

(iii) state or federal law require changes in project design; or

(iv) documentable circumstances occur that are beyond the control of the owner and require changes in the design.

(c) Approval of a request for an amendment does not alter the expiration of approval of the project according to subdivision 3.

(d) Reimbursement for amendments to approved projects is independent of the actual construction costs and based on the allowable appraised value of the completed project. An approved project may not be amended to reduce the scope of an approved project.

EFFECTIVE DATE. This section is effective retroactively from March 1, 2020.

Sec. 107. Minnesota Statutes 2022, section 144A.474, subdivision 3, is amended to read:

Subd. 3. **Survey process.** The survey process for core surveys shall include the following as applicable to the particular licensee and setting surveyed:

(1) presurvey review of pertinent documents and notification to the ombudsman for long-term care;

(2) an entrance conference with available staff;

(3) communication with managerial officials or the registered nurse in charge, if available, and ongoing communication with key staff throughout the survey regarding information needed by the surveyor, clarifications regarding home care requirements, and applicable standards of practice;

(4) presentation of written contact information to the provider about the survey staff conducting the survey, the supervisor, and the process for requesting a reconsideration of the survey results;

(5) a brief tour of ~~a sample of~~ the ~~housing with services establishments~~ establishment in which the provider is providing home care services;

(6) a sample selection of home care clients;

(7) information-gathering through client and staff observations, client and staff interviews, and reviews of records, policies, procedures, practices, and other agency information;

(8) interviews of clients' family members, if available, with clients' consent when the client can legally give consent;

(9) except for complaint surveys conducted by the Office of Health Facilities Complaints, an ~~on-site~~ exit conference~~,~~ with preliminary findings ~~shared and~~ discussed with the provider within one business day after completion of survey activities, ~~documentation that an exit conference occurred,~~ and with written information provided on the process for requesting a reconsideration of the survey results; and

(10) postsurvey analysis of findings and formulation of survey results, including correction orders when applicable.

Sec. 108. Minnesota Statutes 2022, section 144A.474, subdivision 9, is amended to read:

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations under subdivision 11, ~~or any violations determined to be widespread,~~ the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made.

Sec. 109. Minnesota Statutes 2022, section 144A.474, subdivision 12, is amended to read:

Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care providers a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in subdivision 11, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department shall post information on the website with the correction order that the licensee has requested a reconsideration and that the review is pending.

(b) A licensed home care provider may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the provider. The written request for reconsideration must be received by the commissioner within 15 ~~calendar~~ business days of the correction order receipt date. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in the writing or reviewing of the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a home care provider for a correction order reconsideration within 60 days of the date the provider requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the home care provider.

(c) The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full, the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance, the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect home care licensing requirement, the correction order is amended by changing the correction order to the appropriate statutory reference;

(4) correction order was issued under an incorrect citation, the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended, it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

(d) If the correction order findings are changed by the commissioner, the commissioner shall update the correction order website.

(e) This subdivision does not apply to temporary licensees.

Sec. 110. Minnesota Statutes 2022, section 144A.4791, subdivision 10, is amended to read:

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number;

~~(3)~~ (4) a list of known licensed home care providers in the client's immediate geographic area;

~~(4)~~ (5) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

~~(5)~~ (6) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

~~(6)~~ (7) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of ~~the housing with services contract with a housing with services establishment~~ any housing contract.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Sec. 111. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

Subd. 7. **Fines and penalties.** (a) The ~~fee~~ fine for failure to comply with the notification requirements in section 144G.52, subdivision 7, is $1,000.

(b) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 112. Minnesota Statutes 2022, section 144G.18, is amended to read:

144G.18 NOTIFICATION OF CHANGES IN INFORMATION.

Subdivision 1. **Notification.** A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, clause (1), (3), (4), (17), or (18).

Subd. 2. **Fines and penalties.** (a) The fine for failure to comply with the notification requirements of this section is $1,000.

(b) Fines and penalties collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 113. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

Subd. 8. **~~Fine~~ Fines and penalties.** (a) The commissioner may impose a fine for failure to follow the requirements of this section.

(b) The fine for failure to comply with this section is $1,000.

(c) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account

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Sec. 47. **[145.361] LONG COVID AND RELATED CONDITIONS; ASSESSMENT AND MONITORING.**

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

(b) "Long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post-COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

(c) "Related conditions" means conditions related to or similar to long COVID, including but not limited to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and dysautonomia, and postural orthostatic tachycardia syndrome (POTS).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID and related conditions. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID or related conditions and to detect potential public health problems, predict risks, and assist in investigating long COVID and related conditions health inequities;

(2) more accurately target information and resources for communities and patients and their families;

(3) inform health professionals and citizens about risks and early detection;

(4) promote evidence-based practices around long COVID and related conditions prevention and management and to address public concerns and questions about long COVID and related conditions; and

(5) research and track related conditions.

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

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shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 190. **LONG COVID.**

Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post-COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care management and costs; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID and to detect potential public health problems, predict risks, and assist in investigating long COVID health inequities;

(2) more accurately target information and resources for communities and patients and their families;

(3) inform health professionals and citizens about risks and early detection of long COVID known to be elevated in their communities; and

(4) promote evidence-based practices around long COVID prevention and management and to address public concerns and questions about long COVID.

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

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Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award grants and enter into contracts to organizations that serve communities disproportionately impacted by COVID-19, long COVID, or related conditions, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a), LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and award contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID or related conditions, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

Sec. 48. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

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

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Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award contracts and grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a) communities, LGBTQ+ communities, and persons with disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

Sec. 114. Minnesota Statutes 2022, section 145.411, subdivision 1, is amended to read:

Subdivision 1. **Terms.** As used in sections 145.411 to ~~145.416~~ 145.414, the terms defined in this section have the meanings given to them.

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

Sec. 115. Minnesota Statutes 2022, section 145.411, subdivision 5, is amended to read:

Subd. 5. **Abortion.** "Abortion" includes an act, procedure or use of any instrument, medicine or drug which is supplied or prescribed for or administered to ~~a pregnant woman~~ an individual with the intention of terminating, and which results in the termination of, pregnancy.

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

Sec. 116. Minnesota Statutes 2022, section 145.423, subdivision 1, is amended to read:

Subdivision 1. **Recognition; ~~medical~~ care.** ~~A born alive~~ An infant ~~as a result of an abortion~~ who is born alive shall be fully recognized as a human person, and accorded immediate protection under the law. All reasonable measures consistent with good medical practice, including the compilation of appropriate medical records, shall be taken by the responsible medical personnel to ~~preserve the life and health of the born alive infant~~ care for the infant who is born alive.

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

Sec. 117. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

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

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(d) "Lifeline center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(e) "988" or "988 hotline" means the universal telephone number for the national suicide prevention and mental health crisis hotline system within the United States operating through the Suicide and Crisis Lifeline, or its successor, maintained by the assistant secretary for mental health and substance use under section 520E-2 of the Public Health Service Act.

(f) "988 administrator" means the administrator of the 988 Suicide and Crisis Lifeline maintained by the assistant secretary for mental health and substance use under section 520E-3 of the Public Health Service Act.

(g) "988 contact" means a communication with the 988 national suicide prevention and mental health crisis hotline system within the United States via modalities offered that may include call, chat, or text.

(h) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the secretary of veterans affairs under United States Code, title 38, section 170F(h).

Subd. 2. **988 hotline; lifeline centers.** (a) The commissioner shall administer the designation of and oversee a lifeline center or network of lifeline centers to answer 988 contacts from individuals accessing the Suicide and Crisis Lifeline from any location in Minnesota 24 hours per day, seven days per week.

(b) The designated lifeline center or centers must:

(1) have an active agreement with the 988 administrator for participation within the network and with the department;

(2) meet the 988 administrator's requirements and best practice guidelines for operational and clinical standards;

(3) provide data, engage in reporting, and participate in evaluations and related quality improvement activities as required by the 988 administrator and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across crisis and emergency response systems used in the state for the purpose of crisis care coordination;

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(g) "988 Lifeline Center" means a state-identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(d) "988" means the universal telephone number designated as the universal telephone number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline, or its successor, maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(e) "988 administrator" means the administrator of the national 988 Suicide and Crisis Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act.

(f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system within the United States via modalities offered including call, chat, or text.

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

(h) "988 Suicide and Crisis Lifeline" or "988 Lifeline" means the national suicide prevention and mental health crisis hotline system maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24 hours per day, seven days per week.

(b) The designated 988 Lifeline Center must:

(1) have an active agreement with the 988 Suicide and Crisis Lifeline program for participation in the network and the department;

(2) meet the 988 Lifeline program requirements and best practice guidelines for operational and clinical standards;

(3) provide data and reports, and participate in evaluations and related quality improvement activities as required by the 988 Lifeline program and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across mobile crisis and public safety answering points used in the state for the purpose of crisis care coordination;

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(5) connect people to crisis response and outgoing services, including mobile crisis teams, in accordance with guidelines established by the 988 administrator and the department and in collaboration with the Department of Human Services;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers; local community mental health centers, including certified community behavioral health clinics and community behavioral health centers; mobile crisis teams; and emergency departments;

(7) offer follow-up services to individuals accessing the lifeline center that are consistent with guidelines established by the 988 administrator and the department; and

(8) meet requirements set by the 988 administrator and the department for serving high-risk and specialized populations and culturally or ethnically diverse populations.

(c) The commissioner shall use the commissioner's rulemaking authority to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The commissioner, having primary oversight of suicide prevention, shall work with the Suicide and Crisis Lifeline, Veterans Crisis Line, and other SAMHSA-approved networks to ensure consistency of public messaging about 988 services. The commissioner may engage in activities to publicize and raise awareness about 988 services, or may provide grants to other organizations for these purposes.

(e) The commissioner shall provide an annual report to the legislature on usage of the 988 hotline, including answer rates, rates of abandoned calls, and referral rates to 911 emergency response and to mental health crisis teams. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 3. **988 special revenue account.** (a) A 988 special revenue account is established as a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide prevention crisis system according to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's report and order FCC 20-100 adopted July 16, 2020, and national guidelines for crisis care.

(b) The 988 special revenue account shall consist of:

(1) a 988 telecommunications fee imposed under subdivision 4;

(2) a prepaid wireless 988 fee imposed under section 403.161;

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

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers including certified community behavioral health clinics and community behavioral health centers, mobile crisis teams, and community based and hospital emergency departments;

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

(8) meet the requirements set by the 988 Lifeline program and the department for serving at-risk and specialized populations.

(c) The commissioner shall adopt rules to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The department, having primary oversight of suicide prevention, shall work with the 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the purpose of ensuring consistency of public messaging about 988 services.

(f) The commissioner shall provide an annual public report on 988 Lifeline usage, including data on answer rates, abandoned calls, and referrals to 911 emergency response.

(e) The department shall work with representatives from 988 Lifeline Centers and public safety answering points, other public safety agencies, and the commissioner of public safety to facilitate the development of protocols and procedures for interactions between 988 and 911 services across Minnesota. Protocols and procedures shall be developed following available national standards and guidelines.

Subd. 3. **Activities to support the 988 system.** The commissioner shall use money appropriated for the 988 system to fund:

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(3) transfers of state money into the account;

(4) grants and gifts intended for deposit in the account;

(5) interest, premiums, gains, and other earnings of the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The account shall be administered by the commissioner. Money in the account shall only be used to offset costs that are or may reasonably be attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline, including staff and technology infrastructure enhancements needed to achieve the operational standards and best practices set forth by the 988 administrator and the department;

(2) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(3) administration, oversight, and evaluation of the account.

(d) Money in the account:

(1) does not cancel at the end of any state fiscal year and is carried forward in subsequent state fiscal years;

(2) is not subject to transfer to any other account or fund or to transfer, assignment, or reassignment for any use or purpose other than the purposes specified in this subdivision; and

(3) is appropriated to the commissioner for the purposes specified in this subdivision.

(e) The commissioner shall submit an annual report to the legislature and to the Federal Communications Commission on deposits to and expenditures from the account. Notwithstanding section 144.05, subdivision 7, the reports required under this paragraph do not expire.

Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, the commissioner shall impose a monthly statewide fee on each subscriber of a wireline, wireless, or IP-enabled voice service at a rate that provides

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(1) implementing, maintaining, and improving the 988 Suicide and Crisis Lifeline to ensure the efficient and effective routing and handing of calls, chats, and texts made to the 988 Lifeline Centers, including staffing and technological infrastructure enhancements necessary to achieve operational standards and best practices set by the 988 Lifeline and the department;

(2) personnel for 988 Lifeline Centers;

(3) the provision of acute mental health and crisis outreach services to persons who contact a 988 Lifeline Center;

(4) publicizing and raising awareness of 988 services, or providing grants to organizations to publicize and raise awareness of 988 services;

(5) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(6) administration, oversight, and evaluation.

for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The commissioner shall annually recommend to the Public Utilities Commission an adequate and appropriate fee to implement this section. The amount of the fee must comply with the limits in paragraph (c). The commissioner shall provide telecommunication service providers and carriers a minimum of 30 days' notice of each fee change.

(c) The amount of the 988 telecommunications fee must not be more than 25 cents per month on or after January 1, 2024, for each consumer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

(d) Each wireline, wireless, and IP-enabled voice telecommunication service provider shall collect the 988 telecommunications fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(e) The commissioner of public safety shall deposit the money collected from the 988 telecommunications fee to the 988 special revenue account established in subdivision 3.

(f) All 988 telecommunications fee revenue must be used to supplement, and not supplant, federal, state, and local funding for suicide prevention.

(g) The 988 telecommunications fee amount shall be adjusted as needed to provide for continuous operation of the lifeline centers and 988 hotline, volume increases, and maintenance.

(h) The commissioner shall annually report to the Federal Communications Commission on revenue generated by the 988 telecommunications fee.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunications fee established in subdivision 4 does not apply to prepaid wireless telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Subd. 6. **Biennial budget; annual financial report.** The commissioner must prepare a biennial budget for maintaining the 988 system. By December 15 of each year, the commissioner must submit a report to the legislature detailing the expenditures for maintaining the 988 system, the 988 fees collected, the balance of the 988 fund, the 988-related administrative expenses, and the most recent forecast of revenues and expenditures for the 988 special revenue account, including a separate projection of 988 fees from prepaid wireless customers and projections of year-end fund balances.

Subd. 4. **988 Lifeline operating budget; report on data to legislature.** The commissioner shall provide to the legislature a biennial report for maintaining the 988 system. The report must include data on direct and indirect expenditures to maintain the 988 system.

Subd. 7. **Waiver.** A wireless telecommunications service provider or wire-line telecommunications service provider may petition the commissioner for a waiver of all or portions of the requirements of this section. The commissioner may grant a waiver upon a demonstration by the petitioner that the requirement is economically infeasible.

Sec. 49. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

Subd. 4. ~~**Administrative costs**~~ **Administration.** The commissioner may ~~use up to seven percent of the annual appropriation under this section to~~ provide training and technical assistance and ~~to~~ administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Sec. 50. **[145.9011] FETAL AND INFANT DEATH STUDIES.**

Subdivision 1. **Access to data.** (a) For purposes of this section, the subject of the data is defined as any of the following:

(1) a live born infant that died within the first year of life;

(2) a fetal death which meets the criteria required for reporting as defined in section 144.222; or

(3) the biological mother of an infant as defined in clause (1) or of a fetal death as defined in clause (2).

(b) To conduct fetal and infant death studies, the commissioner of health must have access to:

(1) medical data as defined in section 13.384, subdivision 1, paragraph (b); medical examiner data as defined in section 13.83, subdivision 1; and health records created, maintained, or stored by providers as defined in section 144.291, subdivision 2, paragraph (i), on the subject of the data;

(2) data on health and social support services, including but not limited to family home visiting programs and the women, infants, and children (WIC) program; prescription monitoring programs data; and data on behavioral health services, on the subject of the data;

(3) the name of a health care provider that provided prenatal, postpartum, pediatric, and other health services to the subject of the data, which must be provided by a coroner or medical examiner; and

(4) Department of Human Services and other state agency data to identify and receive information on the types and nature of other sources of care and social support received by the subject of the data, and parents and guardians of the subject of the data, to assist with evaluation of social service systems.

Sec. 118. Minnesota Statutes 2022, section 145.87, subdivision 4, is amended to read:

Subd. 4. ~~**Administrative costs**~~ **Administration.** The commissioner may ~~use up to seven percent of the annual appropriation under this section to~~ provide training and technical assistance and ~~to~~ administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

(c) When necessary to conduct a fetal and infant death study, the commissioner must have access to:

(1) data described in this subdivision relevant to fetal and infant death studies from before, during, and after pregnancy or birth for the subject of the data; and

(2) law enforcement reports or incident reports related to the subject of the data and must receive the reports when requested from law enforcement.

(d) The commissioner does not have access to coroner or medical examiner data that are part of an active investigation as described in section 13.83.

(e) The commissioner must have access to all data described within this section without the consent of the subject of the data and without the consent of the parent, other guardian, or legal representative of the subject of the data. The commissioner has access to the data in this subdivision to study fetal or infant deaths that occur on or after July 1, 2021.

(f) The commissioner must make a good faith reasonable effort to notify the subject of the data, parent, spouse, other guardian, or legal representative of the subject of the data before collecting data on the subject of the data. For purposes of this paragraph, "reasonable effort" means one notice is sent by certified mail to the last known address of the subject of the data, parent, spouse, other guardian, or legal representative informing of the data collection and offering a public health nurse support visit if desired.

Subd. 2. **Management of records.** After the commissioner has collected all data about the subject of a fetal or infant death study necessary to perform the study, the data extracted from source records obtained under subdivision 2, other than data identifying the subject of the data, must be transferred to separate records that must be maintained by the commissioner. Notwithstanding section 138.17, after the data have been transferred, all source records obtained under subdivision 2 that are possessed by the commissioner must be destroyed.

Subd. 3. **Classification of data.** (a) Data provided to the commissioner from source records under subdivision 2, including identifying information on individual providers, subjects of the data, their family, or guardians, and data derived by the commissioner under subdivision 3 for the purpose of carrying out fetal or infant death studies, are classified as confidential data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3, and 13.10, subdivision 1, paragraph (a).

(b) Data classified under subdivision 4, paragraph (a), must not be subject to discovery or introduction into evidence in any administrative, civil, or criminal proceeding. Such information otherwise available from an original source must not be immune from discovery or barred from introduction into evidence merely because it was utilized by the commissioner in carrying out fetal or infant death studies.

(c) Summary data on fetal and infant death studies created by the commissioner, which does not identify individual subjects of the data, their families, guardians, or individual providers, must be public in accordance with section 13.05, subdivision 7.

(d) Data provided by the commissioner of human services or other state agency to the commissioner of health under this section retains the same classification as the data held when retained by the commissioner of human services, as required under section 13.03, subdivision 4, paragraph (c).

Subd. 4. **Fetal and infant mortality reviews.** (a) The commissioner of health must convene case review committees to conduct death study reviews, make recommendations, and publicly share summary information, especially for and about racial and ethnic groups, including American Indians and African Americans, that experience significantly disparate rates of fetal and infant mortality.

(b) The case review committees may include, but are not limited to, medical examiners or coroners, representative from health care institutions that provide care to pregnant people and infants, obstetric and pediatric practitioners, Medicaid representatives, state agency women and infant program representatives, and individuals from the communities that experience disparate rates of fetal and infant deaths, and other subject matter experts as necessary.

(c) The case review committees will review data from source records obtained under subdivision 2, other than data identifying the subject, the subject's family, or guardians, or the provider involved in the care of the subject.

(d) A person attending a fetal and infant mortality review committee meeting must not disclose what transpired at the meeting, except as necessary to carry out the purposes of the review committee. The proceedings and records of the review committee are protected nonpublic data as defined in section 13.02, subdivision 13. Discovery and introduction into evidence in legal proceedings of case review committee proceedings and records, and testimony in legal proceedings by review committee members and persons presenting information to the review committee, must occur in compliance with the requirements in section 256.01, subdivision 12, paragraph (e).

(e) Every three years beginning December 1, 2024, the case review committees will provide findings and recommendations to the Maternal and Child Health Advisory Task Force and the commissioner from the committee's review of fetal and infant deaths and provide specific recommendations designed to reduce population-based disparities in fetal and infant deaths.

(f) This paragraph governs case review committee member compensation and expense reimbursement, notwithstanding any other law or policy to the contrary. Members of the case review committee must be compensated by the commissioner of health for actual time spent in work on case reviews at a per diem rate established by the commissioner of health according to funding availability. Compensable time includes preparation for case reviews,

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.

Subd. 5. **Expiration.** Notwithstanding any other law or policy to the contrary, the fetal and infant mortality review committee must not expire.

Sec. 51. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, 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.

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

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 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.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

Sec. 119. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, 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.

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

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 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.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

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(1) operate in partnership with a school or school district and with the permission of the school or school district board;

(2) provide health services through a sponsoring organization that meets the requirements in subdivision 1, paragraph (c); and

(3) provide health services to all students and youth within a school or school district, regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

(d) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

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

Subd. 3. **School-based health center services.** (a) Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

(b) Services provided by a school-based health center must not replace the daily student support provided in the school by educational student service providers, including but not

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(1) operate in partnership with a school or school district and with the permission of the school or school district board;

(2) provide health services through a sponsoring organization; and

(3) provide health services to all students and youth within a school or school district, regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

(d) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

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

Subd. 3. **School-based health center services.** Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

limited to licensed school nurses, educational psychologists, school social workers, and school counselors.

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

Sec. 52. Minnesota Statutes 2022, section 145.924, is amended to read:

145.924 ~~AIDS~~ HIV PREVENTION GRANTS.

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

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

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

(d) The commissioner shall administer a grant program to provide funds to organizations, including Tribal health agencies, to assist with HIV outbreaks.

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

Sec. 120. Minnesota Statutes 2022, section 145.924, is amended to read:

145.924 ~~AIDS~~ HIV PREVENTION GRANTS.

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

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

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

(d) The commissioner shall administer a grant program to provide funds to organizations, including Tribal health agencies, to assist with HIV/AIDS outbreaks.

Sec. 121. Minnesota Statutes 2022, section 145.925, is amended to read:

145.925 ~~FAMILY PLANNING~~ SEXUAL AND REPRODUCTIVE HEALTH SERVICES GRANTS.

Subdivision 1. **~~Eligible organizations; purpose~~ Goal and establishment.** ~~The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services.~~ (a) It is the goal of the state to increase access to sexual and reproductive health services for people who experience barriers, whether geographic, cultural, financial, or other, in access to such services. The commissioner of health shall administer grants to facilitate access to sexual and reproductive health services for people of reproductive age, particularly those from populations that experience barriers to these services.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in sexual and reproductive health service promotion among people of reproductive age.

~~Subd. 1a.~~ **~~Family planning services; defined.~~** ~~"Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.~~

~~Subd. 2.~~ **~~Prohibition.~~** ~~The commissioner shall not make special grants pursuant to this section to any nonprofit corporation which performs abortions. No state funds shall be used under contract from a grantee to any nonprofit corporation which performs abortions. This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or health maintenance organizations certified pursuant to chapter 62D.~~

Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section, "sexual and reproductive health services" means services that promote a state of complete physical, mental, and social well-being in relation to sexuality, reproduction, and the reproductive system and its functions and processes, and not merely the absence of disease or infirmity. These services must be provided in accord with nationally recognized standards and include but are not limited to sexual and reproductive health counseling, voluntary and informed decision-making on sexual and reproductive health, information on and provision of contraceptive methods, sexual and reproductive health screenings and treatment, pregnancy testing and counseling, and other preconception services.

Subd. 3. **~~Minors~~ Grants authorized.** ~~No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated~~

~~minor in any elementary or secondary school building.~~ (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal communities in rural and metropolitan areas of the state to support, sustain, expand, or implement reproductive and sexual health programs for people of reproductive age to increase access to and availability of medically accurate sexual and reproductive health services.

(b) The commissioner of health shall establish application scoring criteria to use in the evaluation of applications submitted for award under this section. These criteria shall include but are not limited to the degree to which applicants' programming responds to demographic factors relevant to subdivision 1, paragraph (a), and paragraph (f).

(c) When determining whether to award a grant or the amount of a grant under this section, the commissioner of health may identify and stratify geographic regions based on the region's need for sexual and reproductive health services. In this stratification, the commissioner may consider data on the prevalence of poverty and other factors relevant to a geographic region's need for sexual and reproductive health services.

(d) The commissioner of health may consider geographic and Tribal communities' representation in the award of grants.

(e) Current recipients of funding under this section shall not be afforded priority over new applicants.

(f) Grant funds shall be used to support new or existing sexual and reproductive health programs that provide person-centered, accessible services; that are culturally and linguistically appropriate, inclusive of all people, and trauma-informed; that protect the dignity of the individual; and that ensure equitable, quality services consistent with nationally recognized standards of care. These services shall include:

(1) education and outreach on medically accurate sexual and reproductive health information;

(2) contraceptive counseling, provision of contraceptive methods, and follow-up;

(3) screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns; and

(4) referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

~~Subd. 4.~~ ~~**Parental notification.**~~ ~~Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.~~

~~Subd. 5.~~ **~~Rules.~~** ~~The commissioner of health shall promulgate rules for approval of plans and budgets of prospective grant recipients, for the submission of annual financial and statistical reports, and the maintenance of statements of source and application of funds by grant recipients. The commissioner of health may not require that any home rule charter or statutory city or county apply for or receive grants under this subdivision as a condition for the receipt of any state or federal funds unrelated to family planning services.~~

Subd. 6. **Public services; individual ~~and employee~~ rights.** The request of any person for ~~family planning~~ sexual and reproductive health services or the refusal to accept any service shall in no way affect the right of the person to receive public assistance, public health services, or any other public service. Nothing in this section shall abridge the right of the ~~individual~~ person to make decisions concerning ~~family planning~~ sexual and reproductive health, nor shall any ~~individual~~ person be required to state a reason for refusing any offer of ~~family planning~~ sexual and reproductive health services.

~~Any employee of the agencies engaged in the administration of the provisions of this section may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal, suspension, demotion, or any other discrimination in employment. The directors or supervisors of the agencies shall reassign the duties of employees in order to carry out the provisions of this section.~~

All information gathered by any agency, entity, or individual conducting programs in ~~family planning~~ sexual and reproductive health is private data on individuals within the meaning of section 13.02, subdivision 12. For any person or entity meeting the definition of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and reproductive health services information provided to, gathered about, or received from a person under this section is also subject to the Minnesota Health Records Act, in sections 144.291 to 144.298.

~~Subd. 7.~~ **~~Family planning services; information required.~~** ~~A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:~~

~~(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;~~

~~(2) A description of any attendant discomforts or risks which might reasonably be expected;~~

~~(3) A fair explanation of the likely results, should a method fail;~~

~~(4) A description of any benefits which might reasonably be expected of any method;~~

~~(5) A disclosure of appropriate alternative methods or procedures;~~

~~(6) An offer to answer any inquiries concerning methods of procedures; and~~

~~(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.~~

~~Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.~~

~~Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant funds for family planning special projects, shall not limit the total amount of funds that can be allocated to an organization. The commissioner shall allocate to an organization receiving grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the organization submits an application that meets grant funding criteria. This subdivision does not affect any procedure established in rule for allocating special project money to the different regions. The commissioner shall revise the rules for family planning special project grants so that they conform to the requirements of this subdivision. In adopting these revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.~~

Sec. 123. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE SETTINGS GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of remediating identified sources of lead in drinking water in schools and licensed child care settings.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to schools and licensed child care settings. Priority shall be given to schools and licensed child care settings with higher levels of lead detected in water samples, evidence of lead service lines, or lead plumbing materials and school districts that serve disadvantaged communities.

Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead contamination in their facilities including but not limited to service connections and premise plumbing, and to implement best practices for water management within the building.

Sec. 124. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD CARE SETTINGS.**

Subdivision 1. **Requirement to test.** (a) By July 1, 2024, licensed or certified child care providers must develop a plan to accurately and efficiently test for the presence of lead in drinking water in child care facilities following either the Department of Health's document "Reducing Lead in Drinking Water: A Technical Guidance for Minnesota's School and

Senate Language S2995-3

Sec. 53. **[145.9275] SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM.**

Subdivision 1. **Grant program.** The commissioner of health shall award grants through a request for proposal process to community-based organizations that serve ethnic communities and focus on public health outreach to Black and people of color communities on the issues of colorism, skin-lightening products, and chemical exposures from these products. Priority in awarding grants shall be given to organizations that have historically provided services to ethnic communities on the skin-lightening and chemical exposure issue for the past four years.

Subd. 2. **Uses of grant funds.** Grant recipients must use grant funds awarded under this section to conduct public awareness and education activities that are culturally specific and community-based and that focus on:

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Child Care Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action" guidance materials.

(b) For purposes of this section, "licensed or certified child care provider" means a child care center licensed under Minnesota Rules, chapter 9503, or a certified license-exempt child care center under chapter 245H.

Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include testing every building serving children and all water fixtures used for consumption of water, including water used in food preparation. All taps must be tested at least once every five years. A licensed or certified child care provider must begin testing in buildings by July 1, 2024, and complete testing in all buildings that serve students within five years.

Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must include steps to remediate if lead is present in drinking water. A licensed or certified child care provider that finds lead at concentrations at or exceeding five parts per billion at a specific location providing water to children within its facilities must take action to reduce lead exposure following guidance and verify the success of remediation by retesting the location for lead. Remediation actions are actions that reduce lead levels from the drinking water fixture as demonstrated by testing. This includes using certified filters, implementing and documenting a building-wide flushing program, and replacing or removing fixtures with elevated lead levels.

Subd. 4. **Reporting results.** (a) A licensed or certified child care provider that tested its buildings for the presence of lead shall make the results of the testing and any remediation steps taken available to parents and staff and notify them of the availability of results. Reporting shall occur no later than 30 days from receipt of results and annually thereafter.

(b) Beginning July 1, 2024, a licensed or certified child care provider must report the provider's test results and remediation activities to the commissioner of health annually on or before July 1 of each year.

Sec. 195. **SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT.**

An organization receiving a grant from the commissioner of health for public awareness and education activities to address issues of colorism, skin-lightening products, and chemical exposure from skin-lightening products must use the grant funds for activities that are culturally specific and community-based and that focus on:

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

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

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

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

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

Sec. 54. **[145.9571] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Sections 145.9571 to 145.9576 are the Healthy Beginnings, Healthy Families Act.

Sec. 55. **[145.9572] MINNESOTA PERINATAL QUALITY COLLABORATIVE.**

Subdivision 1. **Duties.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

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

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

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

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

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

Sec. 187. **HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act is to build equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by supporting the Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent infant mortality, increasing access to culturally relevant developmental and social-emotional screening with follow-up, and sustaining and expanding the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 2. **Grants authorized.** The commissioner must award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 1. The commissioner must give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner must provide content expertise to the grant recipient to further the accomplishment of the purpose.

Sec. 56. **[145.9573] MINNESOTA PARTNERSHIP TO PREVENT INFANT MORTALITY.**

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

(b) The goal of the Minnesota partnership to prevent infant mortality program is to:

(1) build a statewide multisectoral partnership including the state government, local public health agencies, Tribes, private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

Sec. 57. **[145.9574] GRANTS.**

Subdivision 1. **Improving pregnancy and infant outcomes grant.** The commissioner of health must make a grant to a nonprofit organization to create or sustain a multidisciplinary

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 2. The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner shall provide content expertise to the grant recipient to further the accomplishment of the purpose.

Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The commissioner of health shall establish the Minnesota partnership to prevent infant mortality program that is a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

(b) The goals of the Minnesota partnership to prevent infant mortality program are to:

(1) build a statewide multisectoral partnership including the state government, local public health agencies, Tribes, private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, and other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a nonprofit organization to create or sustain a multidisciplinary network of representatives

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.

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.

(b) Grantee activities must:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(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.

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

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.

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.

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 births, 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.

(b) Grantee activities shall:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications 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.

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

Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

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(b) For the purposes of carrying out the grant program under section 145.9573, including for administrative purposes, the commissioner must award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

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

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

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

(5) health equity.

Sec. 58. **[145.9575] DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING WITH FOLLOW-UP.**

Subdivision 1. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health must work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 2. **Duties.** The commissioner must:

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

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

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

(4) review and share the results of the screening with the parent or guardian and support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) ensure children and families are referred to and linked with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

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(b) For the purposes of carrying out the grant program under subdivision 5a, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

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

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

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

(5) health equity.

Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 6a. **Duties.** The commissioner shall:

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

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

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

(4) review and share the results of the screening with the parent or guardian and support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) ensure children and families are referred to and linked with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

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

Subd. 3. **Grants.** The commissioner must award grants to community-based organizations, community health boards, and Tribal Nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants must also be awarded to community-based organizations to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. The commissioner must provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Sec. 59. **[145.9576] MODEL JAIL PRACTICES.**

Subdivision 1. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

Subd. 2. **Grants authorized; model jail practices.** (a) The commissioner of health must award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

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

Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based organizations, community health boards, and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants shall also be awarded to community-based organizations to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

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

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

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

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

Subd. 3. **Technical assistance and oversight; model jail practices.** (a) The commissioner must provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 2, including for administrative purposes, the commissioner must award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

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

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

Sec. 60. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The health equity advisory and leadership (HEAL) council consists of 18 members appointed by the commissioner of health who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059, except that the council shall not expire under subdivision

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Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 7a, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

Sec. 125. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The commissioner shall establish and appoint a health equity advisory and leadership (HEAL) council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059. Meetings shall be held at least quarterly and hosted by

6. The commissioner of health must convene meetings at least quarterly and must provide meeting space and administrative support to the council. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Subd. 5. **Annual report.** The advisory council must submit a report annually by January 15 to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health policy and finance summarizing the work of the council over the previous year and setting goals for the following year.

Sec. 61. **[145.988] COMPREHENSIVE AND COLLABORATIVE RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.**

Subdivision 1. **Establishment; purpose.** The commissioner shall establish the Comprehensive and Collaborative Resource and Referral System for Children to support a comprehensive, collaborative resource and referral system for children from prenatal stage through age eight and their families. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this section.

Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across sectors, including child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support knowledge of and access to local resources that provide early detection and intervention services;

the department. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting on specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 188. **HELP ME CONNECT RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.**

Subdivision 1. **Establishment; purpose.** The commissioner shall establish the Help Me Connect resource and referral system for children as a comprehensive, collaborative resource and referral system for children from the prenatal stage through age eight, and their families. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this section.

Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across sectors, including child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support knowledge of and access to local resources that provide early detection and intervention services;

(2) identifying and providing access to early childhood and family support navigation specialists that can support families and their children's needs; and

(3) linking children and families to appropriate community-based services.

(b) The Help Me Connect system shall provide community outreach that includes support for, and participation in, the Help Me Connect system, including disseminating information on the system and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health services and resources, and other appropriate early childhood information.

(c) The Help Me Connect system shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) The Help Me Connect system shall collect data to increase understanding of the current and ongoing system of support and resources for expectant families and children through age eight and their families, including identification of gaps in service, barriers to finding and receiving appropriate services, and lack of resources.

Sec. 62. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive

(2) identifying and providing access to early childhood and family support navigation specialists that can support families and their children's needs; and

(3) linking children and families to appropriate community-based services.

(b) The Help Me Connect system shall provide community outreach that includes support for, and participation in, the Help Me Connect system, including disseminating information on the system and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers, early childhood education and child care programs, developmental disabilities assessment and intervention programs, mental health services, family and social support programs, child advocacy and legal services, public health services and resources, and other appropriate early childhood information.

(c) The Help Me Connect system shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) The Help Me Connect system shall collect data to increase understanding of the current and ongoing system of support and resources for expectant families and children through age eight and their families, including identification of gaps in service, barriers to finding and receiving appropriate services, and lack of resources.

Sec. 126. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Services Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive

an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities will be distributed based on a formula determined by the Commissioner in consultation with the State Community Health Services Advisory Committee. These funds must be used as described in subdivision 5.

Sec. 63. Minnesota Statutes 2022, section 145A.131, subdivision 2, is amended to read:

Subd. 2. **Local match.** (a) A community health board that receives a local public health grant shall provide at least a 75 percent match for the state funds received through the local public health grant described in subdivision 1 and subject to paragraphs (b) to ~~(d)~~ (f).

(b) Eligible funds must be used to meet match requirements. Eligible funds include funds from local property taxes, reimbursements from third parties, fees, other local funds, and donations or nonfederal grants that are used for community health services described in section 145A.02, subdivision 6.

(c) When the amount of local matching funds for a community health board is less than the amount required under paragraph (a), the local public health grant provided for that community health board under this section shall be reduced proportionally.

(d) A city organized under the provision of sections 145A.03 to 145A.131 that levies a tax for provision of community health services is exempt from any county levy for the same services to the extent of the levy imposed by the city.

Sec. 64. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as described in subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Except as otherwise provided in this paragraph, funding for foundational public health responsibilities as described in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the state community health service advisory committee. If a community health board can demonstrate foundational public health responsibilities are fulfilled, the board may use funds for local priorities developed through the community health assessment and community health improvement planning process.

an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities must be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. A portion of these funds may be used to fund new organizational models, including multijurisdictional and regional partnerships. These funds shall be used in accordance with subdivision 5.

Sec. 127. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Funding for foundational public health responsibilities as outlined in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the State Community Health Services Advisory Committee unless a community health board demonstrates fulfillment of foundational public health responsibilities. If a community health board demonstrates foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

(c) By July 1, 2028, all local public health grant funds must be used first to fulfill foundational public health responsibilities. Once a community health board demonstrates

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Sec. 65. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to tribes.** The commissioner must distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

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foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 128. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to Tribes.** The commissioner shall distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

FOR SECTION 129, SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

Sec. 130. Minnesota Statutes 2022, section 148.261, subdivision 1, is amended to read:

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license and registration of any person to practice advanced practice, professional, or practical nursing under sections 148.171 to 148.285, or to otherwise discipline a licensee or applicant as described in section 148.262. The following are grounds for disciplinary action:

(1) Failure to demonstrate the qualifications or satisfy the requirements for a license contained in sections 148.171 to 148.285 or rules of the board. In the case of a person applying for a license, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements.

(2) Employing fraud or deceit in procuring or attempting to procure a permit, license, or registration certificate to practice advanced practice, professional, or practical nursing or attempting to subvert the licensing examination process. Conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to:

(i) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination;

(ii) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to copy one's answers, or possessing unauthorized materials; or

(iii) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(3) Conviction of a felony or gross misdemeanor reasonably related to the practice of professional, advanced practice registered, or practical nursing. Conviction as used in this subdivision includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or

a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered.

(4) Revocation, suspension, limitation, conditioning, or other disciplinary action against the person's professional or practical nursing license or advanced practice registered nursing credential, in another state, territory, or country; failure to report to the board that charges regarding the person's nursing license or other credential are pending in another state, territory, or country; or having been refused a license or other credential by another state, territory, or country.

(5) Failure to or inability to perform professional or practical nursing as defined in section 148.171, subdivision 14 or 15, with reasonable skill and safety, including failure of a registered nurse to supervise or a licensed practical nurse to monitor adequately the performance of acts by any person working at the nurse's direction.

(6) Engaging in unprofessional conduct, including, but not limited to, a departure from or failure to conform to board rules of professional or practical nursing practice that interpret the statutory definition of professional or practical nursing as well as provide criteria for violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and prevailing professional or practical nursing practice, or any nursing practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause.

(7) Failure of an advanced practice registered nurse to practice with reasonable skill and safety or departure from or failure to conform to standards of acceptable and prevailing advanced practice registered nursing.

(8) Delegating or accepting the delegation of a nursing function or a prescribed health care function when the delegation or acceptance could reasonably be expected to result in unsafe or ineffective patient care.

(9) Actual or potential inability to practice nursing with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition.

(10) Adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or without this state.

(11) Engaging in any unethical conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause.

(12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient, or engaging in sexual exploitation of a patient or former patient.

(13) Obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud.

(14) Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.

(15) Engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws.

(16) Improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law.

(17) Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of advanced practice, professional, or practical nursing.

(18) Violating a rule adopted by the board, an order of the board, or a state or federal law relating to the practice of advanced practice, professional, or practical nursing, or a state or federal narcotics or controlled substance law.

(19) Knowingly providing false or misleading information that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo.

(20) Aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board shall investigate any complaint of a violation of section 609.215, subdivision 1 or 2.

(21) Practicing outside the scope of practice authorized by section 148.171, subdivision 5, 10, 11, 13, 14, 15, or 21.

(22) Making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148.263, or failing to cooperate with an investigation of the board as required by section 148.265.

(23) Engaging in false, fraudulent, deceptive, or misleading advertising.

(24) Failure to inform the board of the person's certification or recertification status as a certified registered nurse anesthetist, certified nurse-midwife, certified nurse practitioner, or certified clinical nurse specialist.

(25) Engaging in clinical nurse specialist practice, nurse-midwife practice, nurse practitioner practice, or registered nurse anesthetist practice without a license and current certification or recertification by a national nurse certification organization acceptable to the board.

~~(26) Engaging in conduct that is prohibited under section 145.412.~~

~~(27)~~ (26) Failing to report employment to the board as required by section 148.211, subdivision 2a, or knowingly aiding, assisting, advising, or allowing a person to fail to report as required by section 148.211, subdivision 2a.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 131. Minnesota Statutes 2022, section 148.512, subdivision 10a, is amended to read:

Subd. 10a. **Hearing aid.** "Hearing aid" means ~~an instrument~~ a prescribed aid, or any of its parts, worn in the ear canal and designed to or represented as being able to aid ~~or enhance~~ human hearing. "Hearing aid" includes the aid's parts, attachments, or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold. Batteries and cords are not parts, attachments, or accessories of a hearing aid. Surgically implanted hearing aids, and assistive listening devices not worn within the ear canal, are not hearing aids.

Sec. 132. Minnesota Statutes 2022, section 148.512, subdivision 10b, is amended to read:

Subd. 10b. **Hearing aid dispensing.** "Hearing aid dispensing" means making ear mold impressions, prescribing~~, or recommending~~ a hearing aid, assisting the consumer in prescription aid selection~~, selling hearing aids 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 dispensing of prescription hearing aids to the consumer. Hearing aid dispensing does not include selling over-the-counter hearing aids.

Sec. 133. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision to read:

Subd. 10c. **Over-the-counter hearing aid or OTC hearing aid.** "Over-the-counter hearing aid" or "OTC hearing aid" has the meaning given to that term in Code of Federal Regulations, title 21, section 800.30(b).

Sec. 134. Minnesota Statutes 2022, section 148.512, is amended by adding a subdivision to read:

Subd. 13a. **Prescription hearing aid.** "Prescription hearing aid" means a hearing aid requiring a prescription from a certified hearing aid dispenser or licensed audiologist that is not an OTC hearing aid.

Sec. 135. Minnesota Statutes 2022, section 148.513, is amended by adding a subdivision to read:

Subd. 4. **Over-the-counter hearing aids.** Nothing in sections 148.511 to 148.5198 shall preclude licensed audiologists from dispensing or selling over-the-counter hearing aids.

Sec. 136. Minnesota Statutes 2022, section 148.515, subdivision 6, is amended to read:

Subd. 6. **Dispensing audiologist examination requirements.** (a) Audiologists are exempt from the written examination requirement in section 153A.14, subdivision 2h, paragraph (a), clause (1).

(b) After July 31, 2005, all applicants for audiologist licensure under sections 148.512 to 148.5198 must achieve a passing score on the practical tests of proficiency described in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described in section 153A.14, subdivision 2h, paragraph (c).

(c) In order to dispense prescription hearing aids as a sole proprietor, member of a partnership, or for a limited liability company, corporation, or any other entity organized for profit, a licensee who obtained audiologist licensure under sections 148.512 to 148.5198, before August 1, 2005, and who is not certified to dispense prescription hearing aids under chapter 153A, must achieve a passing score on the practical tests of proficiency described in section 153A.14, subdivision 2h, paragraph (a), clause (2), within the time period described in section 153A.14, subdivision 2h, paragraph (c). All other audiologist licensees who obtained licensure before August 1, 2005, are exempt from the practical tests.

(d) An applicant for an audiology license who obtains a temporary license under section 148.5175 may dispense prescription hearing aids only under supervision of a licensed audiologist who dispenses prescription hearing aids.

Sec. 137. Minnesota Statutes 2022, section 148.5175, is amended to read:

148.5175 TEMPORARY LICENSURE.

(a) The commissioner shall issue temporary licensure as a speech-language pathologist, an audiologist, or both, to an applicant who:

(1) submits a signed and dated affidavit stating that the applicant is not the subject of a disciplinary action or past disciplinary action in this or another jurisdiction and is not disqualified on the basis of section 148.5195, subdivision 3; and

(2) either:

(i) provides a copy of a current credential as a speech-language pathologist, an audiologist, or both, held in the District of Columbia or a state or territory of the United States; or

(ii) provides a copy of a current certificate of clinical competence issued by the American Speech-Language-Hearing Association or board certification in audiology by the American Board of Audiology.

(b) A temporary license issued to a person under this subdivision expires 90 days after it is issued or on the date the commissioner grants or denies licensure, whichever occurs first.

(c) Upon application, a temporary license shall be renewed twice to a person who is able to demonstrate good cause for failure to meet the requirements for licensure within the initial temporary licensure period and who is not the subject of a disciplinary action or disqualified on the basis of section 148.5195, subdivision 3. Good cause includes but is not limited to inability to take and complete the required practical exam for dispensing prescription hearing ~~instruments~~ aids.

(d) Upon application, a temporary license shall be issued to a person who meets the requirements of section 148.515, subdivisions 2a and 4, but has not completed the requirement in section 148.515, subdivision 6.

Sec. 138. Minnesota Statutes 2022, section 148.5195, subdivision 3, is amended to read:

Subd. 3. **Grounds for disciplinary action by commissioner.** The commissioner may take any of the disciplinary actions listed in subdivision 4 on proof that the individual has:

(1) intentionally submitted false or misleading information to the commissioner or the advisory council;

(2) failed, within 30 days, to provide information in response to a written request by the commissioner or advisory council;

(3) performed services of a speech-language pathologist or audiologist in an incompetent or negligent manner;

(4) violated sections 148.511 to 148.5198;

(5) failed to perform services with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(6) violated any state or federal law, rule, or regulation, and the violation is a felony or misdemeanor, an essential element of which is dishonesty, or which relates directly or indirectly to the practice of speech-language pathology or audiology. Conviction for violating any state or federal law which relates to speech-language pathology or audiology is necessarily considered to constitute a violation, except as provided in chapter 364;

(7) aided or abetted another person in violating any provision of sections 148.511 to 148.5198;

(8) been or is being disciplined by another jurisdiction, if any of the grounds for the discipline is the same or substantially equivalent to those under sections 148.511 to 148.5198;

(9) not cooperated with the commissioner or advisory council in an investigation conducted according to subdivision 1;

(10) advertised in a manner that is false or misleading;

(11) engaged in conduct likely to deceive, defraud, or harm the public; or demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(12) failed to disclose to the consumer any fee splitting or any promise to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(13) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(14) obtained money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(15) performed services for a client who had no possibility of benefiting from the services;

(16) failed to refer a client for medical evaluation or to other health care professionals when appropriate or when a client indicated symptoms associated with diseases that could be medically or surgically treated;

(17) had the certification required by chapter 153A denied, suspended, or revoked according to chapter 153A;

(18) used the term doctor of audiology, doctor of speech-language pathology, AuD, or SLPD without having obtained the degree from an institution accredited by the North Central Association of Colleges and Secondary Schools, the Council on Academic Accreditation in Audiology and Speech-Language Pathology, the United States Department of Education, or an equivalent;

(19) failed to comply with the requirements of section 148.5192 regarding supervision of speech-language pathology assistants; or

(20) if the individual is an audiologist or certified hearing ~~instrument~~ aid dispenser:

(i) prescribed ~~or otherwise recommended~~ to a consumer or potential consumer the use of a prescription hearing ~~instrument~~ aid, unless the prescription from a physician ~~or recommendation from~~, an audiologist, or a certified dispenser is in writing, is based on an audiogram that is delivered to the consumer or potential consumer when the prescription ~~or recommendation~~ is made, and bears the following information in all capital letters of 12-point or larger boldface type: "THIS PRESCRIPTION ~~OR RECOMMENDATION~~ MAY BE FILLED BY, AND PRESCRIPTION HEARING ~~INSTRUMENTS~~ AIDS MAY

BE PURCHASED FROM, THE LICENSED AUDIOLOGIST OR CERTIFIED DISPENSER OF YOUR CHOICE";

(ii) failed to give a copy of the audiogram, upon which the prescription ~~or recommendation~~ is based, to the consumer when the consumer requests a copy;

(iii) failed to provide the consumer rights brochure required by section 148.5197, subdivision 3;

(iv) failed to comply with restrictions on sales of prescription hearing ~~instruments~~ aids in sections 148.5197, subdivision 3, and 148.5198;

(v) failed to return a consumer's prescription hearing ~~instrument~~ aid used as a trade-in or for a discount in the price of a new prescription hearing ~~instrument~~ aid when requested by the consumer upon cancellation of the purchase agreement;

(vi) failed to follow Food and Drug Administration or Federal Trade Commission regulations relating to dispensing prescription hearing ~~instruments~~ aids;

(vii) failed to dispense a prescription hearing ~~instrument~~ aid in a competent manner or without appropriate training;

(viii) delegated prescription hearing ~~instrument~~ aid dispensing authority to a person not authorized to dispense a prescription hearing ~~instrument~~ aid under this chapter or chapter 153A;

(ix) failed to comply with the requirements of an employer or supervisor of a hearing ~~instrument~~ aid dispenser trainee;

(x) violated a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the individual's prescription hearing ~~instrument~~ aid dispensing; or

(xi) failed to include on the audiogram the practitioner's printed name, credential type, credential number, signature, and date.

Sec. 139. Minnesota Statutes 2022, section 148.5196, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The commissioner shall appoint 12 persons to a Speech-Language Pathologist and Audiologist Advisory Council. The 12 persons must include:

(1) three public members, as defined in section 214.02. Two of the public members shall be either persons receiving services of a speech-language pathologist or audiologist, or family members of or caregivers to such persons, and at least one of the public members shall be either a hearing ~~instrument~~ aid user or an advocate of one;

(2) three speech-language pathologists licensed under sections 148.511 to 148.5198, one of whom is currently and has been, for the five years immediately preceding the

appointment, engaged in the practice of speech-language pathology in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, and government agencies;

(3) one speech-language pathologist licensed under sections 148.511 to 148.5198, who is currently and has been, for the five years immediately preceding the appointment, employed by a Minnesota public school district or a Minnesota public school district consortium that is authorized by Minnesota Statutes and who is licensed in speech-language pathology by the Professional Educator Licensing and Standards Board;

(4) three audiologists licensed under sections 148.511 to 148.5198, two of whom are currently and have been, for the five years immediately preceding the appointment, engaged in the practice of audiology and the dispensing of prescription hearing ~~instruments~~ aids in Minnesota and each of whom is employed in a different employment setting including, but not limited to, private practice, hospitals, rehabilitation settings, educational settings, industry, and government agencies;

(5) one nonaudiologist hearing ~~instrument~~ aid dispenser recommended by a professional association representing hearing ~~instrument~~ aid dispensers; and

(6) one physician licensed under chapter 147 and certified by the American Board of Otolaryngology, Head and Neck Surgery.

Sec. 140. Minnesota Statutes 2022, section 148.5197, is amended to read:

148.5197 HEARING AID DISPENSING.

Subdivision 1. **Content of contracts.** Oral statements made by an audiologist or certified dispenser regarding the provision of warranties, refunds, and service on the prescription hearing aid or aids dispensed must be written on, and become part of, the contract of sale, specify the item or items covered, and indicate the person or business entity obligated to provide the warranty, refund, or service.

Subd. 2. **Required use of license number.** The audiologist's license number or certified dispenser's certificate number must appear on all contracts, bills of sale, and receipts used in the sale of prescription hearing aids.

Subd. 3. **Consumer rights information.** An audiologist or certified dispenser shall, at the time of the ~~recommendation or~~ prescription, give a consumer rights brochure, prepared by the commissioner and containing information about legal requirements pertaining to dispensing of prescription hearing aids, to each potential consumer of a prescription hearing aid. The brochure must contain information about the consumer information center described in section 153A.18. A contract for a prescription hearing aid must note the receipt of the brochure by the consumer, along with the consumer's signature or initials.

Subd. 4. **Liability for contracts.** Owners of entities in the business of dispensing prescription hearing aids, employers of audiologists or persons who dispense prescription hearing aids, supervisors of trainees or audiology students, and hearing aid dispensers

conducting the transaction at issue are liable for satisfying all terms of contracts, written or oral, made by their agents, employees, assignees, affiliates, or trainees, including terms relating to products, repairs, warranties, service, and refunds. The commissioner may enforce the terms of prescription hearing aid contracts against the principal, employer, supervisor, or dispenser who conducted the transaction and may impose any remedy provided for in this chapter.

Sec. 141. Minnesota Statutes 2022, section 148.5198, is amended to read:

148.5198 RESTRICTION ON SALE OF PRESCRIPTION HEARING AIDS.

Subdivision 1. **45-calendar-day guarantee and buyer right to cancel.** (a) An audiologist or certified dispenser dispensing a prescription hearing aid in this state must comply with paragraphs (b) and (c).

(b) The audiologist or certified dispenser must provide the buyer with a 45-calendar-day written money-back guarantee. The guarantee must permit the buyer to cancel the purchase for any reason within 45 calendar days after receiving the prescription hearing aid by giving or mailing written notice of cancellation to the audiologist or certified dispenser. If the buyer mails the notice of cancellation, the 45-calendar-day period is counted using the postmark date, to the date of receipt by the audiologist or certified dispenser. If the prescription hearing aid must be repaired, remade, or adjusted during the 45-calendar-day money-back guarantee period, the running of the 45-calendar-day period is suspended one day for each 24-hour period that the prescription hearing aid is not in the buyer's possession. A repaired, remade, or adjusted prescription hearing aid must be claimed by the buyer within three business days after notification of availability, after which time the running of the 45-calendar-day period resumes. The guarantee must entitle the buyer, upon cancellation, to receive a refund of payment within 30 days of return of the prescription hearing aid to the audiologist or certified dispenser. The audiologist or certified dispenser may retain as a cancellation fee no more than $250 of the buyer's total purchase price of the prescription hearing aid.

(c) The audiologist or certified dispenser shall provide the buyer with a contract written in plain English, that contains uniform language and provisions that meet the requirements under the Plain Language Contract Act, sections 325G.29 to 325G.36. The contract must include, but is not limited to, the following: in immediate proximity to the space reserved for the signature of the buyer, or on the first page if there is no space reserved for the signature of the buyer, a clear and conspicuous disclosure of the following specific statement in all capital letters of no less than 12-point boldface type: "MINNESOTA STATE LAW GIVES THE BUYER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON AT ANY TIME PRIOR TO MIDNIGHT OF THE 45TH CALENDAR DAY AFTER RECEIPT OF THE PRESCRIPTION HEARING AID(S). THIS CANCELLATION MUST BE IN WRITING AND MUST BE GIVEN OR MAILED TO THE AUDIOLOGIST OR CERTIFIED DISPENSER. IF THE BUYER DECIDES TO RETURN THE PRESCRIPTION HEARING AID(S) WITHIN THIS 45-CALENDAR-DAY PERIOD, THE BUYER WILL RECEIVE A REFUND OF THE TOTAL PURCHASE PRICE OF THE AID(S) FROM

WHICH THE AUDIOLOGIST OR CERTIFIED DISPENSER MAY RETAIN AS A CANCELLATION FEE NO MORE THAN $250."

Subd. 2. **Itemized repair bill.** Any audiologist, certified dispenser, or company who agrees to repair a prescription hearing aid must provide the owner of the prescription hearing aid, or the owner's representative, with a bill that describes the repair and services rendered. The bill must also include the repairing audiologist's, certified dispenser's, or company's name, address, and telephone number.

This subdivision does not apply to an audiologist, certified dispenser, or company that repairs a prescription hearing aid pursuant to an express warranty covering the entire prescription hearing aid and the warranty covers the entire cost, both parts and labor, of the repair.

Subd. 3. **Repair warranty.** Any guarantee of prescription hearing aid repairs must be in writing and delivered to the owner of the prescription hearing aid, or the owner's representative, stating the repairing audiologist's, certified dispenser's, or company's name, address, telephone number, length of guarantee, model, and serial number of the prescription hearing aid and all other terms and conditions of the guarantee.

Subd. 4. **Misdemeanor.** A person found to have violated this section is guilty of a misdemeanor.

Subd. 5. **Additional.** In addition to the penalty provided in subdivision 4, a person found to have violated this section is subject to the penalties and remedies provided in section 325F.69, subdivision 1.

Subd. 6. **Estimates.** Upon the request of the owner of a prescription hearing aid or the owner's representative for a written estimate and prior to the commencement of repairs, a repairing audiologist, certified dispenser, or company shall provide the customer with a written estimate of the price of repairs. If a repairing audiologist, certified dispenser, or company provides a written estimate of the price of repairs, it must not charge more than the total price stated in the estimate for the repairs. If the repairing audiologist, certified dispenser, or company after commencing repairs determines that additional work is necessary to accomplish repairs that are the subject of a written estimate and if the repairing audiologist, certified dispenser, or company did not unreasonably fail to disclose the possible need for the additional work when the estimate was made, the repairing audiologist, certified dispenser, or company may charge more than the estimate for the repairs if the repairing audiologist, certified dispenser, or company immediately provides the owner or owner's representative a revised written estimate pursuant to this section and receives authorization to continue with the repairs. If continuation of the repairs is not authorized, the repairing audiologist, certified dispenser, or company shall return the prescription hearing aid as close as possible to its former condition and shall release the prescription hearing aid to the owner or owner's representative upon payment of charges for repairs actually performed and not in excess of the original estimate.

Sec. 142. Minnesota Statutes 2022, section 151.37, subdivision 12, is amended to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);

(3) correctional employees of a state or local political subdivision;

(4) staff of community-based health disease prevention or social service programs;

(5) a volunteer firefighter; and

(6) a ~~licensed school~~ nurse or ~~certified public health nurse~~ any other personnel employed by, or under contract with, a ~~school board under section 121A.21~~ charter, public, or private school.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

(d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is authorized to possess and administer according to this subdivision an opiate antagonist in a school setting.

Sec. 143. Minnesota Statutes 2022, section 153A.13, subdivision 3, is amended to read:

Subd. 3. **Hearing ~~instrument~~ aid.** "Hearing ~~instrument~~ aid" means an instrument~~, or any of its parts, worn in the ear canal and designed to or represented as being able to aid or enhance human hearing. "Hearing instrument" includes the instrument's parts, attachments, or accessories, including, but not limited to, ear molds and behind the ear (BTE) devices with or without an ear mold. Batteries and cords are not parts, attachments, or accessories of a hearing instrument. Surgically implanted hearing instruments, and assistive listening devices not worn within the ear canal, are not hearing instruments.~~ as defined in section 148.512, subdivision 10a.

Sec. 144. Minnesota Statutes 2022, section 153A.13, subdivision 4, is amended to read:

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.~~ has the meaning given in section 148.512, subdivision 10b.

Sec. 145. Minnesota Statutes 2022, section 153A.13, subdivision 5, is amended to read:

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:

(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

(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.

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.

Sec. 146. Minnesota Statutes 2022, section 153A.13, subdivision 6, is amended to read:

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.

Sec. 147. Minnesota Statutes 2022, section 153A.13, subdivision 7, is amended to read:

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.

Sec. 148. Minnesota Statutes 2022, section 153A.13, subdivision 9, is amended to read:

Subd. 9. **Supervision.** "Supervision" means monitoring activities of, and accepting responsibility for, the prescription hearing ~~instrument~~ aid dispensing activities of a trainee.

Sec. 149. Minnesota Statutes 2022, section 153A.13, subdivision 10, is amended to read:

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.

Sec. 150. Minnesota Statutes 2022, section 153A.13, subdivision 11, is amended to read:

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).

Sec. 151. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

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.

Sec. 152. Minnesota Statutes 2022, section 153A.13, is amended by adding a subdivision to read:

Subd. 13. **Prescription hearing aid.** "Prescription hearing aid" has the meaning given in section 148.512, subdivision 13a.

Sec. 153. Minnesota Statutes 2022, section 153A.14, subdivision 1, is amended to read:

Subdivision 1. **Application for certificate.** An applicant must:

(1) be 21 years of age or older;

(2) apply to the commissioner for a certificate to dispense prescription hearing ~~instruments~~ aids on application forms provided by the commissioner;

(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;

(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;

(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;

(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;

(7) submit evidence of continuing education credits, if required;

(8) submit all fees as required under section 153A.17; and

(9) consent to a fingerprint-based criminal history records check required under section 144.0572, pay all required fees, and cooperate with all requests for information. An applicant must complete a new criminal background check if more than one year has elapsed since the applicant last applied for a license.

Sec. 154. Minnesota Statutes 2022, section 153A.14, subdivision 2, is amended to read:

Subd. 2. **Issuance of certificate.** (a) The commissioner shall issue a certificate to each dispenser of hearing ~~instruments~~ aids who applies under subdivision 1 if the commissioner determines that the applicant is in compliance with this chapter, has passed an examination administered by the commissioner, has met the continuing education requirements, if required, and has paid the fee set by the commissioner. The commissioner may reject or deny an application for a certificate if there is evidence of a violation or failure to comply with this chapter.

(b) The commissioner shall not issue a certificate to an applicant who refuses to consent to a criminal history background check as required by section 144.0572 within 90 days after submission of an application or fails to submit fingerprints to the Department of Human Services. Any fees paid by the applicant to the Department of Health shall be forfeited if the applicant refuses to consent to the background study.

Sec. 155. Minnesota Statutes 2022, section 153A.14, subdivision 2h, is amended to read:

Subd. 2h. **Certification by examination.** An applicant must achieve a passing score, as determined by the commissioner, on an examination according to paragraphs (a) to (c).

(a) The examination must include, but is not limited to:

(1) A written examination approved by the commissioner covering the following areas as they pertain to prescription hearing ~~instrument~~ aid selling:

(i) basic physics of sound;

(ii) the anatomy and physiology of the ear;

(iii) the function of prescription hearing ~~instruments~~ aids; and

(iv) the principles of prescription hearing ~~instrument~~ aid selection.

(2) Practical tests of proficiency in the following techniques as they pertain to prescription hearing ~~instrument~~ aid selling:

(i) pure tone audiometry, including air conduction testing and bone conduction testing;

(ii) live voice or recorded voice speech audiometry including speech recognition (discrimination) testing, most comfortable loudness level, and uncomfortable loudness measurements of tolerance thresholds;

(iii) masking when indicated;

(iv) recording and evaluation of audiograms and speech audiometry to determine proper selection and fitting of a prescription hearing ~~instrument~~ aid;

(v) taking ear mold impressions;

(vi) using an otoscope for the visual observation of the entire ear canal; and

(vii) state and federal laws, rules, and regulations.

(b) The practical examination shall be administered by the commissioner at least twice a year.

(c) An applicant must achieve a passing score on all portions of the examination within a two-year period. An applicant who does not achieve a passing score on all portions of the examination within a two-year period must retake the entire examination and achieve a passing score on each portion of the examination. An applicant who does not apply for certification within one year of successful completion of the examination must retake the examination and achieve a passing score on each portion of the examination. An applicant may not take any part of the practical examination more than three times in a two-year period.

Sec. 156. Minnesota Statutes 2022, section 153A.14, subdivision 2i, is amended to read:

Subd. 2i. **Continuing education requirement.** On forms provided by the commissioner, each certified dispenser must submit with the application for renewal of certification evidence of completion of ten course hours of continuing education earned within the 12-month period of November 1 to October 31, between the effective and expiration dates of certification. Continuing education courses must be directly related to prescription hearing ~~instrument~~ aid dispensing and approved by the International Hearing Society, the American Speech-Language-Hearing Association, or the American Academy of Audiology. Evidence of completion of the ten course hours of continuing education must be submitted by December 1 of each year. This requirement does not apply to dispensers certified for less than one year.

Sec. 157. Minnesota Statutes 2022, section 153A.14, subdivision 2j, is amended to read:

Subd. 2j. **Required use of certification number.** The certification holder must use the certification number on all contracts, bills of sale, and receipts used in the sale of prescription hearing ~~instruments~~ aids.

Sec. 158. Minnesota Statutes 2022, section 153A.14, subdivision 4, is amended to read:

Subd. 4. **Dispensing of prescription hearing ~~instruments~~ aids without certificate.** Except as provided in subdivisions 4a and 4c, and in sections 148.512 to 148.5198, it is unlawful for any person not holding a valid certificate to dispense a prescription hearing ~~instrument~~ aid as defined in section 153A.13, subdivision 3. A person who dispenses a prescription hearing ~~instrument~~ aid without the certificate required by this section is guilty of a gross misdemeanor.

Sec. 159. Minnesota Statutes 2022, section 153A.14, subdivision 4a, is amended to read:

Subd. 4a. **Trainees.** (a) A person who is not certified under this section may dispense prescription hearing ~~instruments~~ aids as a trainee for a period not to exceed 12 months if the person:

(1) submits an application on forms provided by the commissioner;

(2) is under the supervision of a certified dispenser meeting the requirements of this subdivision;

(3) meets all requirements for certification except passage of the examination required by this section; and

(4) uses the title "dispenser trainee" in contacts with the patients, clients, or consumers.

(b) A certified hearing ~~instrument~~ aid dispenser may not supervise more than two trainees at the same time and may not directly supervise more than one trainee at a time. The certified dispenser is responsible for all actions or omissions of a trainee in connection with the dispensing of prescription hearing ~~instruments~~ aids. A certified dispenser may not supervise a trainee if there are any commissioner, court, or other orders, currently in effect or issued within the last five years, that were issued with respect to an action or omission of a certified dispenser or a trainee under the certified dispenser's supervision.

Until taking and passing the practical examination testing the techniques described in subdivision 2h, paragraph (a), clause (2), trainees must be directly supervised in all areas described in subdivision 4b, and the activities tested by the practical examination. Thereafter, trainees may dispense prescription hearing ~~instruments~~ aids under indirect supervision until expiration of the trainee period. Under indirect supervision, the trainee must complete two monitored activities a week. Monitored activities may be executed by correspondence, telephone, or other telephonic devices, and include, but are not limited to, evaluation of audiograms, written reports, and contracts. The time spent in supervision must be recorded and the record retained by the supervisor.

Sec. 160. Minnesota Statutes 2022, section 153A.14, subdivision 4b, is amended to read:

Subd. 4b. **Prescription hearing testing protocol.** A dispenser when conducting a hearing test for the purpose of prescription hearing ~~instrument~~ aid dispensing must:

(1) comply with the United States Food and Drug Administration warning regarding potential medical conditions required by Code of Federal Regulations, title 21, section ~~801.420~~ 801.422;

(2) complete a case history of the client's hearing;

(3) inspect the client's ears with an otoscope; and

(4) conduct the following tests on both ears of the client and document the results, and if for any reason one of the following tests cannot be performed pursuant to the United States Food and Drug Administration guidelines, an audiologist shall evaluate the hearing and the need for a prescription hearing ~~instrument~~ aid:

(i) air conduction at 250, 500, 1,000, 2,000, 4,000, and 8,000 Hertz. When a difference of 20 dB or more occurs between adjacent octave frequencies the interoctave frequency must be tested;

(ii) bone conduction at 500, 1,000, 2,000, and 4,000 Hertz for any frequency where the air conduction threshold is greater than 15 dB HL;

(iii) monaural word recognition (discrimination), with a minimum of 25 words presented for each ear; and

(iv) loudness discomfort level, monaural, for setting a prescription hearing ~~instrument's~~ aid's maximum power output; and

(5) include masking in all tests whenever necessary to ensure accurate results.

Sec. 161. Minnesota Statutes 2022, section 153A.14, subdivision 4c, is amended to read:

Subd. 4c. **Reciprocity.** (a) A person who has dispensed prescription hearing ~~instruments~~ aids in another jurisdiction may dispense prescription hearing ~~instruments~~ aids as a trainee under indirect supervision if the person:

(1) satisfies the provisions of subdivision 4a, paragraph (a);

(2) submits a signed and dated affidavit stating that the applicant is not the subject of a disciplinary action or past disciplinary action in this or another jurisdiction and is not disqualified on the basis of section 153A.15, subdivision 1; and

(3) provides a copy of a current credential as a hearing ~~instrument~~ aid dispenser held in the District of Columbia or a state or territory of the United States.

(b) A person becoming a trainee under this subdivision who fails to take and pass the practical examination described in subdivision 2h, paragraph (a), clause (2), when next offered must cease dispensing prescription hearing ~~instruments~~ aids unless under direct supervision.

Sec. 162. Minnesota Statutes 2022, section 153A.14, subdivision 4e, is amended to read:

Subd. 4e. **Prescription hearing aids; enforcement.** Costs incurred by the Minnesota Department of Health for conducting investigations of unlicensed prescription hearing aid ~~dispensers~~ dispensing shall be apportioned between all licensed or credentialed professions that dispense prescription hearing aids.

Sec. 163. Minnesota Statutes 2022, section 153A.14, subdivision 6, is amended to read:

Subd. 6. **Prescription hearing ~~instruments~~ aids to comply with federal and state requirements.** The commissioner shall ensure that prescription hearing ~~instruments~~ aids are dispensed in compliance with state requirements and the requirements of the United States Food and Drug Administration. Failure to comply with state or federal regulations may be grounds for enforcement actions under section 153A.15, subdivision 2.

Sec. 164. Minnesota Statutes 2022, section 153A.14, subdivision 9, is amended to read:

Subd. 9. **Consumer rights.** A hearing ~~instrument~~ aid dispenser shall comply with the requirements of sections 148.5195, subdivision 3, clause (20); 148.5197; and 148.5198.

Sec. 165. Minnesota Statutes 2022, section 153A.14, subdivision 11, is amended to read:

Subd. 11. **Requirement to maintain current information.** A dispenser must notify the commissioner in writing within 30 days of the occurrence of any of the following:

(1) a change of name, address, home or business telephone number, or business name;

(2) the occurrence of conduct prohibited by section 153A.15;

(3) a settlement, conciliation court judgment, or award based on negligence, intentional acts, or contractual violations committed in the dispensing of prescription hearing ~~instruments~~ aids by the dispenser; and

(4) the cessation of prescription hearing ~~instrument~~ aid dispensing activities as an individual or a business.

Sec. 166. Minnesota Statutes 2022, section 153A.14, is amended by adding a subdivision to read:

Subd. 12. **Over-the-counter hearing aids.** Nothing in this chapter shall preclude certified hearing aid dispensers from dispensing or selling over-the-counter hearing aids.

Sec. 167. Minnesota Statutes 2022, section 153A.15, subdivision 1, is amended to read:

Subdivision 1. **Prohibited acts.** The commissioner may take enforcement action as provided under subdivision 2 against a dispenser of prescription hearing ~~instruments~~ aids for the following acts and conduct:

(1) dispensing a prescription hearing ~~instrument~~ aid to a minor person 18 years or younger unless evaluated by an audiologist for hearing evaluation and prescription hearing aid evaluation;

(2) being disciplined through a revocation, suspension, restriction, or limitation by another state for conduct subject to action under this chapter;

(3) presenting advertising that is false or misleading;

(4) providing the commissioner with false or misleading statements of credentials, training, or experience;

(5) engaging in conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a consumer;

(6) splitting fees or promising to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(7) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(8) obtaining money, property, or services from a consumer through the use of undue influence, high pressure sales tactics, harassment, duress, deception, or fraud;

(9) performing the services of a certified hearing ~~instrument~~ aid dispenser in an incompetent or negligent manner;

(10) failing to comply with the requirements of this chapter as an employer, supervisor, or trainee;

(11) failing to provide information in a timely manner in response to a request by the commissioner, commissioner's designee, or the advisory council;

(12) being convicted within the past five years of violating any laws of the United States, or any state or territory of the United States, and the violation is a felony, gross misdemeanor, or misdemeanor, an essential element of which relates to prescription hearing ~~instrument~~ aid dispensing, except as provided in chapter 364;

(13) failing to cooperate with the commissioner, the commissioner's designee, or the advisory council in any investigation;

(14) failing to perform prescription hearing ~~instrument~~ aid dispensing with reasonable judgment, skill, or safety due to the use of alcohol or drugs, or other physical or mental impairment;

(15) failing to fully disclose actions taken against the applicant or the applicant's legal authorization to dispense prescription hearing ~~instruments~~ aids in this or another state;

(16) violating a state or federal court order or judgment, including a conciliation court judgment, relating to the activities of the applicant in prescription hearing ~~instrument~~ aid dispensing;

(17) having been or being disciplined by the commissioner of the Department of Health, or other authority, in this or another jurisdiction, if any of the grounds for the discipline are the same or substantially equivalent to those in sections 153A.13 to 153A.18;

(18) misrepresenting the purpose of hearing tests, or in any way communicating that the hearing test or hearing test protocol required by section 153A.14, subdivision 4b, is a medical evaluation, a diagnostic hearing evaluation conducted by an audiologist, or is other than a test to select a prescription hearing ~~instrument~~ aid, except that the hearing ~~instrument~~ aid dispenser can determine the need for or recommend the consumer obtain a medical evaluation consistent with requirements of the United States Food and Drug Administration;

(19) violating any of the provisions of sections 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18; and

(20) aiding or abetting another person in violating any of the provisions of sections 148.5195, subdivision 3, clause (20); 148.5197; 148.5198; and 153A.13 to 153A.18.

Sec. 168. Minnesota Statutes 2022, section 153A.15, subdivision 2, is amended to read:

Subd. 2. **Enforcement actions.** When the commissioner finds that a dispenser of prescription hearing ~~instruments~~ aids has violated one or more provisions of this chapter, the commissioner may do one or more of the following:

(1) deny or reject the application for a certificate;

(2) revoke the certificate;

(3) suspend the certificate;

(4) impose, for each violation, a civil penalty that deprives the dispenser of any economic advantage gained by the violation and that reimburses the Department of Health for costs of the investigation and proceeding resulting in disciplinary action, including the amount paid for services of the Office of Administrative Hearings, the amount paid for services of the Office of the Attorney General, attorney fees, court reporters, witnesses, reproduction of records, advisory council members' per diem compensation, department staff time, and expenses incurred by advisory council members and department staff;

(5) censure or reprimand the dispenser;

(6) revoke or suspend the right to supervise trainees;

(7) revoke or suspend the right to be a trainee;

(8) impose a civil penalty not to exceed $10,000 for each separate violation; or

(9) any other action reasonably justified by the individual case.

Sec. 169. Minnesota Statutes 2022, section 153A.15, subdivision 4, is amended to read:

Subd. 4. **Penalties.** Except as provided in section 153A.14, subdivision 4, a person violating this chapter is guilty of a misdemeanor. The commissioner may impose an automatic civil penalty equal to one-fourth the renewal fee on each hearing ~~instrument seller~~ aid dispenser who fails to renew the certificate required in section 153A.14 by the renewal deadline.

Sec. 170. Minnesota Statutes 2022, section 153A.17, is amended to read:

153A.17 EXPENSES; FEES.

(a) The expenses for administering the certification requirements, including the complaint handling system for hearing aid dispensers in sections 153A.14 and 153A.15, and the Consumer Information Center under section 153A.18, must be paid from initial application and examination fees, renewal fees, penalties, and fines. The commissioner shall only use fees collected under this section for the purposes of administering this chapter. The legislature must not transfer money generated by these fees from the state government special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health under section 16E.22 are not subject to this paragraph.~~

(b) The fees are as follows:

(1) the initial certification application fee is $772.50;

(2) the annual renewal certification application fee is $750;

(3) the initial examination fee for the practical portion is $1,200, and $600 for each time it is taken, thereafter; for individuals meeting the requirements of section 148.515, subdivision 2, the fee for the practical portion of the prescription hearing ~~instrument~~ aid dispensing examination is $600 each time it is taken;

(4) the trainee application fee is $230;

(5) the penalty fee for late submission of a renewal application is $260; and

(6) the fee for verification of certification to other jurisdictions or entities is $25.

(c) The commissioner may prorate the certification fee for new applicants based on the number of quarters remaining in the annual certification period.

(d) All fees are nonrefundable. All fees, penalties, and fines received must be deposited in the state government special revenue fund.

(e) Hearing instrument dispensers who were certified before January 1, 2018, shall pay a onetime surcharge of $22.50 to renew their certification when it expires after October 31, 2020. The surcharge shall cover the commissioner's costs associated with criminal background checks.

Sec. 171. Minnesota Statutes 2022, section 153A.175, is amended to read:

153A.175 PENALTY FEES.

(a) The penalty fee for holding oneself out as a hearing ~~instrument~~ aid dispenser without a current certificate after the credential has expired and before it is renewed is one-half the amount of the certificate renewal fee for any part of the first day, plus one-half the certificate renewal fee for any part of any subsequent days up to 30 days.

(b) The penalty fee for applicants who hold themselves out as hearing ~~instrument~~ aid dispensers after expiration of the trainee period and before being issued a certificate is one-half the amount of the certificate application fee for any part of the first day, plus one-half the certificate application fee for any part of any subsequent days up to 30 days. This paragraph does not apply to applicants not qualifying for a certificate who hold themselves out as hearing ~~instrument~~ aid dispensers.

(c) The penalty fee for practicing prescription hearing ~~instrument~~ aid dispensing and failing to submit a continuing education report by the due date with the correct number or type of hours in the correct time period is $200 plus $200 for each missing clock hour. "Missing" means not obtained between the effective and expiration dates of the certificate, the one-month period following the certificate expiration date, or the 30 days following notice of a penalty fee for failing to report all continuing education hours. The certificate holder must obtain the missing number of continuing education hours by the next reporting due date.

(d) Civil penalties and discipline incurred by certificate holders prior to August 1, 2005, for conduct described in paragraph (a), (b), or (c) shall be recorded as nondisciplinary penalty fees. Payment of a penalty fee does not preclude any disciplinary action reasonably justified by the individual case.

Sec. 172. Minnesota Statutes 2022, section 153A.18, is amended to read:

153A.18 CONSUMER INFORMATION CENTER.

The commissioner shall establish a Consumer Information Center to assist actual and potential purchasers of prescription hearing aids by providing them with information regarding prescription hearing ~~instrument~~ aid sales. The Consumer Information Center shall disseminate information about consumers' legal rights related to prescription hearing ~~instrument~~ aid sales, provide information relating to complaints about dispensers of prescription hearing ~~instruments~~ aids, and provide information about outreach and advocacy services for consumers of prescription hearing ~~instruments~~ aids. In establishing the center and developing the information, the commissioner shall consult with representatives of hearing ~~instrument~~ aid dispensers, audiologists, physicians, and consumers.

Sec. 173. Minnesota Statutes 2022, section 153A.20, is amended to read:

153A.20 HEARING ~~INSTRUMENT~~ AID DISPENSER ADVISORY COUNCIL.

Subdivision 1. **Membership.** (a) The commissioner shall appoint seven persons to a Hearing ~~Instrument~~ Aid Dispenser Advisory Council.

(b) The seven persons must include:

(1) three public members, as defined in section 214.02. At least one of the public members shall be a prescription hearing ~~instrument~~ aid user and one of the public members shall be either a prescription hearing ~~instrument~~ aid user or an advocate of one;

(2) three hearing ~~instrument~~ aid dispensers certified under sections 153A.14 to 153A.20, each of whom is currently, and has been for the five years immediately preceding their appointment, engaged in prescription hearing ~~instrument~~ aid dispensing in Minnesota and who represent the occupation of prescription hearing ~~instrument~~ aid dispensing and who are not audiologists; and

(3) one audiologist licensed as an audiologist under chapter 148 who dispenses prescription hearing ~~instruments~~ aids, recommended by a professional association representing audiologists and speech-language pathologists.

(c) The factors the commissioner may consider when appointing advisory council members include, but are not limited to, professional affiliation, geographical location, and type of practice.

(d) No two members of the advisory council shall be employees of, or have binding contracts requiring sales exclusively for, the same prescription hearing ~~instrument~~ aid manufacturer or the same employer.

Subd. 2. **Organization.** The advisory council shall be organized and administered according to section 15.059. The council may form committees to carry out its duties.

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall:

(1) advise the commissioner regarding hearing ~~instrument~~ aid dispenser certification standards;

(2) provide for distribution of information regarding hearing ~~instrument~~ aid dispenser certification standards;

(3) review investigation summaries of competency violations and make recommendations to the commissioner as to whether the allegations of incompetency are substantiated; and

(4) perform other duties as directed by the commissioner.

Sec. 66. Minnesota Statutes 2022, section 256B.0625, subdivision 49, is amended to read:

Subd. 49. **Community health worker.** (a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has received a certificate from the Minnesota State Colleges and Universities System approved community health worker curriculum.

(b) Community health workers must work under the supervision of a medical assistance enrolled physician, registered nurse, advanced practice registered nurse, physician assistant, mental health professional, or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Effective January 1, 2026, community health workers who are eligible for payment under this subdivision who are providing care coordination or patient education services in an adult day care, respite care, or in-home care setting must complete a training program in Alzheimer's disease and dementia care that has been developed or approved by the commissioner of health, in accordance with section 144.6504, to remain eligible for payment.

~~(c)~~ (d) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

Sec. 174. Minnesota Statutes 2022, section 256B.434, subdivision 4f, is amended to read:

Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a) Effective October 1, 2006, facilities reimbursed under this section may receive a property rate adjustment for construction projects exceeding the threshold in section 256B.431, subdivision 16, and below the threshold in section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1). For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are: (1) purchased within 24 months of the completion of the construction project; (2) purchased after the completion date of any prior construction project; and (3) are not purchased prior to July 14, 2005. Except as otherwise provided in this subdivision, the definitions, rate calculation methods, and principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, shall be used to calculate rate adjustments for allowable construction projects under this subdivision and section 144A.073. Facilities completing construction projects between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible for a property rate adjustment effective on the first day of the month following the completion date. Facilities completing projects after January 1, 2018, are eligible for a property rate adjustment effective on the first day of the month of January or July, whichever occurs immediately following the completion date.

(b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a construction project on or after October 1, 2004, and do not have a contract under subdivision

3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431, subdivision 10, through September 30, 2006. If the request results in the commissioner determining a rate adjustment is allowable, the rate adjustment is effective on the first of the month following project completion. These facilities shall be allowed to accumulate construction project costs for the period October 1, 2004, to September 30, 2006.

(c) Facilities shall be allowed construction project rate adjustments no sooner than 12 months after completing a previous construction project. Facilities must request the rate adjustment according to section 256B.431, subdivision 10.

(d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060, subpart 11. For rate calculations under this section, the number of licensed beds in the nursing facility shall be the number existing after the construction project is completed and the number of days in the nursing facility's reporting period shall be 365.

(e) The value of assets to be recognized for a total replacement project as defined in section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value of assets to be recognized for all other projects shall be computed as described in clause (2).

(1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation. If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be used in the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit under section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1). Applicable credits must be deducted from the cost of the construction project.

(2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be used to compute the maximum amount of assets allowable in a facility's property rate calculation.

(ii) The value of a facility's assets to be compared to the amount in item (i) begins with the total appraised value from the last rate notice a facility received when its rates were set under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each rate year the facility received an inflation factor on its property-related rate when its rates were set under this section. The value of assets listed as previous capital additions, capital additions, and special projects on the facility's base year rate notice and the value of assets related to a construction project for which the facility received a rate adjustment when its rates were determined under this section shall be added to the indexed appraised value.

(iii) The maximum amount of assets to be recognized in computing a facility's rate adjustment after a project is completed is the lesser of the aggregate replacement-cost-new limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the construction project.

(iv) If a facility's current request for a rate adjustment results from the completion of a construction project that was previously approved under section 144A.073, the assets to be added to the rate calculation cannot exceed the lesser of the amount determined under sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction project. A current request that is not the result of a project under section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2, paragraph ~~(a)~~ (c), clause (1). Assets disposed of as a result of a construction project and applicable credits must be deducted from the cost of the construction project.

(f) For construction projects approved under section 144A.073, allowable debt may never exceed the lesser of the cost of the assets purchased, the threshold limit in section 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital debt.

(g) For construction projects that were not approved under section 144A.073, allowable debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously existing capital debt. Amounts of debt taken out that exceed the costs of a construction project shall not be allowed regardless of the use of the funds.

For all construction projects being recognized, interest expense and average debt shall be computed based on the first 12 months following project completion. "Previously existing capital debt" means capital debt recognized on the last rate determined under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt recognized for a construction project for which the facility received a rate adjustment when its rates were determined under this section.

For a total replacement project as defined in section 256B.431, subdivision 17d, the value of previously existing capital debt shall be zero.

(h) In addition to the interest expense allowed from the application of paragraph (f), the amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and (3), will be added to interest expense.

(i) The equity portion of the construction project shall be computed as the allowable assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added. This sum must be divided by 95 percent of capacity days to compute the construction project rate adjustment.

(j) For projects that are not a total replacement of a nursing facility, the amount in paragraph (i) is adjusted for nonreimbursable areas and then added to the current property payment rate of the facility.

(k) For projects that are a total replacement of a nursing facility, the amount in paragraph (i) becomes the new property payment rate after being adjusted for nonreimbursable areas. Any amounts existing in a facility's rate before the effective date of the construction project for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431, subdivision 19, shall be removed from the facility's rates.

(l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060, subpart 10, as the result of construction projects under this section. Allowable equipment shall be included in the construction project costs.

(m) Capital assets purchased after the completion date of a construction project shall be counted as construction project costs for any future rate adjustment request made by a facility under section 144A.071, subdivision 2, ~~clause (a)~~ paragraph (c), clause (1), if they are purchased within 24 months of the completion of the future construction project.

(n) In subsequent rate years, the property payment rate for a facility that results from the application of this subdivision shall be the amount inflated in subdivision 4.

(o) Construction projects are eligible for an equity incentive under section 256B.431, subdivision 16. When computing the equity incentive for a construction project under this subdivision, only the allowable costs and allowable debt related to the construction project shall be used. The equity incentive shall not be a part of the property payment rate and not inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing facilities reimbursed under this section shall be allowed for a duration determined under section 256B.431, subdivision 16, paragraph (c).

Sec. 175. Minnesota Statutes 2022, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; ~~62Q.145;~~ 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

Sec. 67. Minnesota Statutes 2022, section 259.83, subdivision 1, is amended to read:

Subdivision 1. **Services provided.** (a) Agencies shall provide assistance and counseling services upon receiving a request for current information from adoptive parents, birth parents, or adopted persons aged ~~19~~ 18 years of age and ~~over~~ older. The agency shall contact the other adult persons or the adoptive parents of a minor child in a personal and confidential manner to determine whether there is a desire to receive or share information or to have contact. If there is such a desire, the agency shall provide the services requested. The agency shall provide services to adult genetic siblings if there is no known violation of the confidentiality of a birth parent or if the birth parent gives written consent.

(b) Upon a request for assistance or services from an adoptive parent, birth parent, or an adopted person 18 years of age or older, the agency must inform the person:

(1) about the right of an adopted person to request and obtain a copy of the adopted person's original birth record at the age and circumstances specified in section 144.2253; and

(2) about the right of the birth parent named on the adopted person's original birth record to file a contact preference form with the state registrar pursuant to section 144.2253.

In adoptive placements, the agency must provide in writing to the birth parents listed on the original birth record the information required under this section.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 68. Minnesota Statutes 2022, section 259.83, subdivision 1a, is amended to read:

Subd. 1a. **Social and medical history.** (a) If a person aged ~~19~~ 18 years of age and ~~over~~ older who was adopted on or after August 1, 1994, or the adoptive parent requests the detailed nonidentifying social and medical history of the adopted person's birth family that was provided at the time of the adoption, agencies must provide the information to the adopted person or adoptive parent on the applicable form required under sections 259.43 and 260C.212, subdivision 15.

(b) If an adopted person aged ~~19~~ 18 years of age and ~~over~~ older or the adoptive parent requests the agency to contact the adopted person's birth parents to request current nonidentifying social and medical history of the adopted person's birth family, agencies

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

EFFECTIVE DATE. This section is effective the day following final enactment.

must use the applicable form required under sections 259.43 and 260C.212, subdivision 15, when obtaining the information for the adopted person or adoptive parent.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 69. Minnesota Statutes 2022, section 259.83, subdivision 1b, is amended to read:

Subd. 1b. **Genetic siblings.** (a) A person who is at least ~~19~~ 18 years ~~old~~ of age who was adopted or, because of a termination of parental rights, was committed to the guardianship of the commissioner of human services, whether adopted or not, must upon request be advised of other siblings who were adopted or who were committed to the guardianship of the commissioner of human services and not adopted.

(b) Assistance must be provided by the county or placing agency of the person requesting information to the extent that information is available in the existing records at the Department of Human Services. If the sibling received services from another agency, the agencies must share necessary information in order to locate the other siblings and to offer services, as requested. Upon the determination that parental rights with respect to another sibling were terminated, identifying information and contact must be provided only upon mutual consent. A reasonable fee may be imposed by the county or placing agency.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 70. Minnesota Statutes 2022, section 259.83, is amended by adding a subdivision to read:

Subd. 3a. **Birth parent identifying information.** (a) This subdivision applies to adoptive placements where an adopted person does not have a record of live birth registered in this state. Upon written request by an adopted person 18 years of age or older, the agency responsible for or supervising the placement must provide to the requester the following identifying information related to the birth parents listed on that adopted person's original birth record:

(1) each of the birth parent's names; and

(2) each of the birth parent's birthdate and birthplace.

(b) The agency may charge a reasonable fee to the requester for providing the required information under paragraph (a).

(c) The agency, acting in good faith and in a lawful manner in disclosing the identifying information under this subdivision, is not civilly liable for such disclosure.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 71. Minnesota Statutes 2022, section 260C.317, subdivision 4, is amended to read:

Subd. 4. **Rights of terminated parent.** (a) Upon entry of an order terminating the parental rights of any person who is identified as a parent on the original birth record of the

child as to whom the parental rights are terminated, the court shall cause written notice to be made to that person setting forth~~:~~

~~(1) the right of the person to file at any time with the state registrar of vital records a consent to disclosure, as defined in section 144.212, subdivision 11;~~

~~(2)~~ the right of the person to file at any time with the state registrar of vital records ~~an affidavit stating that the information on the original birth record shall not be disclosed as provided in section 144.2252; and~~ a contact preference form under section 144.2253.

~~(3) the effect of a failure to file either a consent to disclosure, as defined in section 144.212, subdivision 11, or an affidavit stating that the information on the original birth record shall not be disclosed.~~

(b) A parent whose rights are terminated under this section shall retain the ability to enter into a contact or communication agreement under section 260C.619 if an agreement is determined by the court to be in the best interests of the child. The agreement shall be filed with the court at or prior to the time the child is adopted. An order for termination of parental rights shall not be conditioned on an agreement under section 260C.619.

EFFECTIVE DATE. This section is effective July 1, 2024.

Sec. 72. Minnesota Statutes 2022, section 403.161, subdivision 1, is amended to read:

Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail transaction is imposed on prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(c) A prepaid wireless 988 fee, in the amount of the monthly charge provided for in section 145.561, subdivision 4, paragraph (b), is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

Sec. 73. Minnesota Statutes 2022, section 403.161, subdivision 3, is amended to read:

Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and,~~ telecommunications access Minnesota, and 988 fees must be collected by the seller from the consumer for each retail transaction occurring in this state. The amount of each fee must be combined into one amount, which must be separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller.

Sec. 74. Minnesota Statutes 2022, section 403.161, subdivision 5, is amended to read:

Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any provider, except that the seller is liable to remit all fees as provided in section 403.162.

Sec. 75. Minnesota Statutes 2022, section 403.161, subdivision 6, is amended to read:

Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by a seller from a consumer must not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

Sec. 76. Minnesota Statutes 2022, section 403.161, subdivision 7, is amended to read:

Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013, ~~or~~ the fee imposed under section 237.52, subdivision 2, or the fee imposed under section 145.561, subdivision 4, as applicable.

(b) The department shall post notice of any fee changes on its website at least 30 days in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor the department's website for notice of fee changes.

(c) Fee changes are effective 60 days after the first day of the first calendar month after the commissioner of public safety or the Public Utilities Commission, as applicable, changes the fee.

Sec. 77. Minnesota Statutes 2022, section 403.162, subdivision 1, is amended to read:

Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue at the times and in the manner provided by chapter 297A with respect to the general sales and use tax. The commissioner of revenue shall establish registration and payment procedures that substantially coincide with the registration and payment procedures that apply in chapter 297A.

Sec. 78. Minnesota Statutes 2022, section 403.162, subdivision 2, is amended to read:

Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by the seller from consumers.

Sec. 79. Minnesota Statutes 2022, section 403.162, subdivision 5, is amended to read:

Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications

access Minnesota fee, and the prepaid wireless 988 fee imposed per retail transaction, divide the fees collected in corresponding proportions. Within 30 days of receipt of the collected fees, the commissioner shall:

(1) deposit the proportion of the collected fees attributable to the prepaid wireless E911 fee in the 911 emergency telecommunications service account in the special revenue fund; ~~and~~

(2) deposit the proportion of collected fees attributable to the prepaid wireless telecommunications access Minnesota fee in the telecommunications access fund established in section 237.52, subdivision 1~~.~~; and

(3) deposit the proportion of the collected fees attributable to the prepaid wireless 988 fee in the 988 special revenue account established in section 145.561, subdivision 3.

(b) The commissioner of revenue may deduct and deposit in a special revenue account an amount not to exceed two percent of collected fees. Money in the account is annually appropriated to the commissioner of revenue to reimburse its direct costs of administering the collection and remittance of prepaid wireless E911 fees ~~and~~, prepaid wireless telecommunications access Minnesota fees, and prepaid wireless 988 fees.

Sec. 176. Minnesota Statutes 2022, section 518A.39, subdivision 2, is amended to read:

Subd. 2. **Modification.** (a) The terms of an order respecting maintenance or support may be modified upon a showing of one or more of the following, any of which makes the terms unreasonable and unfair: (1) substantially increased or decreased gross income of an obligor or obligee; (2) substantially increased or decreased need of an obligor or obligee or the child or children that are the subject of these proceedings; (3) receipt of assistance under the AFDC program formerly codified under sections 256.72 to 256.87 or 256B.01 to ~~256B.40~~ 256B.39, or chapter 256J or 256K; (4) a change in the cost of living for either party as measured by the federal Bureau of Labor Statistics; (5) extraordinary medical expenses of the child not provided for under section 518A.41; (6) a change in the availability of appropriate health care coverage or a substantial increase or decrease in health care coverage costs; (7) the addition of work-related or education-related child care expenses of the obligee or a substantial increase or decrease in existing work-related or education-related child care expenses; or (8) upon the emancipation of the child, as provided in subdivision 5.

(b) It is presumed that there has been a substantial change in circumstances under paragraph (a) and the terms of a current support order shall be rebuttably presumed to be unreasonable and unfair if:

(1) the application of the child support guidelines in section 518A.35, to the current circumstances of the parties results in a calculated court order that is at least 20 percent and at least $75 per month higher or lower than the current support order or, if the current support

order is less than $75, it results in a calculated court order that is at least 20 percent per month higher or lower;

(2) the medical support provisions of the order established under section 518A.41 are not enforceable by the public authority or the obligee;

(3) health coverage ordered under section 518A.41 is not available to the child for whom the order is established by the parent ordered to provide;

(4) the existing support obligation is in the form of a statement of percentage and not a specific dollar amount;

(5) the gross income of an obligor or obligee has decreased by at least 20 percent through no fault or choice of the party; or

(6) a deviation was granted based on the factor in section 518A.43, subdivision 1, clause (4), and the child no longer resides in a foreign country or the factor is otherwise no longer applicable.

(c) A child support order is not presumptively modifiable solely because an obligor or obligee becomes responsible for the support of an additional nonjoint child, which is born after an existing order. Section 518A.33 shall be considered if other grounds are alleged which allow a modification of support.

(d) If child support was established by applying a parenting expense adjustment or presumed equal parenting time calculation under previously existing child support guidelines and there is no parenting plan or order from which overnights or overnight equivalents can be determined, there is a rebuttable presumption that the established adjustment or calculation will continue after modification so long as the modification is not based on a change in parenting time. In determining an obligation under previously existing child support guidelines, it is presumed that the court shall:

(1) if a 12 percent parenting expense adjustment was applied, multiply the obligor's share of the combined basic support obligation calculated under section 518A.34, paragraph (b), clause (5), by 0.88; or

(2) if the parenting time was presumed equal but the parents' parental incomes for determining child support were not equal:

(i) multiply the combined basic support obligation under section 518A.34, paragraph (b), clause (5), by 0.75;

(ii) prorate the amount under item (i) between the parents based on each parent's proportionate share of the combined PICS; and

(iii) subtract the lower amount from the higher amount.

(e) On a motion for modification of maintenance, including a motion for the extension of the duration of a maintenance award, the court shall apply, in addition to all other relevant

factors, the factors for an award of maintenance under section 518.552 that exist at the time of the motion. On a motion for modification of support, the court:

(1) shall apply section 518A.35, and shall not consider the financial circumstances of each party's spouse, if any; and

(2) shall not consider compensation received by a party for employment in excess of a 40-hour work week, provided that the party demonstrates, and the court finds, that:

(i) the excess employment began after entry of the existing support order;

(ii) the excess employment is voluntary and not a condition of employment;

(iii) the excess employment is in the nature of additional, part-time employment, or overtime employment compensable by the hour or fractions of an hour;

(iv) the party's compensation structure has not been changed for the purpose of affecting a support or maintenance obligation;

(v) in the case of an obligor, current child support payments are at least equal to the guidelines amount based on income not excluded under this clause; and

(vi) in the case of an obligor who is in arrears in child support payments to the obligee, any net income from excess employment must be used to pay the arrearages until the arrearages are paid in full.

(f) A modification of support or maintenance, including interest that accrued pursuant to section 548.091, may be made retroactive only with respect to any period during which the petitioning party has pending a motion for modification but only from the date of service of notice of the motion on the responding party and on the public authority if public assistance is being furnished or the county attorney is the attorney of record, unless the court adopts an alternative effective date under paragraph (l). The court's adoption of an alternative effective date under paragraph (l) shall not be considered a retroactive modification of maintenance or support.

(g) Except for an award of the right of occupancy of the homestead, provided in section 518.63, all divisions of real and personal property provided by section 518.58 shall be final, and may be revoked or modified only where the court finds the existence of conditions that justify reopening a judgment under the laws of this state, including motions under section 518.145, subdivision 2. The court may impose a lien or charge on the divided property at any time while the property, or subsequently acquired property, is owned by the parties or either of them, for the payment of maintenance or support money, or may sequester the property as is provided by section 518A.71.

(h) The court need not hold an evidentiary hearing on a motion for modification of maintenance or support.

Senate Language S2995-3

Sec. 80. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the health maintenance organization. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2023~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

House Language UES2995-2

(i) Sections 518.14 and 518A.735 shall govern the award of attorney fees for motions brought under this subdivision.

(j) An enactment, amendment, or repeal of law constitutes a substantial change in the circumstances for purposes of modifying a child support order when it meets the standards for modification in this section.

(k) On the first modification following implementation of amended child support guidelines, the modification of basic support may be limited if the amount of the full variance would create hardship for either the obligor or the obligee. Hardship includes, but is not limited to, eligibility for assistance under chapter 256J.

(l) The court may select an alternative effective date for a maintenance or support order if the parties enter into a binding agreement for an alternative effective date.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 177. Laws 2017, First Special Session chapter 6, article 5, section 11, as amended by Laws 2019, First Special Session chapter 9, article 8, section 20, is amended to read:

Sec. 11. **MORATORIUM ON CONVERSION TRANSACTIONS.**

(a) Notwithstanding Laws 2017, chapter 2, article 2, a nonprofit ~~health~~ service plan corporation operating under Minnesota Statutes, chapter 62C, or a nonprofit health maintenance organization operating under Minnesota Statutes, chapter 62D, as of January 1, 2017, may only merge or consolidate with; convert; or transfer, as part of a single transaction or a series of transactions within a 24-month period, all or a material amount of its assets to an entity that is a corporation organized under Minnesota Statutes, chapter 317A; or to a Minnesota nonprofit hospital within the same integrated health system as the health maintenance organization. For purposes of this section, "material amount" means the lesser of ten percent of such an entity's total admitted net assets as of December 31 of the previous year, or $50,000,000.

(b) Paragraph (a) does not apply if the nonprofit service plan corporation or nonprofit health maintenance organization files an intent to dissolve due to insolvency of the corporation in accordance with Minnesota Statutes, chapter 317A, or insolvency proceedings are commenced under Minnesota Statutes, chapter 60B.

(c) Nothing in this section shall be construed to authorize a nonprofit health maintenance organization or a nonprofit service plan corporation to engage in any transaction or activities not otherwise permitted under state law.

(d) This section expires July 1, ~~2023~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 178. Laws 2022, chapter 99, article 1, section 46, is amended to read:

Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; ~~or~~

(4) developing and making available resources to support health care professionals with self-care and resiliency~~.~~; or

(5) identifying and modifying structural barriers in health care delivery that create unnecessary stress in the workplace.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

(1) a description of the purpose of the program for which the grant funds will be used;

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision 6, encumbrances for grants under this section issued by June 30 of each year may be certified for a period of up to three years beyond the year in which the funds were originally appropriated.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant

program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024.

Sec. 179. Laws 2022, chapter 99, article 3, section 9, is amended to read:

Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a onetime appropriation and is available until June 30, 2027.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 180. **ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS AUTHORIZED.**

Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective factors for mental well-being and decrease disparities in rates of mental health issues among adolescent populations. The commissioner of health shall administer grants to community-based organizations to facilitate mental health promotion programs for adolescents, particularly those from populations that report higher rates of specific mental health needs.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in mental health promotion among adolescents.

Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal public health entities, to implement community-based mental health promotion programs for adolescents in community settings to improve adolescent mental health and reduce disparities between adolescent populations in reported rates of mental health needs.

(b) The commissioner of health, in collaboration with community and professional stakeholders, shall establish criteria for review of applications received under this subdivision to ensure funded programs operate using best practices such as trauma-informed care and positive youth development principles.

(c) Grant funds distributed under this subdivision shall be used to support new or existing community-based mental health promotion programs that include but are not limited to:

(1) training community-based members to facilitate discussions or courses on adolescent mental health promotion skills;

(2) training trusted community members to model positive mental health skills and practices in their existing roles;

(3) training and supporting adolescents to provide peer support; and

(4) supporting community dialogue on mental health promotion and collective stress or trauma.

Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the community-based grant programs funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation, and at the direction of the commissioner, shall provide the commissioner with the information needed to conduct the evaluation.

Sec. 183. **CRITICAL ACCESS DENTAL INFRASTRUCTURE PROGRAM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Critical access dental provider" means a critical access dental provider as defined in Minnesota Statutes, section 256B.76, subdivision 4.

(d) "Dental infrastructure" means:

(1) physical infrastructure of a dental setting, including but not limited to the operations and clinical spaces in a dental clinic; associated heating, ventilation, and air conditioning infrastructure and other mechanical infrastructure; and dental equipment needed to operate a dental clinic; or

(2) mobile dental equipment or other equipment needed to provide dental services via a hub-and-spoke service delivery model or via teledentistry.

Subd. 2. **Grant and loan program established.** The commissioner shall make grants and forgivable loans to critical access dental providers for eligible dental infrastructure projects.

Subd. 3. **Eligible projects.** In order to be eligible for a grant or forgivable loan under this section, a dental infrastructure project must be proposed by a critical access dental provider and must allow the provider to maintain or expand the provider's capacity to serve Minnesota health care program enrollees.

Subd. 4. **Application.** (a) The commissioner must develop forms and procedures for soliciting and reviewing applications for grants and forgivable loans under this section and for awarding grants and forgivable loans. Critical access dental providers seeking a grant or forgivable loan under this section must apply to the commissioner in a time and manner specified by the commissioner. In evaluating applications for grants or forgivable loans for

eligible projects, the commissioner must review applications for completeness and must determine the extent to which:

(1) the project would ensure that the critical access dental provider is able to continue to serve Minnesota health care program enrollees in a manner that would not be possible but for the project; or

(2) the project would increase the number of Minnesota health care program enrollees served by the provider or the clinical complexity of the Minnesota health care program enrollees served by the provider.

(b) The commissioner must award grants and forgivable loans based on the information provided in the grant application.

Subd. 5. **Program oversight.** The commissioner may require and collect from grant and 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

Sec. 81. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

Notwithstanding the terms of office specified to the members upon their appointment, the terms for members appointed to the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in Minnesota Statutes, section 144.059, subdivision 3.

Sec. 191. **MEMBERSHIP TERMS; PALLIATIVE CARE ADVISORY COUNCIL.**

Notwithstanding the terms of office specified to the members upon their appointment, the terms for members appointed to the Palliative Care Advisory Council under Minnesota Statutes, section 144.059, on or after February 1, 2022, shall be three years, as provided in Minnesota Statutes, section 144.059, subdivision 3.

Sec. 192. **PSYCHEDELIC MEDICINE TASK FORCE.**

Subdivision 1. **Establishment; purpose.** The Psychedelic Medicine Task Force is established to advise the legislature on the legal, medical, and policy issues associated with the legalization of psychedelic medicine in the state. For purposes of this section, "psychedelic medicine" means 3,4-methylenedioxymethamphetamine (MDMA), psilocybin, and LSD.

Subd. 2. **Membership; compensation.** (a) The Psychedelic Medicine Task Force shall consist of:

(1) the governor or a designee;

(2) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader of the house of representatives, and two members of the senate, one appointed by the senate majority leader and one appointed by the senate minority leader;

(3) the commissioner of health or a designee;

(4) the commissioner of public safety or a designee;

(5) the commissioner of human services or a designee;

(6) the attorney general or a designee;

(7) the executive director of the Board of Pharmacy or a designee;

(8) the commissioner of commerce or a designee; and

(9) members of the public, appointed by the governor, who have relevant knowledge and expertise, including:

(i) two members representing Indian Tribes within the boundaries of Minnesota, one representing the Ojibwe Tribes and one representing the Dakota Tribes;

(ii) one member with expertise in the treatment of substance use disorders;

(iii) one member with experience working in public health policy;

(iv) two veterans with treatment-resistant mental health conditions;

(v) two patients with treatment-resistant mental health conditions;

(vi) one psychiatrist with experience treating treatment-resistant mental health conditions, including post-traumatic stress disorder;

(vii) one health care practitioner with experience in integrative medicine;

(viii) one psychologist with experience treating treatment-resistant mental health conditions, including post-traumatic stress disorder; and

(ix) one member with demonstrable experience in the medical use of psychedelic medicine.

(b) Members listed in paragraph (a), clauses (1) and (3) to (8), and members appointed under paragraph (a), clause (9), may be reimbursed for expenses under Minnesota Statutes, section 15.059, subdivision 6. Members appointed under paragraph (a), clause (2), may receive per diem compensation from their respective bodies according to the rules of their respective bodies.

(c) Members shall be designated or appointed to the task force by July 15, 2023.

Subd. 3. **Organization.** (a) The commissioner of health or the commissioner's designee shall convene the first meeting of the task force.

(b) At the first meeting, the members of the task force shall elect a chairperson and other officers as the members deem necessary.

(c) The first meeting of the task force shall occur by August 1, 2023. The task force shall meet monthly or as determined by the chairperson.

Subd. 4. **Staff.** The commissioner of health shall provide support staff, office and meeting space, and administrative services for the task force.

Subd. 5. **Duties.** The task force shall:

(1) survey existing studies in the scientific literature on the therapeutic efficacy of psychedelic medicine in the treatment of mental health conditions, including depression, anxiety, post-traumatic stress disorder, bipolar disorder, and any other mental health conditions and medical conditions for which a psychedelic medicine may provide an effective treatment option;

(2) compare the efficacy of psychedelic medicine in treating the conditions described in clause (1) with the efficacy of treatments currently used for these conditions; and

(3) develop a comprehensive plan that covers:

(i) statutory changes necessary for the legalization of psychedelic medicine;

(ii) state and local regulation of psychedelic medicine;

(iii) federal law, policy, and regulation of psychedelic medicine, with a focus on retaining state autonomy to act without conflicting with federal law, including methods to resolve conflicts such as seeking an administrative exemption to the federal Controlled Substances Act under United States Code, title 21, section 822(d), and Code of Federal Regulations, title 21, part 1307.03; seeking a judicially created exemption to the federal Controlled Substances Act; petitioning the United States Attorney General to establish a research program under United States Code, title 21, section 872(e); using the Food and Drug Administration's expanded access program; and using authority under the federal Right to Try Act; and

(iv) education of the public on recommendations made to the legislature and others about necessary and appropriate actions related to the legalization of psychedelic medicine in the state.

Subd. 6. **Reports.** The task force shall submit two reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services that detail the task force's findings regarding the legalization of psychedelic medicine in the state, including the comprehensive plan developed under subdivision 5. The first report must be submitted by February 1, 2024, and the second report must be submitted by January 1, 2025.

FOR SECTION 193, SEE ARTICLE 2, HEALTH INSURANCE

Sec. 194. **RETURN OF CHARITABLE ASSETS.**

If a health system that is organized as a charitable organization, and that includes M Health Fairview University of Minnesota Medical Center, sells or transfers control to an

out-of-state nonprofit entity or to any for-profit entity, the health system must return to the general fund any charitable assets the health system received from the state.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to transactions completed on or after that date.

FOR SECTION 196, SEE ARTICLE 2, HEALTH INSURANCE

Sec. 197. **STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER TRANSACTIONS.**

(a) The commissioner of health shall study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-domiciled nonprofit health maintenance organizations and for-profit health maintenance organizations. The recommendations must at least address:

(1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance organizations;

(2) issues related to public benefit assets held by a nonprofit health maintenance organization, including identifying the portion of the organization's assets that are considered public benefit assets to be protected, establishing a fair and independent process to value to the assets, and how public benefit assets should be stewarded for the public good;

(3) designating a state agency or executive branch office with authority to review and approve or disapprove a nonprofit health maintenance organization's plan to convert to a for-profit organization; and

(4) establishing a process for the public to learn about and provide input on a nonprofit health maintenance organization's proposed conversion to a for-profit organization.

(b) To fulfill the requirements under this section, the commissioner:

(1) may consult with the commissioners of human services and commerce;

(2) may enter into one or more contracts for professional or technical services;

(3) notwithstanding any law to the contrary, may use data submitted under Minnesota Statutes, sections 62U.04 and 144.695 to 144.705, and other data held by the commissioner for purposes of regulating health maintenance organizations or already submitted to the commissioner by health carriers; and

(4) may collect from health maintenance organizations and their parent or affiliated companies, financial data and other information, including nonpublic data and trade secret data, that are deemed necessary by the commissioner to conduct the study and develop the recommendations under this section. Health maintenance organizations must provide the commissioner with any information requested by the commissioner under this clause, in the form and manner specified by the commissioner. Any data collected by the commissioner

Sec. 82. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment preferences of a patient with an advanced serious illness who is nearing the end of the their life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall develop recommendations for a statewide registry of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner for the provision of care or services.

(b) The commissioner shall develop recommendations on the following:

under this clause is classified as confidential data as defined in Minnesota Statutes, section 13.02, subdivision 3 or protected nonpublic data as defined in Minnesota Statutes, section 13.02, subdivision 13.

(c) No later than October 1, 2023, the commissioner must seek public comments on the regulation of conversion transactions involving nonprofit health maintenance organizations.

(d) The commissioner may use the enforcement authority in Minnesota Statutes, section 62D.17, if a health maintenance organization fails to comply with a request for information under paragraph (b), clause (4).

(e) The commissioner shall submit preliminary findings from this study to the chairs of the legislative committees with jurisdiction over health and human services by January 15, 2024, and shall submit a final report and recommendations to the legislature by June 30, 2024.

Sec. 198. **STUDY OF THE DEVELOPMENT OF A STATEWIDE REGISTRY FOR PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Life-sustaining treatment" means any medical procedure, pharmaceutical drug, medical device, or medical intervention that maintains life by sustaining, restoring, or supplanting a vital function. Life-sustaining treatment does not include routine care necessary to sustain patient cleanliness and comfort.

(d) "POLST" means a provider order for life-sustaining treatment, signed by a physician, advanced practice registered nurse, or physician assistant, to ensure that the medical treatment preferences of a patient with an advanced serious illness who is nearing the end of life are honored.

(e) "POLST form" means a portable medical form used to communicate a physician's, advanced practice registered nurse's, or physician assistant's order to help ensure that a patient's medical treatment preferences are conveyed to emergency medical service personnel and other health care providers.

Subd. 2. **Establishment.** (a) The commissioner, in consultation with the advisory committee established in paragraph (c), shall develop recommendations for a statewide registry of POLST forms to ensure that a patient's medical treatment preferences are followed by all health care providers. The registry must allow for the submission of completed POLST forms and for the forms to be accessed by health care providers and emergency medical service personnel in a timely manner for the provision of care or services.

(b) The commissioner shall develop recommendations on the following:

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a statewide registry of POLST forms to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2024.

Sec. 83. **DIRECTION TO THE COMMISSIONER; ALZHEIMER'S PUBLIC INFORMATION PROGRAM.**

(a) The commissioner of health shall design and make publicly available materials for a statewide public information program that:

(1) promotes the benefits of early detection and the importance of discussing cognition with a health care provider;

(2) outlines the benefits of cognitive testing, the early warning signs of cognitive impairment, and the difference between normal cognitive aging and dementia; and

(3) provides awareness of Alzheimer's disease and other dementias.

(b) The commissioner shall include in the program materials messages directed at the general population, as well as messages designed to reach underserved communities including but not limited to rural populations, Native and Indigenous communities, and communities of color. The program materials shall include culturally specific messages developed in consultation with leaders of targeted cultural communities who have experience with Alzheimer's disease and other dementias. The commissioner shall develop the materials for the program by June 30, 2024, and make them available online to local and county public health agencies and other interested parties.

(c) To the extent funds remain available for this purpose, the commissioner shall implement an initial statewide public information campaign using the developed program

(1) electronic capture, storage, and security of information in the registry;

(2) procedures to protect the accuracy and confidentiality of information submitted to the registry;

(3) limits as to who can access the registry;

(4) where the registry should be housed;

(5) ongoing funding models for the registry; and

(6) any other action needed to ensure that patients' rights are protected and that their health care decisions are followed.

(c) The commissioner shall create an advisory committee with members representing physicians, physician assistants, advanced practice registered nurses, nursing homes, emergency medical system providers, hospice and palliative care providers, the disability community, attorneys, medical ethicists, and the religious community.

Subd. 3. **Report.** The commissioner shall submit recommendations on establishing a statewide registry of POLST forms to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2024, and implement the registry no later than December 1, 2024.

materials. The campaign must include culturally specific messages and the development of a community digital public forum. These messages may be disseminated by television and radio public service announcements, social media and digital advertising, print materials, or other means.

(d) The commissioner may contract with one or more third parties to initially implement some or all of the public information campaign, provided the contracted third party has prior experience promoting Alzheimer's awareness and the contract is awarded through a competitive process. The public information campaign must be implemented by July 1, 2025.

(e) By June 30, 2026, the commissioner shall report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over public health or aging on the development of the program materials and initial implementation of the public information campaign, including how and where the funds appropriated for this purpose were spent.

Sec. 84. **MORATORIUM ON GREEN BURIALS; STUDY.**

Subdivision 1. **Definition.** For purposes of this section, "green burial" means a burial of a dead human body in a manner that minimizes environmental impact and does not inhibit decomposition of the body by using practices that include at least the following:

(1) the human body is not embalmed prior to burial or is embalmed only with nontoxic chemicals;

(2) a biodegradable casket or shroud is used for burial; and

(3) the casket or shroud holding the human body is not placed in an outer burial container when buried.

Subd. 2. **Moratorium.** Between July 1, 2023, and July 1, 2025, a green burial shall not be performed in this state unless the green burial is performed in a cemetery that permits green burials and at which green burials are permitted by any applicable ordinances or regulations.

Subd. 3. **Study and report.** (a) The commissioner of health shall study the environmental and health impacts of green burials and develop recommendations for the performance of green burials to prevent environmental harm, including contamination of groundwater and surface water, and to protect the health of workers performing green burials, mourners, and the public. The study and recommendations may address topics that include:

(1) the siting of locations where green burials are permitted;

(2) the minimum distance a green burial location must have from groundwater, surface water, and drinking water;

(3) the minimum depth at which a body buried via green burial must be buried, the minimum soil depth below the body, and the minimum soil depth covering the body;

(4) the maximum density of green burial interments in a green burial location;

(5) procedures used by individuals who come in direct contact with a body awaiting green burial to minimize the risk of infectious disease transmission from the body;

(6) methods to temporarily inhibit decomposition of an unembalmed body awaiting green burial; and

(7) the time period within which an unembalmed body awaiting green burial must be buried or held in a manner that delays decomposition.

(b) The commissioner shall submit the study and recommendations, including any statutory changes needed to implement the recommendations, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and the environment by February 1, 2025.

Sec. 85. **ADOPTION LAW CHANGES; PUBLIC AWARENESS CAMPAIGN.**

(a) The commissioner of human services must, in consultation with licensed child-placing agencies, provide information and educational materials to adopted persons and birth parents about the changes in law made by this article affecting access to birth records.

(b) The commissioner of human services must provide notice on the department's website about the changes in the law. The commissioner or the commissioner's designee, in consultation with licensed child-placement agencies, must coordinate a public awareness campaign to advise the public about the changes in law made by this article.

EFFECTIVE DATE. This section is effective August 1, 2023.

Sec. 86. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims Recovery Program.

Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of:

(1) victims who experienced trauma, including historical trauma, resulting from events such as assault or another violent physical act, intimidation, false accusations, wrongful conviction, a hate crime, the violent death of a family member, or experiences of discrimination or oppression based on the victim's race, ethnicity, or national origin; and

(2) the families and heirs of victims described in clause (1), who experienced trauma, including historical trauma, because of their proximity or connection to the victim.

Sec. 186. **EMMETT LOUIS TILL VICTIMS RECOVERY PROGRAM.**

Subdivision 1. **Short title.** This section shall be known as the Emmett Louis Till Victims Recovery Program.

Subd. 2. **Program established; grants.** (a) The commissioner of health shall establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of:

(1) victims who experienced trauma, including historical trauma, resulting from events such as assault or another violent physical act, intimidation, false accusations, wrongful conviction, a hate crime, the violent death of a family member, or experiences of discrimination or oppression based on the victim's race, ethnicity, or national origin; and

(2) the families and heirs of victims described in clause (1), who experienced trauma, including historical trauma, because of their proximity or connection to the victim.

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(b) The commissioner, in consultation with victims, families, and heirs described in paragraph (a), shall award competitive grants to applicants for projects to provide the following services to victims, families, and heirs described in paragraph (a):

(1) health and wellness services, which may include services and support to address physical health, mental health, cultural needs, and spiritual or faith-based needs;

(2) remembrance and legacy preservation activities;

(3) cultural awareness services;

(4) spiritual and faith-based support; and

(5) community resources and services to promote healing for victims, families, and heirs described in paragraph (a).

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims, families, and heirs described in paragraph (a).

Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024, and an additional report by January 15, 2025, on the operation and results of the grant program, to the extent available. These reports must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report due January 15, 2024, must include information on grant program activities to date and an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs who experienced trauma as described in subdivision 2, paragraph (a). The report due January 15, 2025, must include a summary of the services offered by grant recipients; an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a); and an evaluation of the grant program's goals and outcomes.

Sec. 87. **EMPLOYEE SAFETY AND SECURITY GRANTS.**

Subdivision 1. **Establishment.** The commissioner of health must establish a competitive grant program for workplace safety grants for eligible health care entities to increase the employee safety or security. Each grant award must be for at least $5,000, but no more than $100,000.

Subd. 2. **Eligible applicants.** A health care entity located in this state is eligible to apply for a grant. For purposes of this section, a health care entity includes but is not limited to

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(b) The commissioner, in consultation with victims, families, and heirs described in paragraph (a), shall award competitive grants to applicants for projects to provide the following services to victims, families, and heirs described in paragraph (a):

(1) health and wellness services, which may include services and support to address physical health, mental health, and cultural needs;

(2) remembrance and legacy preservation activities;

(3) cultural awareness services; and

(4) community resources and services to promote healing for victims, families, and heirs described in paragraph (a).

(c) In awarding grants under this section, the commissioner must prioritize grant awards to community-based organizations experienced in providing support and services to victims, families, and heirs described in paragraph (a).

Subd. 3. **Evaluation.** Grant recipients must provide the commissioner with information required by the commissioner to evaluate the grant program, in a time and manner specified by the commissioner.

Subd. 4. **Reports.** The commissioner must submit a status report by January 15, 2024, and an additional report by January 15, 2025, on the operation and results of the grant program, to the extent available. These reports must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health care. The report due January 15, 2024, must include information on grant program activities to date and an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs who experienced trauma resulting from government-sponsored activities. The report due January 15, 2025, must include a summary of the services offered by grant recipients; an assessment of the need to continue to offer services provided by grant recipients to victims, families, and heirs described in subdivision 2, paragraph (a); and an evaluation of the grant program's goals and outcomes.

Sec. 200. **WORKPLACE SAFETY GRANTS; HEALTH CARE ENTITIES AND HUMAN SERVICES PROVIDERS.**

Subdivision 1. **Grant program established.** The commissioner of health shall administer a program to award workplace safety grants to health care entities and human services providers to increase safety measures at health care settings and at human services workplaces providing behavioral health care; services for children, families, and vulnerable adults; services for older adults and people with disabilities; and other social services or related care.

Subd. 2. **Eligible applicants; application.** (a) Entities eligible for a grant under this section shall include health systems, hospitals, medical clinics, dental clinics, ambulance

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the following: health care systems, long-term care facilities, hospitals, nursing facilities, medical clinics, dental clinics, community health clinics, and ambulance services.

Subd. 3. **Applications.** An entity seeking a grant under this section must apply to the commissioner in a form and manner prescribed by the commissioner. The grant applicant, in its application, must include:

(1) a proposed plan for how the grant funds will be used to improve employee safety or security;

(2) a description of the achievable objectives the applicant plans to achieve through the use of the grant funds; and

(3) a process for documenting and evaluating the results achieved through the use of the grant funds.

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services, community health clinics, county human services agencies, Tribal human services agencies, and other human services provider organizations.

(b) An entity seeking a grant under this section must submit an application to the commissioner in a form and manner prescribed by the commissioner. An application must include information about:

(1) the type of entity or organization seeking grant funding;

(2) the specific safety measures or activities for which the applicant will use the grant funding;

(3) the specific policies that will be implemented or upheld to ensure that individuals' rights to privacy and data protection are protected during the use of safety equipment obtained or operated through grant funding;

(4) a proposed budget for each of the specific activities for which the applicant will use the grant funding;

(5) an outline of efforts to enhance or improve existing safety measures or proposed new measures to improve the safety of staff at the entity, agency, or organization;

(6) sample consent forms for any safety equipment that has capacity to record, store, or share audio or video that will be collected from patients or clients prior to implementation of grant-funded safety measures, excluding equipment located in public spaces in provider-controlled, licensed settings;

(7) how the grant-funded measures will lead to long-term improvements in safety and stability for staff and for patients and clients accessing health care or services from the applicant; and

(8) methods the applicant will use to evaluate effectiveness of the safety measures and changes that will be made if the measures are deemed ineffective.

Subd. 3. **Grant awards.** Grants must be awarded to eligible applicants that meet application requirements on a first-come, first-served basis. Forty percent of grant funds must be awarded to eligible applicants located outside of the seven-county metropolitan area. Each grant award must be for at least $5,000, but no more than $100,000.

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Subd. 4. **Eligible uses.** Grant funds must be used for the following purposes:

(1) training for employees on self-defense;

(2) training for employees on de-escalation methods;

(3) creating and implementing a health care-based violence intervention programs (HBVI); or

(4) technology system improvements designed to improve employee safety or security.

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Subd. 4. **Allowable uses of grant funds.** (a) Grant funds may be used for one or more of the following:

(1) the procurement and installation of safety equipment, including but not limited to cellular telephones; personal radios; wearable tracking devices for staff to share their location with supervisors, subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) data privacy requirements outlined in Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E; security systems and cameras in public spaces of provider-controlled, licensed settings or of health care settings; and panic buttons;

(2) training for staff, which may include:

(i) sessions and exercises for crisis management, strategies for de-escalating conflict situations, safety planning, and self-defense in accordance with positive support strategies under Minnesota Rules, chapter 9544, and person-centered planning and service delivery according to Minnesota Statutes, section 245D.07, subdivision 1a;

(ii) training in culturally informed and culturally affirming practices, including linguistic training;

(iii) training in trauma-informed social, emotional, and behavioral support; and

(iv) other training topics, sessions, and exercises the commissioner determines to be appropriate;

(3) facility safety improvements, including but not limited to a threat and vulnerability review and barrier protection;

(4) support services, counseling, and additional resources for staff who have experienced safety concerns or trauma-related incidents in the workplace;

(5) installation and implementation of an internal data incident tracking system to track and prevent workplace safety incidents; and

(6) other prevention and mitigation measures and safety training, resources, and support services the commissioner determines to be appropriate.

(b) The following restrictions apply to the eligible uses of grant funds under paragraph (a):

(1) safety equipment must not include:

(i) tools or devices that facilitate physical or chemical restraint;

(ii) barriers, environmental modifications, or other tools or devices that facilitate individual seclusion, except plexiglass barriers in office settings are allowed;

(iii) wearable body cameras; or

(iv) wearable tracking devices that have the capacity to store location data;

(2) security cameras must only be used in staff spaces and entry points of buildings and may not be used in common areas, bedrooms, and bathrooms;

(3) in settings that are required to comply with the positive supports rule, all safety equipment or measures must comply with Minnesota Rules, chapter 9544;

(4) settings licensed under Minnesota Statutes, section 245D, must follow person-centered practices according to Minnesota Statutes, section 245D.07;

(5) any safety equipment purchased with grant funding that has electronic monitoring capacity must be used according to Minnesota Statutes, section 144.6502, or the brain injury, community alternative care, community access for disability inclusion, and developmental disabilities federal waiver plan language that outlines monitoring technology use;

(6) prior to the use of safety equipment that has capacity to record, store, and share audio, video, or a combination thereof, the grant recipient must:

(i) provide patients or clients with information about electronic monitoring in a way that is most accessible to the patients or clients, including the definition of electronic monitoring, the type of device that will be in use, how the footage captured will be used, with whom the footage captured will be shared, and a statement that a patient or client has the right to decline use of safety equipment that has capacity to record, store, and share audio, video, or a combination thereof;

(ii) provide notice every time electronic monitoring devices are in use; and

(iii) obtain written consent from anyone whose audio or video may be recorded during the time the device is in use and, if applicable, from guardians of individuals whose audio or video may be recorded during the time the device is in use; and

(7) in settings that provide home and community-based services, if at any point a client or their guardian declines the use of safety equipment that has capacity to record, store, or share audio, video, or a combination thereof or revokes prior consent to such use, the provider must cease using the safety equipment immediately and indefinitely. A provider may not deny or delay the provision of services as a result of an individual's decision to decline the use of safety equipment that has capacity to record, store, or share audio, video, or a combination thereof.

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Subd. 5. **Grant allocations.** For grants awarded prior to January 1, 2025, the commissioner must ensure that approximately 60 percent of awards are to health care entities in the seven-county metropolitan area and 40 percent are to health care entities outside of the seven-county metropolitan area. If funds remain on January 1, 2025, the commissioner may award grants to health care entities regardless of where the entity is located.

Subd. 6. **Report.** By January 15, 2026, the commissioner of health must report to the legislative committees with jurisdiction over health policy and finance on the grants awarded by this section. The report must include the following information:

(1) the name of each grantee, the amount awarded to the grantee, and how the grantee used the funds; and

(2) the percentage of awards made to entities outside of the seven-county metropolitan area.

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(c) All video, audio, or other personally identifiable information collected through safety equipment paid for by grant funds under this section must:

(1) be treated consistently with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements outlined in Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E;

(2) be subject to applicable rules of evidence and procedure if admitted into evidence in a civil, criminal, or administrative proceeding; and

(3) not result in the denial or delay of services provided to an individual.

Subd. 5. **Report.** Within two years after receiving grant funds under this section, each grant recipient must submit a report to the commissioner. The commissioner must submit a compilation of the reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services, the Office of Ombudsman for Long-Term Care, and Office of Ombudsman for Mental Health and Developmental Disabilities. Grant recipient reports to the commissioner must include:

(1) the number of workplace safety incidents that occurred over the course of the grant period;

(2) the number and type of safety measures funded by the grants, and how those safety measures helped alleviate or de-escalate workplace safety incidents;

(3) the number of staff benefiting from safety measures implemented through grant funding;

(4) the number of patients or clients benefiting from safety measures implemented through grant funding;

(5) practices implemented concurrently with the use of safety equipment that ensured that the rights of patients or clients served were upheld;

(6) the number of patients or clients who declined to consent to the use of any safety equipment that had capacity to record, store, or share audio, video, or a combination thereof;

(7) an evaluation of the effectiveness of the safety measures, including assessment of whether and how the grant funding has led or will lead to improved safety and service provisions for staff, patients, and clients; and

Sec. 88. **EQUITABLE HEALTH CARE TASK FORCE.**

Subdivision 1. **Establishment; composition of task force.** The equitable health care task force consists of up to 20 members appointed by the commissioner of health from both metropolitan and greater Minnesota. Members must include representatives of:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x/ communities;

(4) American Indian communities and Tribal Nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, queer, intergender, and asexual (LGBTQIA+) communities;

(7) organizations that advocate for the rights of individuals using the health care system;

(8) health care providers of primary care and specialty care; and

(9) organizations that provide health coverage in Minnesota.

Subd. 2. **Organization and meetings.** The task force shall be organized and administered under Minnesota Statutes, section 15.059. The commissioner of health must convene meetings of the task force at least quarterly. Subcommittees or workgroups may be established as necessary. Task force meetings are subject to Minnesota Statutes, chapter 13D. The task force shall expire on June 30, 2025.

Subd. 3. **Duties of task force.** The task force shall examine inequities in how people access and receive health care based on race, religion, culture, sexual orientation, gender identity, age, or disability and identify strategies to ensure that all Minnesotans can receive care and coverage that is respectful and ensures optimal health outcomes, to include:

(1) identifying inequities experienced by Minnesotans in interacting with the health care system that originate from or can be attributed to their race, religion, culture, sexual orientation, gender identity, age, or disability status;

(8) changes to policy or practice that were made if safety measures implemented using grant funds were deemed ineffective.

Subd. 6. **Technical assistance.** The commissioner must provide technical assistance to grant applicants throughout the application process and to applicants and grant recipients regarding grant distribution and required grant recipient reporting

(2) conducting community engagement across multiple systems, sectors, and communities to identify barriers for these population groups that result in diminished standards of care and foregone care;

(3) identifying promising practices to improve the experience of care and health outcomes for individuals in these population groups; and

(4) making recommendations to the commissioner of health and to the chairs and ranking minority members of the legislative with primary jurisdiction over health policy and finance for changes in health care system practices or health insurance regulations that would address identified issues.

Sec. 89. **RULEMAKING AUTHORITY.**

The commissioner of health must adopt rules using the expedited rulemaking process under Minnesota Statutes, section 14.389, to implement the installation of submerged closed loop heat exchanger systems according to Minnesota Statutes, sections 103I.209 and 103I.210. The rules must incorporate, and are limited to, the provisions in those sections.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 90. **REPORT; CLOSED LOOP HEAT EXCHANGER SYSTEM.**

By December 31, 2024, the commissioner of health must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy. The report must include a recommendation on whether additional requirements are necessary to ensure that the construction and operation of submerged closed loop heat exchangers do not create the risk of material adverse impacts on the state's groundwater caused by the chemical or biological composition of the circulating fluids by operation of the well as part of the submerged closed loop heat exchanger. Unless specifically authorized by subsequent act of the legislature, the commissioner must not adopt any rules or requirements to implement the recommendations included in the report.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 91. **CLOSED LOOP HEAT EXCHANGER SYSTEM MONITORING AND REPORTING.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given to them.

(b) "Accredited laboratory" means a laboratory that is certified under Minnesota Rules, chapter 4740.

(c) "Permit holder" means persons who receive a permit under this section and includes the property owner and licensed well contractor.

Subd. 2. **Monitoring and reporting requirements.** (a) The system owner is responsible for monitoring and reporting to the commissioner for permitted submerged closed loop heat

exchanger systems installed under the provisional program. The commissioner must identify projects subject to reporting by including a permit condition.

(b) The closed loop heat exchanger owner must implement a closed loop water monitoring plan.

(c) The system owner must analyze the closed loop water for:

(1) aluminum;

(2) arsenic;

(3) copper;

(4) iron;

(5) lead;

(6) manganese;

(7) zinc;

(8) total coliform;

(9) escherichia coli (E. coli);

(10) heterotrophic plate count;

(11) legionella;

(12) pH;

(13) electrical conductivity;

(14) dissolved oxygen; and

(15) temperature.

(d) The system owner must provide the results for the sampling event, including the parameters in paragraph (c), clauses (1) to (11), to the commissioner within 30 days of the date of the report provided by an accredited laboratory. Paragraph (c), clauses (12) to (15), may be measured in the field and reported along with the laboratory results.

Subd. 3. **Evaluation of permit conditions.** (a) In order to determine whether additional permit conditions are necessary and appropriate to ensure that the construction and operation of a submerged closed loop heat exchanger does not create the risk of material adverse impacts on the state's groundwater, the commissioner shall require semiannual sampling of the circulating fluids in accordance with subdivision 2 to determine whether there have been any material changes in the chemical or biological composition of the circulating fluids.

(b) The information required by this section shall be collected from each submerged closed loop heat exchanger system installed after June 30, 2023, under this provisional

program. The commissioner shall identify up to ten systems for which report submission is required, and this requirement shall be included in the permit conditions. The information shall be provided to the commissioner on a semiannual basis and the final semiannual submission shall include information from the period from January 1, 2024, through July 1, 2024.

Subd. 4. **Report requirements.** Every closed loop heat exchanger owner that holds a permit issued under this section must provide a report to the commissioner for each permit by September 30, 2024. The report must describe the status, operation, and performance of each submerged closed loop heat exchanger system. The report may be in a format determined by the system owner and must include:

(1) date of the report;

(2) a narrative description of system installation, operation, and status, including dates;

(3) mean monthly temperature of the water entering the building;

(4) mean monthly temperature of the water leaving the building;

(5) maintenance performed on the system, including dates, identification of heat exchangers or components that were addressed, and descriptions of actions that occurred; and

(6) any maintenance issues, material failures, leaks, and repairs, including dates and descriptions of the heat exchangers or components involved, issues, failures, leaks, and repairs.

EFFECTIVE DATE. This section is effective the day following final enactment and expires on December 31, 2024.

Sec. 199. **VACCINES FOR UNINSURED AND UNDERINSURED ADULTS.**

The commissioner of health shall administer a program to provide vaccines to uninsured and underinsured adults. The commissioner shall determine adult eligibility for free or low-cost vaccines under this program and shall enroll clinics to participate in the program and administer vaccines recommended by the Centers for Disease Control and Prevention. In administering the program, the commissioner shall address racial and ethnic disparities in vaccine coverage rates. State money appropriated for purposes of this section shall be used to supplement, but not supplant, available federal funding for purposes of this section.

Sec. 201. **TASK FORCE ON PREGNANCY HEALTH AND SUBSTANCE USE DISORDERS.**

Subdivision 1. **Establishment.** The Task Force on Pregnancy Health and Substance Use Disorders is established to recommend protocols for when physicians, advanced practice

registered nurses, and physician assistants should administer a toxicology test and requirements for reporting for prenatal exposure to a controlled substance.

Subd. 2. **Membership.** (a) The task force shall consist of the following members:

(1) a physician licensed in Minnesota to practice obstetrics and gynecology who provides care primarily to medical assistance enrollees during pregnancy appointed by the American College of Obstetricians and Gynecologists;

(2) a physician licensed in Minnesota to practice pediatrics or family medicine who provides care primarily to medical assistance enrollees with substance use disorders or who provides addiction medicine care during pregnancy appointed by the Minnesota Medical Association;

(3) a certified nurse-midwife licensed as an advanced practice registered nurse in Minnesota who provides care primarily to medical assistance enrollees with substance use disorders or provides addiction medicine care during pregnancy appointed by the Minnesota Advanced Practice Registered Nurses Coalition;

(4) two representatives of county social services agencies, one from a county outside the seven-county metropolitan area and one from a county within the seven-county metropolitan area, appointed by the Minnesota Association of County Social Service Administrators;

(5) one representative from the Board of Social Work;

(6) two Tribal representatives appointed by the Minnesota Indian Affairs Council;

(7) two members who identify as Black or African American and who have lived experience with the child welfare system and substance use disorders appointed by the Cultural and Ethnic Communities Leadership Council;

(8) two members who are licensed substance use disorder treatment providers appointed by the Minnesota Association of Resources for Recovery and Chemical Health;

(9) one member representing hospitals appointed by the Minnesota Hospital Association;

(10) one designee of the commissioner of health with expertise in substance use disorders and treatment;

(11) two members who identify as Native American or American Indian and who have lived experience with the child welfare system and substance use disorders appointed by the Minnesota Indian Affairs Council;

(12) two members from the Council for Minnesotans of African Heritage; and

(13) one member of the Minnesota Perinatal Quality Collaborative.

(b) Appointments to the task force must be made by October 1, 2023.

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Subd. 3. **Chairs; meetings.** (a) The task force shall elect a chair and cochair at the first meeting, which shall be convened no later than October 15, 2023.

(b) Task force meetings are subject to the Minnesota Open Meeting Law under Minnesota Statutes, chapter 13D.

Subd. 4. **Administrative support.** The Department of Health must provide administrative support and meeting space for the task force.

Subd. 5. **Duties; reports.** (a) The task force shall develop recommended protocols for when a toxicology test for prenatal exposure to a controlled substance should be administered to a birthing parent and a newborn infant. The task force must also recommend protocols for providing notice or reporting of prenatal exposure to a controlled substance to local welfare agencies under Minnesota Statutes, chapter 260E.

(b) No later than December 1, 2024, the task force must submit a written report to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services on the task force's activities and recommendations on the protocols developed under paragraph (a).

Subd. 6. **Expiration.** The task force shall expire upon submission of the report required under subdivision 5, paragraph (b), or December 1, 2024, whichever is later.

Sec. 202. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall change the term "cancer surveillance system" to "cancer reporting system" wherever it appears in the next edition of Minnesota Statutes and Minnesota Rules and in the online publication.

(b) The revisor of statutes shall amend the headnote for Minnesota Statutes, section 145.423, to read "RECOGNITION OF INFANT WHO IS BORN ALIVE."

FOR PARAGRAPH (C), SEE ARTICLE 3, KEEPING NURSES AT THE BEDSIDE

Sec. 92. **REPEALER.**

(a) Minnesota Statutes 2022, section 144.059, subdivision 10, is repealed.

Sec. 203. **REPEALER.**

(a) Minnesota Rules, parts 4640.1500; 4640.1600; 4640.1700; 4640.1800; 4640.1900; 4640.2000; 4640.2100; 4640.2200; 4640.2300; 4640.2400; 4640.2500; 4640.2600; 4640.2700; 4640.2800; 4640.2900; 4640.3000; 4640.3100; 4640.3200; 4640.3300; 4640.3400; 4640.3500; 4640.3600; 4640.3700; 4640.3800; 4640.3900; 4640.4000; 4640.4100; 4640.4200; 4640.4300; 4640.6100; 4640.6200; 4640.6300; 4640.6400; 4645.0300; 4645.0400; 4645.0500; 4645.0600; 4645.0700; 4645.0800; 4645.0900; 4645.1000; 4645.1100; 4645.1200; 4645.1300; 4645.1400; 4645.1500; 4645.1600; 4645.1700; 4645.1800; 4645.1900; 4645.2000; 4645.2100; 4645.2200; 4645.2300; 4645.2400; 4645.2500; 4645.2600; 4645.2700; 4645.2800; 4645.2900; 4645.3000; 4645.3100; 4645.3200; 4645.3300; 4645.3400; 4645.3500; 4645.3600; 4645.3700; 4645.3800; 4645.3805; 4645.3900; 4645.4000; 4645.4100; 4645.4200; 4645.4300;

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(b) Minnesota Statutes 2022, sections 144.212, subdivision 11; 259.83, subdivision 3; 259.89; and 260C.637, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective July 1, 2024.

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4645.4400; 4645.4500; 4645.4600; 4645.4700; 4645.4800; 4645.4900; 4645.5100; and 4645.5200, are repealed effective January 1, 2024.

(b) Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7, and 8; 144.059, subdivision 10; 144.9505, subdivision 3; 145.4235; and 153A.14, subdivision 5, are repealed.

(c) Minnesota Rules, part 4615.3600, is repealed effective the day following final enactment.

(d) Minnesota Rules, parts 4700.1900; 4700.2000; 4700.2100; 4700.2210; 4700.2300, subparts 1, 3, 4, 4a, and 5; 4700.2410; 4700.2420; and 4700.2500, are repealed.

(e) Minnesota Statutes 2022, sections 62Q.145; 145.1621; 145.411, subdivisions 2 and 4; 145.412; 145.413, subdivisions 2 and 3; 145.4131; 145.4132; 145.4133; 145.4134; 145.4135; 145.4136; 145.415; 145.416; 145.423, subdivisions 2, 3, 4, 5, 6, 7, 8, and 9; 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248; 145.4249; 256B.011; 256B.40; 261.28; and 393.07, subdivision 11, are repealed effective the day following final enactment.