

**SENATE  
STATE OF MINNESOTA  
NINETY-THIRD SESSION**

**S.F. No. 2995**

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/20/2023	2118	Introduction and first reading
		Referred to Health and Human Services
04/12/2023		Comm report: To pass as amended and re-refer to Finance

1.1 A bill for an act

1.2 relating to health; appropriating money for the Department of Health, health-related

1.3 boards, Council on Disability, ombudsman for mental health and disabilities,

1.4 ombudsperson for families, ombudsperson for American Indian families, Office

1.5 of the Foster Youth Ombudsperson, MNsure, Rare Disease Advisory Council, and

1.6 the Department of Revenue; establishing the Health Care Spending Growth Target

1.7 Commission and Health Care Spending Technical Advisory Council; identifying

1.8 ways to reduce spending by health care organizations and group purchasers and

1.9 low-value care; assessing alternative payment methods in rural health care;

1.10 assessing feasibility for a health provider directory; requiring compliance with the

1.11 No Surprises Act in billing; modifying prescription drug price provisions and

1.12 continuity of care provisions; compiling health encounter data; establishing certain

1.13 advisory councils, committees, and grant programs; modifying lead testing in

1.14 schools and remediation requirements; modifying lead service line requirements;

1.15 requiring lead testing in drinking water in child care settings; establishing Minnesota

1.16 One Health Microbial Stewardship Collaborative, a comprehensive drug overdose

1.17 and morbidity program, a Sentinel Event Review Committee, law

1.18 enforcement-involved deadly force encounters advisory committee, and cultural

1.19 communications program; setting certain fees; providing for clinical health care

1.20 training; establishing a climate resiliency program; changing assisted living

1.21 provisions; establishing a program to monitor long COVID, a 988 suicide crisis

1.22 lifeline, school-based health centers, Healthy Beginnings, Healthy Families Act,

1.23 and Comprehensive and Collaborative Resource and Referral System for Children;

1.24 funding for community health boards; developing COVID-19 pandemic delayed

1.25 preventive care; changing certain health board fees; establishing easy enrollment

1.26 health insurance outreach program; setting certain fees; requiring reports; amending

1.27 Minnesota Statutes 2022, sections 12A.08, subdivision 3; 62J.84, subdivisions 2,

1.28 3, 4, 6, 7, 8, 9, by adding subdivisions; 62K.15; 62Q.01, by adding a subdivision;

1.29 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56,

1.30 subdivision 2; 62Q.73, subdivisions 1, 7; 62U.04, subdivisions 4, 5, 6; 121A.335,

1.31 subdivisions 3, 5, by adding a subdivision; 144.122; 144.1505; 144.226,

1.32 subdivisions 3, 4; 144.383; 144G.16, subdivision 7; 144G.18; 144G.57, subdivision

1.33 8; 145.925; 145A.131, subdivisions 1, 5; 145A.14, by adding a subdivision;

1.34 148B.392, subdivision 2; 151.065, subdivisions 1, 2, 3, 4, 6; 270B.14, by adding

1.35 a subdivision; 403.161; 403.162; Laws 2022, chapter 99, article 1, section 46;

1.36 article 3, section 9; proposing coding for new law in Minnesota Statutes, chapters

1.37 62J; 62V; 115; 144; 145; 148; 290; repealing Minnesota Statutes 2022, sections

1.38 62J.84, subdivision 5; 62U.10, subdivisions 6, 7, 8; 145.4235; 145.4241; 145.4242;

2.1 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248; 145.4249; 145.925,  
2.2 subdivisions 1a, 3, 4, 7, 8.

2.3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

2.4 **ARTICLE 1**

2.5 **APPROPRIATIONS**

2.6 Section 1. **HEALTH APPROPRIATIONS.**

2.7 The sums shown in the columns marked "Appropriations" are appropriated to the agencies  
2.8 and for the purposes specified in this article. The appropriations are from the general fund,  
2.9 or another named fund, and are available for the fiscal years indicated for each purpose.

2.10 The figures "2024" and "2025" used in this article mean that the appropriations listed under  
2.11 them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively.

2.12 "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium"  
2.13 is fiscal years 2024 and 2025.

2.14 **APPROPRIATIONS**

2.15 **Available for the Year**

2.16 **Ending June 30**

2.17 **2024**

**2025**

2.18 **Sec. 2. COMMISSIONER OF HEALTH**

2.19 **Subdivision 1. Total Appropriation** **\$ 457,377,000 \$ 454,644,000**

2.20 **Appropriations by Fund**

2.21		<u>2024</u>	<u>2025</u>
2.22	<u>General</u>	<u>310,084,000</u>	<u>300,108,000</u>
2.23	<u>State Government</u>		
2.24	<u>Special Revenue</u>	<u>83,373,000</u>	<u>85,902,000</u>
2.25	<u>Health Care Access</u>	<u>52,207,000</u>	<u>56,921,000</u>
2.26	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

2.27 The amounts that may be spent for each  
2.28 purpose are specified in the following  
2.29 subdivisions.

2.30 **Subd. 2. Health Improvement**

2.31 **Appropriations by Fund**

2.32	<u>General</u>	<u>240,491,000</u>	<u>230,169,000</u>
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3.1	<u>State Government</u>		
3.2	<u>Special Revenue</u>	<u>12,392,000</u>	<u>12,682,000</u>
3.3	<u>Health Care Access</u>	<u>52,207,000</u>	<u>56,921,000</u>
3.4	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

3.5 **(a) Base Level Adjustments.** The general  
 3.6 fund base is \$218,487,000 in fiscal year 2026  
 3.7 and \$218,257,000 in fiscal year 2027. The  
 3.8 health care access fund base is \$56,976,000  
 3.9 in fiscal year 2026 and \$56,375,000 in fiscal  
 3.10 year 2027.

3.11 **(b) Telehealth; Payment Parity.** Of the  
 3.12 amount appropriated in Laws 2021, First  
 3.13 Special Session chapter 7, article 16, section  
 3.14 3, subdivision 2, \$1,200,000 from the general  
 3.15 fund in fiscal year 2023 is for the studies of  
 3.16 telehealth expansion and payment parity and  
 3.17 is available for use until June 30, 2024.

3.18 **(c) Address Growing Health Care Costs.**  
 3.19 \$2,110,000 in fiscal year 2024 and \$3,150,000  
 3.20 in fiscal year 2025 are from the general fund  
 3.21 to address health care spending growth under  
 3.22 Minnesota Statutes, section 62J.0411.

3.23 **(d) Adolescent Mental Health Promotion.**  
 3.24 \$2,790,000 in fiscal year 2024 and \$2,790,000  
 3.25 in fiscal year 2025 are from the general fund  
 3.26 for adolescent mental health promotion under  
 3.27 Minnesota Statutes, section 145.57. Of the  
 3.28 total appropriation each year, \$2,250,000 is  
 3.29 for grants and \$540,000 is for administration.

3.30 **(e) Advancing Equity Through Capacity**  
 3.31 **Building and Resource Allocation.**  
 3.32 \$1,486,000 in fiscal year 2024 and \$1,486,000  
 3.33 in fiscal year 2025 are from the general fund  
 3.34 to advance equity in procurement and  
 3.35 grantmaking under Minnesota Statutes, section

4.1 144.9821. Of the total appropriation each year,  
4.2 \$500,000 is for grants and \$1,382,000 is for  
4.3 administration. The base for this appropriation  
4.4 is \$1,510,000 in fiscal year 2026 and  
4.5 \$1,510,000 in fiscal year 2027. Of the total  
4.6 appropriated in fiscal year 2026 and fiscal year  
4.7 2027, \$500,000 is for grants and \$1,010,000  
4.8 is for administration.

4.9 **(f) Advancing Equity through Community**  
4.10 **Engagement and Systems Transformation.**  
4.11 \$1,602,000 in fiscal year 2024 and \$1,602,000  
4.12 in fiscal year 2025 are from the general fund  
4.13 to advance equitable and inclusive community  
4.14 engagement under Minnesota Statutes, section  
4.15 144.9282. Of the total appropriation each year  
4.16 in fiscal year 2024 and fiscal year 2025,  
4.17 \$930,000 is for grants and \$672,000 is for  
4.18 administration. The base for this appropriation  
4.19 is \$1,930,000 in fiscal year 2026 and  
4.20 \$1,930,000 in fiscal year 2027. Of this total  
4.21 appropriation in fiscal year 2026 and fiscal  
4.22 year 2027, \$1,000,000 is for grants and  
4.23 \$930,000 is for administration.

4.24 **(g) Community Health Workers.** \$971,000  
4.25 in fiscal year 2024 and \$971,000 in fiscal year  
4.26 2025 are to expand and strengthen the  
4.27 community health workforce across Minnesota  
4.28 under Minnesota Statutes, section 144.1462.

4.29 **(h) Community Mental Well-being.**  
4.30 \$2,350,000 in fiscal year 2024 and \$2,350,000  
4.31 in fiscal year 2025 are from the general fund  
4.32 for mental health resources and  
4.33 post-COVID-19 recovery and healing for  
4.34 communities that have been disproportionately  
4.35 impacted by COVID-19 under Minnesota

5.1 Statutes, section 145.361. Of the total  
5.2 appropriated each year, \$1,680,000 is for  
5.3 grants and \$670,000 is for administration. This  
5.4 is a onetime appropriation.

5.5 **(i) Community Solutions for Healthy Child**  
5.6 **Development Grants.** \$4,980,000 in fiscal  
5.7 year 2024 and \$5,055,000 in fiscal year 2025  
5.8 are from the general fund to improve child  
5.9 development outcomes and well-being of  
5.10 children of color and American Indian children  
5.11 and their families, under Minnesota Statutes,  
5.12 section 145.9257. Of the total appropriation  
5.13 in fiscal year 2024, \$4,000,000 is for grants  
5.14 and \$980,000 is for administration and in  
5.15 fiscal year 2025, \$4,000,000 is for grants and  
5.16 \$1,055,000 is for administration.

5.17 **(j) Comprehensive Overdose and Morbidity**  
5.18 **Prevention Act.** \$11,428,000 in fiscal year  
5.19 2024 and \$10,770,000 in fiscal year 2025 are  
5.20 from the general fund for comprehensive  
5.21 overdose and morbidity prevention strategies  
5.22 under Minnesota Statutes, section 144.0526.  
5.23 Of the total appropriation in fiscal year 2024,  
5.24 \$7,580,000 is for grants and \$3,848,000 is for  
5.25 administration and in fiscal year 2025,  
5.26 \$7,580,000 is for grants and \$3,190,000 is for  
5.27 administration. The base for this appropriation  
5.28 is \$9,708,000 in fiscal year 2026 and  
5.29 \$9,708,000 in fiscal year 2027. Of the total  
5.30 base appropriation in fiscal year 2026 and  
5.31 fiscal year 2027, \$7,480,000 is for grants and  
5.32 \$2,228,000 is for administration.

5.33 **(k) COVID-19 Pandemic Delayed**  
5.34 **Preventive Care.** \$7,500,000 in fiscal year  
5.35 2024 and \$7,500,000 in fiscal year 2025 are

6.1 from the general fund to support  
6.2 community-based organizations and health  
6.3 care to increase access to preventive and  
6.4 chronic disease management services for  
6.5 communities disproportionately impacted by  
6.6 COVID-19. Of the total appropriation each  
6.7 year, \$6,100,000 is for grants and \$1,400,000  
6.8 is for administration. This is a onetime  
6.9 appropriation.

6.10 **(l) Emergency Preparedness and Response.**  
6.11 \$16,825,000 in fiscal year 2024 and  
6.12 \$16,662,000 in fiscal year 2025 are from the  
6.13 general fund for public health emergency  
6.14 preparedness and response, the sustainability  
6.15 of the strategic stockpile, and COVID-19  
6.16 pandemic response transition. Of this total  
6.17 appropriation in fiscal year 2024, \$8,400,000  
6.18 is for grants and \$8,425,000 is for  
6.19 administration and in fiscal year 2025,  
6.20 \$8,400,000 is for grants and \$8,262,000 is for  
6.21 administration. The general fund base for this  
6.22 appropriation is \$15,141,000 in fiscal year  
6.23 2026 and \$15,141,000 in fiscal year 2027. Of  
6.24 the total general fund base appropriated in  
6.25 fiscal year 2026 and fiscal year 2027 under  
6.26 this paragraph, \$8,400,000 is for grants and  
6.27 \$6,741,000 is for administration.

6.28 **(m) Healthy Beginnings, Healthy Families.**  
6.29 \$12,052,000 in fiscal year 2024 and  
6.30 \$11,853,000 in fiscal year 2025 are from the  
6.31 general fund for a comprehensive approach to  
6.32 ensure healthy outcomes for children and  
6.33 families under Minnesota Statutes, section  
6.34 145.9571. Of the total appropriation in fiscal  
6.35 year 2024, \$8,750,000 is for grants and

7.1 \$3,302,000 is for administration and in fiscal  
7.2 year 2025, \$8,750,000 is for grants and  
7.3 \$3,103,000 is for administration. The general  
7.4 fund base for this appropriation is \$11,798,000  
7.5 in fiscal year 2026 and \$11,798,000 in fiscal  
7.6 year 2027. Of the total general fund base  
7.7 appropriation in fiscal year 2024 and in fiscal  
7.8 year 2025, \$8,750,000 is for grants and  
7.9 \$3,048,000 is for administration.

7.10 **(n) Help Me Connect.** \$463,000 in fiscal year  
7.11 2024 and \$921,000 in fiscal year 2025 are  
7.12 from the general fund for the Help Me  
7.13 Connect program under Minnesota Statutes,  
7.14 section 145.988.

7.15 **(o) Home Visiting.** \$12,500,000 in fiscal year  
7.16 2024 and \$12,500,000 in fiscal year 2025 are  
7.17 from the general fund to start up or expand  
7.18 home visiting programs for priority  
7.19 populations under Minnesota Statutes, section  
7.20 145.87. Of the total appropriation,  
7.21 \$11,250,000 each year is for grants and  
7.22 \$1,250,000 is for administration.

7.23 **(p) Improving the Health and Well-being**  
7.24 **of People with Disabilities.** \$1,278,000 in  
7.25 fiscal year 2024 and \$1,278,000 in fiscal year  
7.26 2025 are from the general fund to improve the  
7.27 health and well-being of people with  
7.28 disabilities under Minnesota Statutes, section  
7.29 144.0753. Of the total appropriation in fiscal  
7.30 year 2024 and in fiscal year 2025, \$500,000  
7.31 is for grants and \$778,000 is for  
7.32 administration. The general fund base for this  
7.33 appropriation is \$1,434,000 in fiscal year 2026  
7.34 and \$1,434,000 in fiscal year 2027. Of the  
7.35 total base appropriation in fiscal year 2024

8.1 and in fiscal year 2025, \$335,000 is for grants  
8.2 and \$1,099,000 is for administration.

8.3 **(q) No Surprises Act Enforcement.**

8.4 \$1,210,000 in fiscal year 2024 and \$1,090,000  
8.5 in fiscal year 2025 are from the general fund  
8.6 for implementation of the federal No Surprises  
8.7 Act portion of the Consolidated  
8.8 Appropriations Act, 2021, under Minnesota  
8.9 Statutes, section 62Q.021, and assessment of  
8.10 feasibility of a statewide provider directory.  
8.11 The general fund base for this appropriation  
8.12 is \$855,000 in fiscal year 2026 and \$855,000  
8.13 in fiscal year 2027.

8.14 **(r) African American Health.** \$2,182,000 in  
8.15 fiscal year 2024 and \$2,182,000 in fiscal year  
8.16 2025 are from the general fund to establish an  
8.17 Office of African American Health at the  
8.18 Minnesota Department of Health under  
8.19 Minnesota Statutes, section 144.0756. Of the  
8.20 total appropriation in fiscal year 2024 and in  
8.21 fiscal year 2025, \$1,000,000 each year is for  
8.22 grants and \$1,182,000 is for administration.  
8.23 The general fund base for this appropriation  
8.24 is \$2,182,000 in fiscal year 2026 and  
8.25 \$2,117,000 in fiscal year 2027. Of the total  
8.26 base appropriation in fiscal year 2026,  
8.27 \$1,000,000 is for grants and \$1,182,000 is for  
8.28 administration and in fiscal year 2027,  
8.29 \$1,000,000 is for grants and \$1,117,000 is for  
8.30 administration.

8.31 **(s) American Indian Health.** \$2,089,000 in  
8.32 fiscal year 2024 and \$2,089,000 in fiscal year  
8.33 2025 are from the general fund for the Office  
8.34 of American Indian Health at the Minnesota  
8.35 Department of Health under Minnesota



9.1 Statutes, section 144.0757. Of the total  
9.2 appropriation each year, \$1,000,000 is for  
9.3 grants and \$1,089,000 is for administration.

9.4 **(t) Public Health System Transformation.**  
9.5 \$17,120,000 in fiscal year 2024 and  
9.6 \$17,120,000 in fiscal year 2025 are from the  
9.7 general fund for public health system  
9.8 transformation. Of the total appropriation in  
9.9 this paragraph:

9.10 (1) \$15,000,000 is for grants to community  
9.11 health boards under Minnesota Statutes,  
9.12 section 145A.131, subdivision 1, paragraph  
9.13 (f);

9.14 (2) \$750,000 is for grants to Tribal  
9.15 governments under Minnesota Statutes, section  
9.16 145A.14, subdivision 2, paragraph (b);

9.17 (3) \$500,000 is for a public health AmeriCorps  
9.18 program grant under Minnesota Statutes,  
9.19 section 144.0759; and

9.20 (4) \$870,000 is for oversight and  
9.21 administration of activities under this  
9.22 paragraph.

9.23 **(u) Health Care Workforce.** \$13,350,000 in  
9.24 fiscal year 2024 and \$15,364,000 in fiscal year  
9.25 2025 are from the health care access fund to  
9.26 revitalize the Minnesota health care workforce.  
9.27 The health care access fund base for this  
9.28 appropriation is \$14,819,000 in fiscal year  
9.29 2026 and \$14,818,000 in fiscal year 2027. Of  
9.30 the amounts appropriated in this paragraph:

9.31 (1) \$1,500,000 in fiscal year 2024, \$4,050,000  
9.32 in fiscal year 2025, \$5,850,000 in fiscal year  
9.33 2026, and \$5,850,000 in fiscal year 2027 are  
9.34 for rural training tracks and rural clinicals

10.1 grants under Minnesota Statutes, section  
10.2 144.1508;

10.3 (2) \$420,000 in fiscal year 2024, \$420,000 in  
10.4 fiscal year 2025, \$420,000 in fiscal year 2026,  
10.5 and \$420,000 in fiscal year 2027 are for  
10.6 immigrant international medical graduate  
10.7 training grants under Minnesota Statutes,  
10.8 section 144.1911;

10.9 (3) \$7,500,000 in fiscal year 2024, \$6,689,000  
10.10 in fiscal year 2025, \$5,752,000 in fiscal year  
10.11 2026, and \$5,854,000 in fiscal year 2027 are  
10.12 for site-based clinical training grants under  
10.13 Minnesota Statutes, section 144.1505;

10.14 (4) \$1,000,000 in fiscal year 2024, \$1,000,000  
10.15 in fiscal year 2025, \$0 in fiscal year 2026, and  
10.16 \$0 in fiscal year 2027 are for mental health  
10.17 for health care professional grants. Amounts  
10.18 in this paragraph are available until June 30,  
10.19 2027;

10.20 (5) \$920,000 in fiscal year 2024, \$920,000 in  
10.21 fiscal year 2025, \$920,000 in fiscal year 2026,  
10.22 and \$920,000 in fiscal year 2027 are for  
10.23 primary care employee recruitment education  
10.24 loan forgiveness under Minnesota Statutes,  
10.25 section 144.1504;

10.26 (6) 1,508,000 in fiscal year 2024, \$1,783,000  
10.27 in fiscal year 2025, \$1,375,000 in fiscal year  
10.28 2026, and \$1,272,000 in fiscal year 2027 are  
10.29 for administration of grants and loan  
10.30 forgiveness in this section; and

10.31 (7) \$502,000 in fiscal year 2024, \$502,000 in  
10.32 fiscal year 2025, \$502,000 in fiscal year 2026,  
10.33 and \$502,000 in fiscal year 2027 are for  
10.34 workforce research and data on shortages,

11.1 maldistribution of health care providers in  
11.2 Minnesota, and determinants of practicing in  
11.3 rural areas.

11.4 (v) **School Health.** \$1,432,000 in fiscal year  
11.5 2024 and \$1,932,000 in fiscal year 2025 are  
11.6 from the general fund for school-based health  
11.7 centers under Minnesota Statutes, section  
11.8 145.903. Of the total appropriation in fiscal  
11.9 year 2024 and in fiscal year 2025, \$800,000  
11.10 is for grants and \$632,000 is for  
11.11 administration. The general fund base for this  
11.12 appropriation is \$2,983,000 in fiscal year 2026  
11.13 and \$2,983,000 in fiscal year 2027. Of the  
11.14 total base appropriation in fiscal year 2026  
11.15 and in fiscal year 2027, \$2,300,000 is for  
11.16 grants and \$683,000 is for administration.

11.17 (w) **Sentinel Event Reviews for**  
11.18 **Police-involved Deadly Encounters.**  
11.19 \$561,000 in fiscal year 2024 and \$561,000 in  
11.20 fiscal year 2025 are from the general fund to  
11.21 establish a Sentinel Event Review Committee  
11.22 under Minnesota Statutes, section 144.0551.  
11.23 Of the total appropriation each year, \$50,000  
11.24 is for grants and \$511,000 is for  
11.25 administration.

11.26 (x) **Long COVID.** \$3,146,000 in fiscal year  
11.27 2024 and \$3,146,000 in fiscal year 2025 are  
11.28 from the general fund to address long COVID  
11.29 and post-COVID conditions under Minnesota  
11.30 Statutes, section 145.361. Of the total  
11.31 appropriation in fiscal year 2024 and in fiscal  
11.32 year 2025, \$900,000 is for grants and  
11.33 \$2,246,000 is for administration.

11.34 (y) **Telehealth in Libraries.** \$911,000 in  
11.35 fiscal year 2024 and \$911,000 in fiscal year

12.1 2025 are appropriated from the general fund  
12.2 for a telehealth in libraries pilot program. Of  
12.3 the total appropriation in fiscal year 2024 and  
12.4 2025, \$750,000 is for grants and \$161,000 is  
12.5 for administration. The general fund base for  
12.6 this appropriation is \$131,000 for  
12.7 administration in fiscal year 2026 and \$0 in  
12.8 fiscal year 2027. Appropriations in this  
12.9 paragraph are available until June 30, 2027.

12.10 **(z) TANF Appropriations.** (1) TANF funds  
12.11 must be used as follows:

12.12 (i) \$3,579,000 in fiscal year 2024 and  
12.13 \$3,579,000 in fiscal year 2025 are from the  
12.14 TANF fund for home visiting and nutritional  
12.15 services listed under Minnesota Statutes,  
12.16 section 145.882, subdivision 7, clauses (6) and  
12.17 (7). Funds must be distributed to community  
12.18 health boards according to Minnesota Statutes,  
12.19 section 145A.131, subdivision 1;

12.20 (ii) \$2,000,000 in fiscal year 2024 and  
12.21 \$2,000,000 in fiscal year 2025 are from the  
12.22 TANF fund for decreasing racial and ethnic  
12.23 disparities in infant mortality rates under  
12.24 Minnesota Statutes, section 145.928,  
12.25 subdivision 7;

12.26 (iii) \$4,978,000 in fiscal year 2024 and  
12.27 \$4,978,000 in fiscal year 2025 are from the  
12.28 TANF fund for the family home visiting grant  
12.29 program under Minnesota Statutes, section  
12.30 145A.17. \$4,000,000 of the funding in each  
12.31 fiscal year must be distributed to community  
12.32 health boards under Minnesota Statutes,  
12.33 section 145A.131, subdivision 1. \$978,000 of  
12.34 the funding in each fiscal year must be  
12.35 distributed to Tribal governments under

13.1 Minnesota Statutes, section 145A.14,  
 13.2 subdivision 2a;  
 13.3 (iv) \$1,156,000 in fiscal year 2024 and  
 13.4 \$1,156,000 in fiscal year 2025 are from the  
 13.5 TANF fund for family planning grants under  
 13.6 Minnesota Statutes, section 145.925; and  
 13.7 (v) the commissioner may use up to 6.23  
 13.8 percent of the funds appropriated from the  
 13.9 TANF fund each fiscal year to conduct the  
 13.10 ongoing evaluations required under Minnesota  
 13.11 Statutes, section 145A.17, subdivision 7, and  
 13.12 training and technical assistance as required  
 13.13 under Minnesota Statutes, section 145A.17,  
 13.14 subdivisions 4 and 5.

13.15 (2) TANF Carryforward. Any unexpended  
 13.16 balance of the TANF appropriation in the first  
 13.17 year does not cancel but is available in the  
 13.18 second year.

13.19 Subd. 3. **Health Protection**

	<u>Appropriations by Fund</u>	
13.20		
13.21	<u>General</u>	<u>51,101,000</u> <u>51,534,000</u>
13.22	<u>State Government</u>	
13.23	<u>Special Revenue</u>	<u>70,981,000</u> <u>73,220,000</u>

13.24 (a) **Base Level Adjustments.** The general  
 13.25 fund base is \$36,773,000 in fiscal year 2026  
 13.26 and \$36,669,000 in fiscal year 2027.

13.27 (b) **Climate Resiliency.** \$8,924,000 in fiscal  
 13.28 year 2024 and \$8,924,000 in fiscal year 2025  
 13.29 are from the general fund for climate resiliency  
 13.30 actions under Minnesota Statutes, section  
 13.31 144.9981. Of the fiscal year 2024 and 2025  
 13.32 appropriations, \$1,424,000 is for  
 13.33 administration and \$7,500,000 is for grants.  
 13.34 The general fund base for this appropriation

- 14.1 is \$2,292,000 in fiscal year 2026 and  
14.2 \$2,292,000 in fiscal year 2027, of which  
14.3 \$1,292,000 is for administration and  
14.4 \$1,000,000 is for grants.
- 14.5 **(c) Homeless Mortality Study.** \$134,000 in  
14.6 fiscal year 2024 and \$149,000 in fiscal year  
14.7 2025 are from the general fund for a homeless  
14.8 mortality study. The general fund base for this  
14.9 appropriation is \$104,000 in fiscal year 2026  
14.10 and \$0 in fiscal year 2027.
- 14.11 **(d) Lead Remediation in Schools and Child**  
14.12 **Care Settings.** \$500,000 in fiscal year 2024  
14.13 and \$500,000 in fiscal year 2025 are from the  
14.14 general fund to reduce lead in drinking water  
14.15 in schools and child care facilities under  
14.16 Minnesota Statutes, section 145.9272. Of the  
14.17 total appropriation in fiscal year 2024,  
14.18 \$146,000 is for grants and \$354,000 is for  
14.19 administration and in fiscal year 2025,  
14.20 \$239,000 is for grants and \$261,000 is for  
14.21 administration.
- 14.22 **(e) Lead Service Line Inventory.** \$3,000,000  
14.23 in fiscal year 2024 and \$3,000,000 in fiscal  
14.24 year 2025 are from the general fund for lead  
14.25 service line inventories under Minnesota  
14.26 Statutes, section 144.383. Of the total  
14.27 appropriation in fiscal year 2024 and in fiscal  
14.28 year 2025, \$2,678,000 is for grants and  
14.29 \$322,000 is for administration. This is a  
14.30 onetime appropriation.
- 14.31 **(f) Antimicrobial Stewardship.** \$312,000 in  
14.32 fiscal year 2024 and \$312,000 in fiscal year  
14.33 2025 are from the general fund for the  
14.34 Minnesota One Health Antibiotic Stewardship

15.1 Collaborative under Minnesota Statutes,  
 15.2 section 144.0526.

15.3 **(g) Strengthening Public Drinking Water**  
 15.4 **Systems Infrastructure.** \$8,155,000 in fiscal  
 15.5 year 2024 and \$8,155,000 in fiscal year 2025  
 15.6 are from the general fund to strengthen the  
 15.7 infrastructure and security of public water  
 15.8 systems and their source water protection areas  
 15.9 under Minnesota Statutes, section 144.3832.

15.10 Of the total appropriation in fiscal year 2024  
 15.11 and in fiscal year 2025, \$2,630,000 is for  
 15.12 administration and \$5,525,000 is for grants.

15.13 The general fund base for this appropriation  
 15.14 is \$3,323,000 in fiscal year 2026 and

15.15 \$3,323,000 in fiscal year 2027. Of the total  
 15.16 base appropriation in fiscal year 2026 and in  
 15.17 fiscal year 2027, \$1,348,000 is for

15.18 administration and \$1,975,000 is for grants.

15.19 **Subd. 4. Health Operations**

15.20 Appropriations by Fund

15.21 General                      18,492,000      18,405,000

15.22 **Sec. 3. HEALTH-RELATED BOARDS**

15.23 Subdivision 1. Total Appropriation                      \$      30,824,000 \$      31,572,000

15.24 Appropriations by Fund

15.25 State Government

15.26 Special Revenue                      30,748,000      31,534,000

15.27 Health Care Access                      76,000              38,000

15.28 This appropriation is from the state  
 15.29 government special revenue fund unless  
 15.30 specified otherwise. The amounts that may be  
 15.31 spent for each purpose are specified in the  
 15.32 following subdivisions.

16.1	<b><u>Subd. 2. Board of Behavioral Health and</u></b>		
16.2	<b><u>Therapy</u></b>	<u>1,022,000</u>	<u>1,044,000</u>
16.3	<b><u>Subd. 3. Board of Chiropractic Examiners</u></b>	<u>773,000</u>	<u>790,000</u>
16.4	<b><u>Subd. 4. Board of Dentistry</u></b>	<u>4,100,000</u>	<u>4,163,000</u>
16.5	<b><u>(a) Administrative services unit; operating</u></b>		
16.6	<b><u>costs. Of this appropriation, \$1,936,000 in</u></b>		
16.7	<b><u>fiscal year 2024 and \$1,960,000 in fiscal year</u></b>		
16.8	<b><u>2025 are for operating costs of the</u></b>		
16.9	<b><u>administrative services unit. The</u></b>		
16.10	<b><u>administrative services unit may receive and</u></b>		
16.11	<b><u>expend reimbursements for services it</u></b>		
16.12	<b><u>performs for other agencies.</u></b>		
16.13	<b><u>(b) Administrative services unit; volunteer</u></b>		
16.14	<b><u>health care provider program. Of this</u></b>		
16.15	<b><u>appropriation, \$150,000 in fiscal year 2024</u></b>		
16.16	<b><u>and \$150,000 in fiscal year 2025 are to pay</u></b>		
16.17	<b><u>for medical professional liability coverage</u></b>		
16.18	<b><u>required under Minnesota Statutes, section</u></b>		
16.19	<b><u>214.40.</u></b>		
16.20	<b><u>(c) Administrative services unit; retirement</u></b>		
16.21	<b><u>costs. Of this appropriation, \$237,000 in fiscal</u></b>		
16.22	<b><u>year 2024 and \$237,000 in fiscal year 2025</u></b>		
16.23	<b><u>are for the administrative services unit to pay</u></b>		
16.24	<b><u>for the retirement costs of health-related board</u></b>		
16.25	<b><u>employees. This funding may be transferred</u></b>		
16.26	<b><u>to the health board incurring retirement costs.</u></b>		
16.27	<b><u>Any board that has an unexpended balance for</u></b>		
16.28	<b><u>an amount transferred under this paragraph</u></b>		
16.29	<b><u>shall transfer the unexpended amount to the</u></b>		
16.30	<b><u>administrative services unit. If the amount</u></b>		
16.31	<b><u>appropriated in the first year of the biennium</u></b>		
16.32	<b><u>is not sufficient, the amount from the second</u></b>		
16.33	<b><u>year of the biennium is available.</u></b>		
16.34	<b><u>(d) Administrative services unit; contested</u></b>		
16.35	<b><u>cases and other legal proceedings. Of this</u></b>		



17.1 appropriation, \$200,000 in fiscal year 2024  
 17.2 and \$200,000 in fiscal year 2025 are for costs  
 17.3 of contested case hearings and other  
 17.4 unanticipated costs of legal proceedings  
 17.5 involving health-related boards funded under  
 17.6 this section. Upon certification by a  
 17.7 health-related board to the administrative  
 17.8 services unit that costs will be incurred and  
 17.9 that there is insufficient money available to  
 17.10 pay for the costs out of money currently  
 17.11 available to that board, the administrative  
 17.12 services unit is authorized to transfer money  
 17.13 from this appropriation to the board for  
 17.14 payment of those costs with the approval of  
 17.15 the commissioner of management and budget.  
 17.16 The commissioner of management and budget  
 17.17 must require any board that has an unexpended  
 17.18 balance for an amount transferred under this  
 17.19 paragraph to transfer the unexpended amount  
 17.20 to the administrative services unit to be  
 17.21 deposited in the state government special  
 17.22 revenue fund.

17.23	<b><u>Subd. 5. Board of Dietetics and Nutrition</u></b>		
17.24	<b><u>Practice</u></b>	<u>213,000</u>	<u>217,000</u>
17.25	<b><u>Subd. 6. Board of Executives for Long-term</u></b>		
17.26	<b><u>Services and Supports</u></b>	<u>705,000</u>	<u>736,000</u>
17.27	<b><u>Subd. 7. Board of Marriage and Family Therapy</u></b>	<u>443,000</u>	<u>456,000</u>
17.28	<b><u>Subd. 8. Board of Medical Practice</u></b>	<u>5,779,000</u>	<u>5,971,000</u>
17.29	<b><u>Subd. 9. Board of Nursing</u></b>	<u>6,039,000</u>	<u>6,275,000</u>
17.30	<b><u>Subd. 10. Board of Occupational Therapy</u></b>		
17.31	<b><u>Practice</u></b>	<u>468,000</u>	<u>480,000</u>
17.32	<b><u>Subd. 11. Board of Optometry</u></b>	<u>270,000</u>	<u>280,000</u>
17.33	<b><u>Subd. 12. Board of Pharmacy</u></b>		

18.1	<u>Appropriations by Fund</u>		
18.2	<u>State Government</u>		
18.3	<u>Special Revenue</u>	<u>5,266,000</u>	<u>5,206,000</u>
18.4	<u>Health Care Access</u>	<u>76,000</u>	<u>38,000</u>
18.5	<b><u>Base level adjustment.</u></b> <u>The state government</u>		
18.6	<u>special revenue fund base is \$5,056,000 in</u>		
18.7	<u>fiscal year 2026 and \$5,056,000 in fiscal year</u>		
18.8	<u>2027. The health care access fund base is \$0</u>		
18.9	<u>in fiscal year 2026 and \$0 in fiscal year 2027.</u>		
18.10	<u>Subd. 13. Board of Physical Therapy</u>	<u>678,000</u>	<u>694,000</u>
18.11	<u>Subd. 14. Board of Podiatric Medicine</u>	<u>253,000</u>	<u>257,000</u>
18.12	<u>Subd. 15. Board of Psychology</u>	<u>2,618,000</u>	<u>2,734,000</u>
18.13	<b><u>Health professionals service program.</u></b> <u>This</u>		
18.14	<u>appropriation includes \$1,234,000 in fiscal</u>		
18.15	<u>year 2024 and \$1,324,000 in fiscal year 2025</u>		
18.16	<u>for the health professional services program.</u>		
18.17	<u>Subd. 16. Board of Social Work</u>	<u>1,779,000</u>	<u>1,839,000</u>
18.18	<u>Subd. 17. Board of Veterinary Medicine</u>	<u>382,000</u>	<u>392,000</u>
18.19	<b><u>Sec. 4. EMERGENCY MEDICAL SERVICES</u></b>		
18.20	<b><u>REGULATORY BOARD</u></b>	<b><u>\$ 4,317,000</u></b>	<b><u>\$ 4,376,000</u></b>
18.21	<b><u>(a) Cooper/Sams Volunteer Ambulance</u></b>		
18.22	<b><u>Program.</u></b> <u>\$950,000 in fiscal year 2024 and</u>		
18.23	<u>\$950,000 in fiscal year 2025 are for the</u>		
18.24	<u>Cooper/Sams volunteer ambulance program</u>		
18.25	<u>under Minnesota Statutes, section 144E.40.</u>		
18.26	<u>(1) Of this amount, \$861,000 in fiscal year</u>		
18.27	<u>2024 and \$861,000 in fiscal year 2025 are for</u>		
18.28	<u>the ambulance service personnel longevity</u>		
18.29	<u>award and incentive program under Minnesota</u>		
18.30	<u>Statutes, section 144E.40.</u>		
18.31	<u>(2) Of this amount, \$89,000 in fiscal year 2024</u>		
18.32	<u>and \$89,000 in fiscal year 2025 are for</u>		
18.33	<u>operations of the ambulance service personnel</u>		

19.1 longevity award and incentive program under  
 19.2 Minnesota Statutes, section 144E.40.

19.3 (b) EMSRB Operations. \$2,421,000 in fiscal  
 19.4 year 2024 and \$2,480,000 in fiscal year 2025  
 19.5 are for board operations.

19.6 (c) Regional Grants for Continuing  
 19.7 Education. \$585,000 in fiscal year 2024 and  
 19.8 \$585,000 in fiscal year 2025 are for regional  
 19.9 emergency medical services programs to be  
 19.10 distributed equally to the eight emergency  
 19.11 medical service regions under Minnesota  
 19.12 Statutes, section 144E.52.

19.13 (d) Ambulance Training Grants. \$361,000  
 19.14 in fiscal year 2024 and \$361,000 in fiscal year  
 19.15 2025 are for training grants under Minnesota  
 19.16 Statutes, section 144E.35.

19.17 Sec. 5. COUNCIL ON DISABILITY                   \$           1,652,000 \$           2,032,000

19.18 Sec. 6. OMBUDSMAN FOR MENTAL  
 19.19 HEALTH AND DEVELOPMENTAL  
 19.20 DISABILITIES   \$           3,441,000 \$           3,644,000

19.21 Department of Psychiatry Monitoring.  
 19.22 \$100,000 in fiscal year 2024 and \$100,000 in  
 19.23 fiscal year 2025 are for monitoring the  
 19.24 Department of Psychiatry at the University of  
 19.25 Minnesota.

19.26 Sec. 7. OMBUDSPERSON FOR FAMILIES           \$           759,000 \$           776,000

19.27 Sec. 8. OMBUDSPERSON FOR AMERICAN  
 19.28 INDIAN FAMILIES   \$           336,000 \$           340,000

19.29 Sec. 9. OFFICE OF THE FOSTER YOUTH  
 19.30 OMBUDSPERSON   \$           742,000 \$           759,000

19.31 Sec. 10. MNSURE.

19.32                                   Appropriations by Fund

19.33 <u>General</u>	<u>11,095,000</u>	<u>14,296,000</u>
19.34 <u>Health Care Access</u>	<u>800,000</u>	<u>0</u>

20.1 (a) The health care access fund appropriation  
 20.2 is onetime and available until June 30, 2026.

20.3 (b) The general fund appropriations must be  
 20.4 transferred to the enterprise account  
 20.5 established under Minnesota Statutes, section  
 20.6 62V.07, for the purpose of establishing a  
 20.7 single end-to-end IT system with seamless,  
 20.8 real-time interoperability between qualified  
 20.9 health plan eligibility and enrollment services.

20.10 (c) **Base level adjustment.** The general fund  
 20.11 base is \$3,591,000 in fiscal year 2026 and  
 20.12 \$70,000 in fiscal year 2027.

20.13 <b>Sec. 11. <u>RARE DISEASE ADVISORY</u></b>					
20.14 <b><u>COUNCIL</u></b>	<b><u>\$</u></b>	<b><u>654,000</u></b>	<b><u>\$</u></b>	<b><u>602,000</u></b>	

20.15 <b>Sec. 12. <u>REVENUE</u></b>					
	<b><u>\$</u></b>	<b><u>40,000</u></b>	<b><u>\$</u></b>	<b><u>4,000</u></b>	

20.16 **Easy enrollment.** \$40,000 in fiscal year 2024  
 20.17 and \$4,000 in fiscal year 2025 are appropriated  
 20.18 from the general fund to the commissioner of  
 20.19 revenue for the administrative costs associated  
 20.20 with the easy enrollment program.

20.21 **Sec. 13. TRANSFERS; ADMINISTRATION.**

20.22 Positions, salary money, and nonsalary administrative money may be transferred within  
 20.23 the Department of Health as the commissioner considers necessary with the advance approval  
 20.24 of the commissioner of management and budget. The commissioner shall inform the chairs  
 20.25 and ranking minority members of the legislative committees with jurisdiction over health  
 20.26 finance quarterly about transfers made under this section.

20.27 **Sec. 14. INDIRECT COSTS NOT TO FUND PROGRAMS.**

20.28 The commissioner of health shall not use indirect cost allocations to pay for the  
 20.29 operational costs of any program for which they are responsible.

21.1 Sec. 15. EXPIRATION OF UNCODIFIED LANGUAGE.

21.2 All uncodified language contained in this article expires on June 30, 2025, unless a  
 21.3 different expiration date is explicit.

21.4 **ARTICLE 2**

21.5 **HEALTH DEPARTMENT POLICY**

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

21.7 Subd. 3. **Implementation.** To implement the requirements of this section, the  
 21.8 commissioner may cooperate with private health care providers and facilities, Tribal nations,  
 21.9 and community health boards as defined in section 145A.02<sub>2</sub>; provide grants to assist  
 21.10 community health boards; and Tribal nations; use volunteer services of individuals qualified  
 21.11 to provide public health services<sub>2</sub>; and enter into cooperative or mutual aid agreements to  
 21.12 provide public health services.

21.13 Sec. 2. [62J.0411] HEALTH CARE SPENDING GROWTH TARGET  
 21.14 COMMISSION.

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

21.17 (b) "Commission" means the Minnesota Health Care Spending Growth Target  
 21.18 Commission.

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

21.20 (d) "Provider" or "health care provider" means a health care professional who is licensed  
 21.21 or registered by the state to perform health care services within the provider's scope of  
 21.22 practice and in accordance with state law.

21.23 (e) "Health plan" means a health plan as defined in section 62A.011.

21.24 (f) "Health plan company" means a health carrier as defined under section 62A.011,  
 21.25 subdivision 2.

21.26 (g) "Health care system" means a medical facility as defined in section 144.561.

21.27 (h) "Hospital" means an entity licensed under sections 144.50 to 144.58.

21.28 Subd. 2. Commission membership. (a) The commissioner of health shall establish a  
 21.29 health care spending growth target commission that shall consist of 14 members representing  
 21.30 the following:

- 22.1 (1) two members who are persons with expertise and experience in advocating on behalf  
 22.2 of patients;
- 22.3 (2) two Minnesota residents who are health care consumers;
- 22.4 (3) two members of the business community who purchase health insurance for their  
 22.5 employees;
- 22.6 (4) two members representing public purchasers of health insurance for their employees;
- 22.7 (5) one licensed and certified health care provider employed at a federally qualified  
 22.8 health center;
- 22.9 (6) one member representing a health care system or urban hospitals;
- 22.10 (7) one member representing rural hospitals;
- 22.11 (8) one member representing health plans;
- 22.12 (9) one member who is an expert in health care financing and administration; and
- 22.13 (10) one member who is an expert in health economics.
- 22.14 (b) All members appointed must have the knowledge and demonstrated expertise in:
- 22.15 (1) health care finance, health economics, and health care management or administration  
 22.16 at a senior level;
- 22.17 (2) health care consumer advocacy;
- 22.18 (3) representing the health care workforce as a leader in a labor organization;
- 22.19 (4) purchasing health insurance representing business management or health benefits  
 22.20 administration;
- 22.21 (5) delivering primary care, health plan administration, or public or population health;  
 22.22 or
- 22.23 (6) addressing health disparities and structural inequities.
- 22.24 (c) No member may participate in commission proceedings involving an individual  
 22.25 provider, purchaser, or patient, or specific activity or transaction, if the member has direct  
 22.26 financial interest in the outcome of the commissions' proceedings other than as an individual  
 22.27 consumer of health care services.
- 22.28 Subd. 3. **Terms.** (a) The commissioner shall make recommendations for commission  
 22.29 membership. Commission members shall be appointed by the governor. The initial  
 22.30 appointments to the commission shall be made by September 1, 2023. The initial appointed

23.1 commission members shall serve staggered terms of two, three, or four years determined  
23.2 by lot by the secretary of state. Following the initial appointments, the commission members  
23.3 shall serve four-year terms. Members may not serve more than two consecutive terms.

23.4 (b) The commission is governed by section 15.059.

23.5 (c) A commission member may resign at any time by giving written notice to the  
23.6 commission.

23.7 Subd. 4. **Chair; other officers.** (a) The governor shall annually designate a member to  
23.8 serve as chair of the commission. The chair shall serve for one year. If there is a vacancy  
23.9 for any cause, the governor shall make an appointment to become immediately effective.

23.10 (b) The commission shall elect a vice-chair and other officers from its membership as  
23.11 it deems necessary.

23.12 Subd. 5. **Compensation.** Commission members may be compensated according to  
23.13 section 15.059.

23.14 Subd. 6. **Meetings.** (a) Meetings of the commission, including any public hearings, are  
23.15 subject to chapter 13D.

23.16 (b) The commission must meet publicly monthly on the creation of the program until  
23.17 the initial targets are established.

23.18 (c) After the growth targets are established, the commission shall hold no less than  
23.19 quarterly meetings at which it considers summary data presented by the commissioner and  
23.20 drafts main findings for their reporting, considers updates to the program and target levels,  
23.21 discusses findings with health care providers and payers, and identifies additional needed  
23.22 analysis and strategies to limit health care spending growth.

23.23 Subd. 7. **Duties of the commission.** (a) The commission is responsible for the  
23.24 development of the health care spending growth targets program, maintenance, and reporting  
23.25 on progress toward targets to the legislature and the public. Duties include all activities  
23.26 necessary for the successful implementation of the program in the state with the goal of  
23.27 limiting health care spending growth that includes:

23.28 (1) establishing a statement of purpose;

23.29 (2) developing a methodology to establish the health care spending growth targets, the  
23.30 economic indicators to be used in establishing the initial target level, as well as levels over  
23.31 time. The target must:

23.32 (i) use a clear and operational definition of total health care spending for the state;

- 24.1 (ii) promote a predictable and sustainable rate of growth for total health care spending  
24.2 as measured by an established economic indicator, such as the rate of increase of the state's  
24.3 economy or of the personal income of residents of the state, or a combination;
- 24.4 (iii) apply to all health care providers and health plan companies in the health care system  
24.5 in the state; and
- 24.6 (iv) be measurable on a per capita basis, statewide basis, health plan basis, and health  
24.7 care provider basis;
- 24.8 (3) establishing a methodology for calculating health care cost growth:
- 24.9 (i) statewide;
- 24.10 (ii) for each health care provider and health plan company, which, at the discretion of  
24.11 the commission, may account for variability by age and sex; and
- 24.12 (iii) taking into consideration the need for variability in targets across public and private  
24.13 payers;
- 24.14 (iv) incorporating health equity considerations; and
- 24.15 (v) considering the impact of targets on health care access and disparities;
- 24.16 (4) identifying data to be used for tracking performance under the targets and methods  
24.17 of data collection necessary for efficient implementation by the commissioner as specified  
24.18 in subdivision 9. In identifying data and methods, the commission shall:
- 24.19 (i) consider the availability, timeliness, quality, and usefulness of existing data;
- 24.20 (ii) assess the need for additional investments in data collection, data validation, or  
24.21 analysis capacity to support efficient collection and aggregation of data to support the  
24.22 commission's activities;
- 24.23 (iii) limit the reporting burden as much as possible; and
- 24.24 (iv) identify and define the entities which are required to report;
- 24.25 (5) establishing requirements for health care providers and health plan companies to  
24.26 report data and other information necessary to calculate health care cost growth, after  
24.27 accounting for analysis under clause (3). Health care providers and health plans must report  
24.28 data in the form and manner established by the commissioner;
- 24.29 (6) by June 15, 2024, establishing target levels consistent with the methodology in clause  
24.30 (2) for a five-year period with the goal of limiting health care spending growth;



25.1 (7) conducting, at a minimum, annual public hearings to present findings from spending  
25.2 growth target monitoring;

25.3 (8) reviewing, periodically, all components of the program methodology, including  
25.4 economic indicators and other factors, and, as appropriate, revise established target levels  
25.5 in clause (3). Any changes to target levels require a two-thirds majority vote of the  
25.6 commission;

25.7 (9) based on analysis of drivers of health care spending conducted by the commissioner  
25.8 and evidence from public testimony, explore strategies and new policies, and future legislative  
25.9 proposals that include the ability to establish accountability mechanisms that can contribute  
25.10 to achieving targets or limiting health care spending growth without increasing disparities  
25.11 in access to health care;

25.12 (10) exploring the addition of quality of care or primary care spending goals as part of  
25.13 the program; and

25.14 (11) completing the reports in subdivision 10.

25.15 (b) In developing the target program, the commission must:

25.16 (1) evaluate and ensure that the program does not place a disproportionate burden on  
25.17 communities most impacted by health disparities, the providers who primarily serve  
25.18 communities most impacted by health disparities, or individuals who reside in rural areas  
25.19 or have high health care needs;

25.20 (2) explicitly consider payment models that help ensure financial sustainability of rural  
25.21 health care delivery systems and the ability to provide population health; and

25.22 (3) consult with stakeholders representing patients, health care providers, payers of  
25.23 health care services, and others.

25.24 Subd. 8. **Administration.** The commissioner of health shall provide office space,  
25.25 equipment and supplies, as well as analytic staff support to the commission and the technical  
25.26 advisory council, established in section 62J.0412.

25.27 Subd. 9. **Duties of the commissioner.** (a) The commissioner, in consultation with the  
25.28 commissioners of commerce and human services, shall be responsible for providing  
25.29 administrative and staff support to the commission, including by performing and procuring  
25.30 consulting or analytic services. Duties include:

26.1 (1) establishing the form and manner of data reporting, including reporting methods and  
26.2 dates, consistent with program design and timelines formalized by the commission in  
26.3 subdivision 7;

26.4 (2) collecting data identified by the commission for use in the program in a form and  
26.5 manner that ensures the collection of high-quality, transparent data;

26.6 (3) providing analytical support, including by conducting background research or  
26.7 environmental scans, evaluating the suitability of available data, performing needed analysis  
26.8 and data modeling, calculating performance under the spending trends, and researching  
26.9 drivers of spending growth trends;

26.10 (4) synthesizing and reporting to the commission;

26.11 (5) assisting health care entities subject to the targets with reporting of data, internal  
26.12 analysis of spending growth trends, and, as necessary, methodological issues;

26.13 (6) supporting the commission's administrative duties and day-to-day operations including  
26.14 planning, directing, coordinating, and executing the program's essential functions; and

26.15 (7) making appointments and staffing the health care spending technical advisory council  
26.16 in section 62J.0412.

26.17 (b) In fulfilling the duties in paragraph (a), the commissioner may contract with entities  
26.18 with expertise in health economics, health finance, and actuarial science.

26.19 Subd. 10. **Reports.** (a) The commission shall be responsible for the following reports  
26.20 to the to the chairs and ranking members of the legislative committees with primary  
26.21 jurisdiction over health care. These reports should be freely available to the public and  
26.22 include:

26.23 (1) written progress updates about the development and implementation of the health  
26.24 care growth target program by February 15 of 2024 and 2025. The updates must include  
26.25 reporting on commission membership and activities, program design decisions, planned  
26.26 timelines for implementation of the program, and progress of implementation. The reports  
26.27 must include comprehensive methodological details underlying program design decisions;  
26.28 and

26.29 (2) by March 31, 2026, and annually thereafter, submit a report on health care spending  
26.30 trends subject to the health care growth targets that must include:

26.31 (i) spending growth in aggregate for entities subject to health care growth targets relative  
26.32 to established target levels;

27.1 (ii) findings from the analyses of cost drivers of health care spending growth;  
 27.2 (iii) estimates of the impact of health care spending growth on Minnesota residents,  
 27.3 including for those communities most impacted by health disparities, related to Minnesota  
 27.4 residents' access to insurance and care, value of health care, and ability to pursue other  
 27.5 spending priorities;

27.6 (iv) potential and observed impact of the health care growth targets on the financial  
 27.7 viability of the rural delivery system;

27.8 (v) changes under consideration for revising the methodology to monitor spending level  
 27.9 targets; and

27.10 (vi) recommended policy provisions that may affect health care spending growth trends,  
 27.11 including broader and more transparent adoption of value-based payment arrangements.

27.12 (b) The commission may delegate drafting of reports to the commissioner and any  
 27.13 contractors the commissioner deems necessary.

27.14 Subd. 11. Access to information. (a) The commission may request that a state agency  
 27.15 provide at no cost the commission with any publicly available information related to the  
 27.16 establishment of targets under this section or monitoring performance under those targets  
 27.17 in a usable format as requested by the commission or the commissioner.

27.18 (b) The commission or commissioner may request from a state agency unique or custom  
 27.19 data sets, and the agency may charge the commission or the commissioner for providing  
 27.20 the data at the same rate the agency would charge any other public or private entity.

27.21 (c) Any information provided to the commission by a state agency must be de-identified.  
 27.22 For purposes of this subdivision, "de-identified" means the process used to prevent the  
 27.23 identity of a person from being connected with information and ensuring all identifiable  
 27.24 information has been removed.

27.25 (d) Any data submitted to the commission or the commissioner shall retain their original  
 27.26 classification under the Minnesota Data Practices Act in chapter 13.

27.27 Subd. 12. Exemption on expiration. Notwithstanding section 15.059, the commission  
 27.28 shall not expire.

27.29 Sec. 3. [62J.0412] HEALTH CARE SPENDING TECHNICAL ADVISORY  
 27.30 COUNCIL.

27.31 Subdivision 1. Definitions. For purposes of this section, the following definitions have  
 27.32 the meanings given.

28.1 (a) "Council" means the Health Care Spending Technical Advisory Council.

28.2 (b) "Commission" means the Minnesota Health Care Spending Growth Target  
28.3 Commission.

28.4 Subd. 2. **Establishment.** The commissioner of health shall appoint a 15-member technical  
28.5 advisory council to provide technical advice to the commission. Members shall be appointed  
28.6 based on their knowledge and demonstrated expertise in one or more of the following areas:

28.7 (1) health care spending trends and drivers;

28.8 (2) equitable access to health care services;

28.9 (3) health insurance operation and finance;

28.10 (4) actuarial science;

28.11 (5) the practice of medicine;

28.12 (6) patient perspectives;

28.13 (7) clinical and health services research; and

28.14 (8) the health care marketplace.

28.15 Subd. 3. **Membership.** The council's membership shall consist of the following:

28.16 (1) two members representing patients and health care consumers, at least one of whom  
28.17 must have experience working with communities experiencing health disparities;

28.18 (2) the commissioner of health or a designee;

28.19 (3) the commissioner of human services or a designee;

28.20 (4) one member who is a health services researcher at the University of Minnesota;

28.21 (5) two members who represent nonprofit group purchasers;

28.22 (6) one member who represents for-profit group purchasers;

28.23 (7) two members who represent medical care systems;

28.24 (8) one member who represents independent health care providers; and

28.25 (9) two members who represent employee benefit plans, with one representing a public  
28.26 employer.

28.27 Subd. 4. **Terms.** (a) The initial appointments to the council shall be made by September  
28.28 30, 2023. The council members shall serve staggered terms of two, three, or four years

29.1 determined by lot by the secretary of state. Members may not serve more than two  
 29.2 consecutive terms.

29.3 (b) All council member terms will end on September 30, 2027.

29.4 (c) Removal and vacancies of council members is governed by section 15.059.

29.5 Subd. 5. **Meetings.** The council shall meet up to six meetings per calendar year at the  
 29.6 request of the commission.

29.7 Subd. 6. **Duties.** The council shall:

29.8 (1) provide technical advice to the commission on the development and implementation  
 29.9 of the health care cost growth targets, designs, drivers of spending, reporting, and other  
 29.10 items related to the commission duties;

29.11 (2) provide technical input on data sources for measuring health care spending; and

29.12 (3) advise how to measure the impact on:

29.13 (i) communities most impacted by health disparities;

29.14 (ii) the providers who primarily serve communities most impacted by health disparities;

29.15 (iii) individuals with disabilities;

29.16 (iv) individuals with health coverage through medical assistance or MinnesotaCare; or

29.17 (v) individuals who reside in rural areas.

29.18 Sec. 4. **[62J.0413] IDENTIFY STRATEGIES FOR REDUCTION OF**  
 29.19 **ADMINISTRATIVE SPENDING AND LOW-VALUE CARE.**

29.20 (a) The commissioner of health shall develop recommendations for strategies to reduce  
 29.21 the volume and growth of administrative spending by health care organizations and group  
 29.22 purchasers, and the magnitude of low-value care delivered to Minnesota residents. The  
 29.23 commissioner shall:

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

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

29.28 (3) conduct an environmental scan and key informant interviews with experts in health  
 29.29 care finance, health economics, health care management or administration, and the

30.1 administration of health insurance benefits to determine drivers of spending growth for  
 30.2 spending on administrative services or the provision of low-value care; and

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

30.7 (b) By March 31, 2025, the commissioner shall deliver the recommendations to the  
 30.8 chairs and ranking minority members of house and senate committees with jurisdiction over  
 30.9 health and human services finance and policy.

30.10 **Sec. 5. [62J.0414] PAYMENT MECHANISMS IN RURAL HEALTH CARE.**

30.11 (a) The commissioner shall develop a plan to assess readiness of rural communities and  
 30.12 rural health care providers to adopt value based, global budgeting or alternative payment  
 30.13 systems and recommend steps needed to implement them. The commissioner may use the  
 30.14 development of case studies and modeling of alternate payment systems to demonstrate  
 30.15 value-based payment systems that ensure a baseline level of essential community or regional  
 30.16 health services and address population health needs.

30.17 (b) The commissioner shall develop recommendations for pilot projects with the aim of  
 30.18 ensuring financial viability of rural health care systems in the context of spending growth  
 30.19 targets. The commissioner shall share findings with the Minnesota health care cost growth  
 30.20 target commission.

30.21 **Sec. 6. [62J.571] STATEWIDE HEALTH CARE PROVIDER DIRECTORY.**

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

30.24 (b) "Health care provider directory" means an electronic catalog and index that supports  
 30.25 management of health care provider information, both individual and organizational, in a  
 30.26 directory structure for public use to find available providers and networks and support state  
 30.27 agency responsibilities.

30.28 (c) "Health care provider" means a practicing provider that accepts reimbursement from  
 30.29 a group purchaser, as defined in section 62J.03, subdivision 6.

30.30 (d) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

31.1 Subd. 2. **Health care provider directory.** (a) The commissioner shall assess the  
31.2 feasibility and stakeholder commitment to develop, manage, and maintain a statewide  
31.3 electronic directory of health care providers. The assessment must take into consideration  
31.4 consumer information needs; state agency applications; stakeholder needs; technical  
31.5 requirements; alignment with national standards; governance; operations; legal and policy  
31.6 considerations; and existing directories.

31.7 Subd. 3. **Consultation.** The commissioner shall assess the feasibility of the directory in  
31.8 consultation with stakeholders, including but not limited to consumers, group purchasers,  
31.9 health care providers, community health boards, and state agencies.

31.10 **Sec. 7. [62J.811] PROVIDER BALANCE BILLING REQUIREMENTS.**

31.11 Subdivision 1. **Billing requirements.** (a) Each health care provider and health facility  
31.12 shall comply with Consolidated Appropriations Act, 2021, Division BB also known as the  
31.13 "No Surprises Act," including any federal regulations adopted under that act.

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

31.17 Subd. 2. **Investigations and compliance.** (a) The commissioner shall, to the extent  
31.18 practicable, seek the cooperation of health care providers and facilities, and may provide  
31.19 any support and assistance as available, in obtaining compliance with this section.

31.20 (b) The commissioner shall determine the manner and processes for fulfilling any  
31.21 responsibilities and taking any of the actions in paragraphs (c) to (f).

31.22 (c) A person who believes a health care provider or facility has not complied with the  
31.23 requirements of the No Surprises Act or this section may file a complaint with the  
31.24 commissioner in the manner determined by the commissioner.

31.25 (d) The commissioner shall conduct compliance reviews and investigate complaints  
31.26 filed under this section in the manner determined by the commissioner to ascertain whether  
31.27 health care providers and facilities are complying with this section.

31.28 (e) The commissioner may report violations under this section to other relevant federal  
31.29 and state departments and jurisdictions as appropriate, including the attorney general and  
31.30 relevant licensing boards, and may also coordinate on investigations and enforcement of  
31.31 this section with other relevant federal and state departments and jurisdictions as appropriate,  
31.32 including the attorney general and relevant licensing boards.

32.1 (f) A health care provider or facility may contest whether the finding of facts constitute  
 32.2 a violation of this section according to the contested case proceeding in sections 14.57 to  
 32.3 14.62, subject to appeal according to sections 14.63 to 14.68.

32.4 (g) Any data collected by the commissioner as part of an active investigation or active  
 32.5 compliance review under this section are classified as protected nonpublic data pursuant to  
 32.6 section 13.02, subdivision 13, in the case of data not on individuals and confidential pursuant  
 32.7 to section 13.02, subdivision 3, in the case of data on individuals. Data describing the final  
 32.8 disposition of an investigation or compliance review are classified as public.

32.9 Subd. 3. **Civil penalty.** (a) The commissioner, in monitoring and enforcing this section,  
 32.10 may levy a civil monetary penalty against each health care provider or facility found to be  
 32.11 in violation of up to \$100 for each violation, but may not exceed \$25,000 for identical  
 32.12 violations during a calendar year.

32.13 (b) No civil monetary penalty shall be imposed under this section for violations that  
 32.14 occur prior to January 1, 2024.

32.15 Sec. 8. Minnesota Statutes 2022, section 62J.84, subdivision 2, is amended to read:

32.16 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision  
 32.17 have the meanings given.

32.18 (b) "Biosimilar" means a drug that is produced or distributed pursuant to a biologics  
 32.19 license application approved under United States Code, title 42, section 262(K)(3).

32.20 (c) "Brand name drug" means a drug that is produced or distributed pursuant to:

32.21 (1) ~~an original~~, a new drug application approved under United States Code, title 21,  
 32.22 section 355(c), except for a generic drug as defined under Code of Federal Regulations,  
 32.23 title 42, section 447.502; or

32.24 (2) a biologics license application approved under United States Code, title ~~45~~ 42, section  
 32.25 262(a)(c).

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

32.27 (e) "Generic drug" means a drug that is marketed or distributed pursuant to:

32.28 (1) an abbreviated new drug application approved under United States Code, title 21,  
 32.29 section 355(j);

32.30 (2) an authorized generic as defined under Code of Federal Regulations, title ~~45~~ 42,  
 32.31 section 447.502; or



33.1 (3) a drug that entered the market the year before 1962 and was not originally marketed  
33.2 under a new drug application.

33.3 (f) "Manufacturer" means a drug manufacturer licensed under section 151.252.

33.4 (g) "New prescription drug" or "new drug" means a prescription drug approved for  
33.5 marketing by the United States Food and Drug Administration (FDA) for which no previous  
33.6 wholesale acquisition cost has been established for comparison.

33.7 (h) "Patient assistance program" means a program that a manufacturer offers to the public  
33.8 in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs  
33.9 by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other  
33.10 means.

33.11 (i) "Prescription drug" or "drug" has the meaning provided in section 151.441, subdivision  
33.12 8.

33.13 (j) "Price" means the wholesale acquisition cost as defined in United States Code, title  
33.14 42, section 1395w-3a(c)(6)(B).

33.15 (k) "30-day supply" means the total daily dosage units of a prescription drug  
33.16 recommended by the prescribing label approved by the FDA for 30 days. If the  
33.17 FDA-approved prescribing label includes more than one recommended daily dosage, the  
33.18 30-day supply is based on the maximum recommended daily dosage on the FDA-approved  
33.19 prescribing label.

33.20 (l) "Course of treatment" means the total dosage of a single prescription for a prescription  
33.21 drug recommended by the FDA-approved prescribing label. If the FDA-approved prescribing  
33.22 label includes more than one recommended dosage for a single course of treatment, the  
33.23 course of treatment is the maximum recommended dosage on the FDA-approved prescribing  
33.24 label.

33.25 (m) "Drug product family" means a group of one or more prescription drugs that share  
33.26 a unique generic drug description or nontrade name and dosage form.

33.27 (n) "National drug code" means the three-segment code maintained by the federal Food  
33.28 and Drug Administration that includes a labeler code, a product code, and a package code  
33.29 for a drug product and that has been converted to an 11-digit format consisting of five digits  
33.30 in the first segment, four digits in the second segment, and two digits in the third segment.  
33.31 A three-segment code shall be considered converted to an 11-digit format when, as necessary,  
33.32 at least one "0" has been added to the front of each segment containing less than the specified  
33.33 number of digits such that each segment contains the specified number of digits.

34.1 (o) "Pharmacy" or "pharmacy provider" means a place of business licensed by the Board  
 34.2 of Pharmacy under section 151.19 in which prescription drugs are prepared, compounded,  
 34.3 or dispensed under the supervision of a pharmacist.

34.4 (p) "Pharmacy benefits manager" or "PBM" means an entity licensed to act as a pharmacy  
 34.5 benefits manager under section 62W.03.

34.6 (q) "Pricing unit" means the smallest dispensable amount of a prescription drug product  
 34.7 that could be dispensed.

34.8 (r) "Reporting entity" means any manufacturer, pharmacy, pharmacy benefits manager,  
 34.9 wholesale drug distributor, or any other entity required to submit data under section 62J.84.

34.10 (s) "Wholesale drug distributor" or "wholesaler" means an entity that:

34.11 (1) is licensed to act as a wholesale drug distributor under section 151.47; and

34.12 (2) distributes prescription drugs, of which it is not the manufacturer, to persons or  
 34.13 entities, or both, other than a consumer or patient in the state.

34.14 Sec. 9. Minnesota Statutes 2022, section 62J.84, subdivision 3, is amended to read:

34.15 Subd. 3. **Prescription drug price increases reporting.** (a) Beginning January 1, 2022,  
 34.16 a drug manufacturer must submit to the commissioner the information described in paragraph  
 34.17 (b) for each prescription drug for which the price was \$100 or greater for a 30-day supply  
 34.18 or for a course of treatment lasting less than 30 days and:

34.19 (1) for brand name drugs where there is an increase of ten percent or greater in the price  
 34.20 over the previous 12-month period or an increase of 16 percent or greater in the price over  
 34.21 the previous 24-month period; and

34.22 (2) for generic or biosimilar drugs where there is an increase of 50 percent or greater in  
 34.23 the price over the previous 12-month period.

34.24 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to  
 34.25 the commissioner no later than 60 days after the price increase goes into effect, in the form  
 34.26 and manner prescribed by the commissioner, the following information, if applicable:

34.27 (1) the ~~name~~ description and price of the drug and the net increase, expressed as a  
 34.28 percentage, with the following listed separately:

34.29 (i) the national drug code;

34.30 (ii) the product name;

34.31 (iii) the dosage form;

- 35.1 (iv) the strength;
- 35.2 (v) the package size;
- 35.3 (2) the factors that contributed to the price increase;
- 35.4 (3) the name of any generic version of the prescription drug available on the market;
- 35.5 (4) the introductory price of the prescription drug when it was ~~approved for marketing~~
- 35.6 ~~by the Food and Drug Administration and the net yearly increase, by calendar year, in the~~
- 35.7 ~~price of the prescription drug during the previous five years~~ introduced for sale in the United
- 35.8 States and the price of the drug on the last day of each of the five calendar years preceding
- 35.9 the price increase;
- 35.10 (5) the direct costs incurred during the previous 12-month period by the manufacturer
- 35.11 that are associated with the prescription drug, listed separately:
- 35.12 (i) to manufacture the prescription drug;
- 35.13 (ii) to market the prescription drug, including advertising costs; and
- 35.14 (iii) to distribute the prescription drug;
- 35.15 (6) the total sales revenue for the prescription drug during the previous 12-month period;
- 35.16 (7) the manufacturer's net profit attributable to the prescription drug during the previous
- 35.17 12-month period;
- 35.18 (8) the total amount of financial assistance the manufacturer has provided through patient
- 35.19 prescription assistance programs during the previous 12-month period, if applicable;
- 35.20 (9) any agreement between a manufacturer and another entity contingent upon any delay
- 35.21 in offering to market a generic version of the prescription drug;
- 35.22 (10) the patent expiration date of the prescription drug if it is under patent;
- 35.23 (11) the name and location of the company that manufactured the drug; ~~and~~
- 35.24 (12) if a brand name prescription drug, the ~~ten highest prices~~ price paid for the
- 35.25 prescription drug during the previous calendar year in ~~any country other than~~ the ten
- 35.26 countries, excluding the United States., that charged the highest single price for the
- 35.27 prescription drug; and
- 35.28 (13) if the prescription drug was acquired by the manufacturer during the previous
- 35.29 12-month period, all of the following information:
- 35.30 (i) price at acquisition;

36.1 (ii) price in the calendar year prior to acquisition;

36.2 (iii) name of the company from which the drug was acquired;

36.3 (iv) date of acquisition; and

36.4 (v) acquisition price.

36.5 (c) The manufacturer may submit any documentation necessary to support the information  
36.6 reported under this subdivision.

36.7 Sec. 10. Minnesota Statutes 2022, section 62J.84, subdivision 4, is amended to read:

36.8 Subd. 4. **New prescription drug price reporting.** (a) Beginning January 1, 2022, no  
36.9 later than 60 days after a manufacturer introduces a new prescription drug for sale in the  
36.10 United States that is a new brand name drug with a price that is greater than the tier threshold  
36.11 established by the Centers for Medicare and Medicaid Services for specialty drugs in the  
36.12 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than  
36.13 30 days or a new generic or biosimilar drug with a price that is greater than the tier threshold  
36.14 established by the Centers for Medicare and Medicaid Services for specialty drugs in the  
36.15 Medicare Part D program for a 30-day supply or for a course of treatment lasting less than  
36.16 30 days and is not at least 15 percent lower than the referenced brand name drug when the  
36.17 generic or biosimilar drug is launched, the manufacturer must submit to the commissioner,  
36.18 in the form and manner prescribed by the commissioner, the following information, if  
36.19 applicable:

36.20 (1) the description of the drug, with the following listed separately:

36.21 (i) the national drug code;

36.22 (ii) the product name;

36.23 (iii) the dosage form;

36.24 (iv) the strength;

36.25 (v) the package size;

36.26 ~~(1)~~ (2) the price of the prescription drug;

36.27 ~~(2)~~ (3) whether the Food and Drug Administration granted the new prescription drug a  
36.28 breakthrough therapy designation or a priority review;

36.29 ~~(3)~~ (4) the direct costs incurred by the manufacturer that are associated with the  
36.30 prescription drug, listed separately:

- 37.1 (i) to manufacture the prescription drug;
- 37.2 (ii) to market the prescription drug, including advertising costs; and
- 37.3 (iii) to distribute the prescription drug; and
- 37.4 ~~(4)~~ (5) the patent expiration date of the drug if it is under patent.
- 37.5 (b) The manufacturer may submit documentation necessary to support the information
- 37.6 reported under this subdivision.

37.7 Sec. 11. Minnesota Statutes 2022, section 62J.84, subdivision 6, is amended to read:

37.8 Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner

37.9 shall post on the department's website, or may contract with a private entity or consortium

37.10 that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the

37.11 following information:

37.12 (1) a list of the prescription drugs reported under subdivisions ~~3, 4, and 5~~, to 6 and 9 to

37.13 14 and the manufacturers of those prescription drugs; and

37.14 (2) information reported to the commissioner under subdivisions ~~3, 4, and 5~~ to 6 and 9

37.15 to 14.

37.16 (b) The information must be published in an easy-to-read format and in a manner that

37.17 identifies the information that is disclosed on a per-drug basis and must not be aggregated

37.18 in a manner that prevents the identification of the prescription drug.

37.19 (c) The commissioner shall not post to the department's website or a private entity

37.20 contracting with the commissioner shall not post any information described in this section

37.21 if the information is not public data under section 13.02, subdivision 8a; or is trade secret

37.22 information under section 13.37, subdivision 1, paragraph (b); or is trade secret information

37.23 pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section

37.24 1836, as amended. If a manufacturer believes information should be withheld from public

37.25 disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify

37.26 that information and describe the legal basis in writing when the manufacturer submits the

37.27 information under this section. If the commissioner disagrees with the manufacturer's request

37.28 to withhold information from public disclosure, the commissioner shall provide the

37.29 manufacturer written notice that the information will be publicly posted 30 days after the

37.30 date of the notice.

37.31 (d) If the commissioner withholds any information from public disclosure pursuant to

37.32 this subdivision, the commissioner shall post to the department's website a report describing

38.1 the nature of the information and the commissioner's basis for withholding the information  
38.2 from disclosure.

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

38.9 Sec. 12. Minnesota Statutes 2022, section 62J.84, subdivision 7, is amended to read:

38.10 Subd. 7. **Consultation.** (a) The commissioner may consult with a private entity or  
38.11 consortium that satisfies the standards of section 62U.04, subdivision 6, the University of  
38.12 Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format  
38.13 of the information reported under this section; in posting information pursuant to subdivision  
38.14 6; and in taking any other action for the purpose of implementing this section.

38.15 (b) The commissioner may consult with representatives of the ~~manufacturers~~ reporting  
38.16 entities to establish a standard format for reporting information under this section and may  
38.17 use existing reporting methodologies to establish a standard format to minimize  
38.18 administrative burdens to the state and ~~manufacturers~~ reporting entities.

38.19 Sec. 13. Minnesota Statutes 2022, section 62J.84, subdivision 8, is amended to read:

38.20 Subd. 8. **Enforcement and penalties.** (a) A ~~manufacturer~~ reporting entity may be subject  
38.21 to a civil penalty, as provided in paragraph (b), for:

38.22 (1) failing to register under subdivision 15;

38.23 ~~(1)~~ (2) failing to submit timely reports or notices as required by this section;

38.24 ~~(2)~~ (3) failing to provide information required under this section; or

38.25 ~~(3)~~ (4) providing inaccurate or incomplete information under this section.

38.26 (b) The commissioner shall adopt a schedule of civil penalties, not to exceed \$10,000  
38.27 per day of violation, based on the severity of each violation.

38.28 (c) The commissioner shall impose civil penalties under this section as provided in  
38.29 section 144.99, subdivision 4.

39.1 (d) The commissioner may remit or mitigate civil penalties under this section upon terms  
39.2 and conditions the commissioner considers proper and consistent with public health and  
39.3 safety.

39.4 (e) Civil penalties collected under this section shall be deposited in the health care access  
39.5 fund.

39.6 Sec. 14. Minnesota Statutes 2022, section 62J.84, subdivision 9, is amended to read:

39.7 Subd. 9. **Legislative report.** (a) No later than May 15, 2022, and by January 15 of each  
39.8 year thereafter, the commissioner shall report to the chairs and ranking minority members  
39.9 of the legislative committees with jurisdiction over commerce and health and human services  
39.10 policy and finance on the implementation of this section, including but not limited to the  
39.11 effectiveness in addressing the following goals:

39.12 (1) promoting transparency in pharmaceutical pricing for the state and other payers;

39.13 (2) enhancing the understanding on pharmaceutical spending trends; and

39.14 (3) assisting the state and other payers in the management of pharmaceutical costs.

39.15 (b) The report must include a summary of the information submitted to the commissioner  
39.16 under subdivisions 3, 4, and 5 to 6 and 9 to 14.

39.17 Sec. 15. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
39.18 read:

39.19 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than  
39.20 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the  
39.21 department's website a list of prescription drugs that the department determines to represent  
39.22 a substantial public interest and for which the department intends to request data under  
39.23 subdivisions 9 to 14, subject to paragraph (c). The department shall base its inclusion of  
39.24 prescription drugs on any information the department determines is relevant to providing  
39.25 greater consumer awareness of the factors contributing to the cost of prescription drugs in  
39.26 the state, and the department shall consider drug product families that include prescription  
39.27 drugs:

39.28 (1) that triggered reporting under subdivisions 3, 4, or 6 during the previous calendar  
39.29 quarter;

40.1 (2) for which average claims paid amounts exceeded 125 percent of the price as of the  
40.2 claim incurred date during the most recent calendar quarter for which claims paid amounts  
40.3 are available; or

40.4 (3) that are identified by members of the public during a public comment period process.

40.5 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under  
40.6 paragraph (a), the department shall notify, via email, reporting entities registered with the  
40.7 department of the requirement to report under subdivisions 9 to 14.

40.8 (c) No more than 500 prescription drugs may be designated as having a substantial public  
40.9 interest in any one notice.

40.10 Sec. 16. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
40.11 read:

40.12 **Subd. 11. Manufacturer prescription drug substantial public interest reporting. (a)**  
40.13 **Beginning January 1, 2024, a manufacturer must submit to the commissioner the information**  
40.14 **described in paragraph (b) for any prescription drug:**

40.15 (1) included in a notification to report issued to the manufacturer by the department  
40.16 under subdivision 10;

40.17 (2) which the manufacturer manufactures or repackages;

40.18 (3) for which the manufacturer sets the wholesale acquisition cost; and

40.19 (4) for which the manufacturer has not submitted data under subdivision 3 or 6 during  
40.20 the 120-day period prior to the date of the notification to report.

40.21 (b) For each of the drugs described in paragraph (a), the manufacturer shall submit to  
40.22 the commissioner no later than 60 days after the date of the notification to report, in the  
40.23 form and manner prescribed by the commissioner, the following information, if applicable:

40.24 (1) a description of the drug with the following listed separately:

40.25 (i) the national drug code;

40.26 (ii) the product name;

40.27 (iii) the dosage form;

40.28 (iv) the strength; and

40.29 (v) the package size;

40.30 (2) the price of the drug product on the later of:



- 41.1 (i) the day one year prior to the date of the notification to report;
- 41.2 (ii) the introduced to market date; or
- 41.3 (iii) the acquisition date;
- 41.4 (3) the price of the drug product on the date of the notification to report;
- 41.5 (4) the introductory price of the prescription drug when it was introduced for sale in the
- 41.6 United States and the price of the drug on the last day of each of the five calendar years
- 41.7 preceding the date of the notification to report;
- 41.8 (5) the direct costs incurred during the 12-month period prior to the date of the notification
- 41.9 to report by the manufacturers that are associated with the prescription drug, listed separately:
- 41.10 (i) to manufacture the prescription drug;
- 41.11 (ii) to market the prescription drug, including advertising costs; and
- 41.12 (iii) to distribute the prescription drug;
- 41.13 (6) the number of units of the prescription drug sold during the 12-month period prior
- 41.14 to the date of the notification to report;
- 41.15 (7) the total sales revenue for the prescription drug during the 12-month period prior to
- 41.16 the date of the notification to report;
- 41.17 (8) the total rebate payable amount accrued for the prescription drug during the 12-month
- 41.18 period prior to the date of the notification to report;
- 41.19 (9) the manufacturer's net profit attributable to the prescription drug during the 12-month
- 41.20 period prior to the date of the notification to report;
- 41.21 (10) the total amount of financial assistance the manufacturer has provided through
- 41.22 patient prescription assistance programs during the 12-month period prior to the date of the
- 41.23 notification to report, if applicable;
- 41.24 (11) any agreement between a manufacturer and another entity contingent upon any
- 41.25 delay in offering to market a generic version of the prescription drug;
- 41.26 (12) the patent expiration date of the prescription drug if the prescription drug is under
- 41.27 patent;
- 41.28 (13) the name and location of the company that manufactured the drug;

42.1 (14) if the prescription drug is a brand name prescription drug, the ten countries other  
42.2 than the United States that paid the highest prices for the prescription drug during the  
42.3 previous calendar year and their prices; and

42.4 (15) if the prescription drug was acquired by the manufacturer within a 12-month period  
42.5 prior to the date of the notification to report, all of the following information:

42.6 (i) the price at acquisition;

42.7 (ii) the price in the calendar year prior to acquisition;

42.8 (iii) the name of the company from which the drug was acquired;

42.9 (iv) the date of acquisition; and

42.10 (v) the acquisition price.

42.11 (c) The manufacturer may submit any documentation necessary to support the information  
42.12 reported under this subdivision.

42.13 Sec. 17. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
42.14 read:

42.15 Subd. 12. **Pharmacy prescription drug substantial public interest reporting.** (a)  
42.16 Beginning January 1, 2024, a pharmacy must submit to the commissioner the information  
42.17 described in paragraph (b) for any prescription drug included in a notification to report  
42.18 issued to the pharmacy by the department under subdivision 9.

42.19 (b) For each of the drugs described in paragraph (a), the pharmacy shall submit to the  
42.20 commissioner no later than 60 days after the date of the notification to report, in the form  
42.21 and manner prescribed by the commissioner, the following information, if applicable:

42.22 (1) a description of the drug with the following listed separately:

42.23 (i) the national drug code;

42.24 (ii) the product name;

42.25 (iii) the dosage form;

42.26 (iv) the strength; and

42.27 (v) the package size;

42.28 (2) the number of units of the drug acquired during the 12-month period prior to the date  
42.29 of the notification to report;

43.1 (3) the total spent before rebates by the pharmacy to acquire the drug during the 12-month  
43.2 period prior to the date of the notification to report;

43.3 (4) the total rebate receivable amount accrued by the pharmacy for the drug during the  
43.4 12-month period prior to the date of the notification to report;

43.5 (5) the number of pricing units of the drug dispensed by the pharmacy during the  
43.6 12-month period prior to the date of the notification to report;

43.7 (6) the total payment receivable by the pharmacy for dispensing the drug including  
43.8 ingredient cost, dispensing fee, and administrative fees during the 12-month period prior  
43.9 to the date of the notification to report;

43.10 (7) the total rebate payable amount accrued by the pharmacy for the drug during the  
43.11 12-month period prior to the date of the notification to report; and

43.12 (8) the average cash price paid by consumers per pricing unit for prescriptions dispensed  
43.13 where no claim was submitted to a health care service plan or health insurer during the  
43.14 12-month period prior to the date of the notification to report.

43.15 (c) The pharmacy may submit any documentation necessary to support the information  
43.16 reported under this subdivision.

43.17 Sec. 18. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
43.18 read:

43.19 Subd. 13. **PBM prescription drug substantial public interest reporting.** (a) Beginning  
43.20 January 1, 2024, a PBM must submit to the commissioner the information described in  
43.21 paragraph (b) for any prescription drug included in a notification to report issued to the  
43.22 PBM by the department under subdivision 9.

43.23 (b) For each of the drugs described in paragraph (a), the PBM shall submit to the  
43.24 commissioner no later than 60 days after the date of the notification to report, in the form  
43.25 and manner prescribed by the commissioner, the following information, if applicable:

43.26 (1) a description of the drug with the following listed separately:

43.27 (i) the national drug code;

43.28 (ii) the product name;

43.29 (iii) the dosage form;

43.30 (iv) the strength; and

43.31 (v) the package size;

44.1 (2) the number of pricing units of the drug product filled for which the PBM administered  
44.2 claims during the 12-month period prior to the date of the notification to report;

44.3 (3) the total reimbursement amount accrued and payable to pharmacies for pricing units  
44.4 of the drug product filled for which the PBM administered claims during the 12-month  
44.5 period prior to the date of the notification to report;

44.6 (4) the total reimbursement or administrative fee amount, or both, accrued and receivable  
44.7 from payers for pricing units of the drug product filled for which the PBM administered  
44.8 claims during the 12-month period prior to the date of the notification to report;

44.9 (5) the total rebate receivable amount accrued by the PBM for the drug product during  
44.10 the 12-month period prior to the date of the notification to report; and

44.11 (6) the total rebate payable amount accrued by the PBM for the drug product during the  
44.12 12-month period prior to the date of the notification to report.

44.13 (c) The PBM may submit any documentation necessary to support the information  
44.14 reported under this subdivision.

44.15 Sec. 19. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
44.16 read:

44.17 Subd. 14. **Wholesaler prescription drug substantial public interest reporting.** (a)  
44.18 Beginning January 1, 2024, a wholesaler must submit to the commissioner the information  
44.19 described in paragraph (b) for any prescription drug included in a notification to report  
44.20 issued to the wholesaler by the department under subdivision 10.

44.21 (b) For each of the drugs described in paragraph (a), the wholesaler shall submit to the  
44.22 commissioner no later than 60 days after the date of the notification to report, in the form  
44.23 and manner prescribed by the commissioner, the following information, if applicable:

44.24 (1) a description of the drug with the following listed separately:

44.25 (i) the national drug code;

44.26 (ii) the product name;

44.27 (iii) the dosage form;

44.28 (iv) the strength; and

44.29 (v) the package size;

44.30 (2) the number of units of the drug product acquired by the wholesale drug distributor  
44.31 during the 12-month period prior to the date of the notification to report;

45.1 (3) the total spent before rebates by the wholesale drug distributor to acquire the drug  
45.2 product during the 12-month period prior to the date of the notification to report;

45.3 (4) the total rebate receivable amount accrued by the wholesale drug distributor for the  
45.4 drug product during the 12-month period prior to the date of the notification to report;

45.5 (5) the number of units of the drug product sold by the wholesale drug distributor during  
45.6 the 12-month period prior to the date of the notification to report;

45.7 (6) gross revenue from sales in the United States generated by the wholesale drug  
45.8 distributor for this drug product during the 12-month period prior to the date of the  
45.9 notification to report; and

45.10 (7) total rebate payable amount accrued by the wholesale drug distributor for the drug  
45.11 product during the 12-month period prior to the date of the notification to report.

45.12 (c) The wholesaler may submit any documentation necessary to support the information  
45.13 reported under this subdivision.

45.14 Sec. 20. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
45.15 read:

45.16 Subd. 15. **Registration requirements.** Beginning January 1, 2024, a reporting entity  
45.17 subject to this chapter shall register with the department in a form and manner prescribed  
45.18 by the commissioner.

45.19 Sec. 21. Minnesota Statutes 2022, section 62J.84, is amended by adding a subdivision to  
45.20 read:

45.21 Subd. 16. **Rulemaking.** For the purposes of this section, the commissioner may use the  
45.22 expedited rulemaking process under section 14.389.

45.23 Sec. 22. Minnesota Statutes 2022, section 62Q.01, is amended by adding a subdivision to  
45.24 read:

45.25 Subd. 6b. **No Surprises Act.** "No Surprises Act" means Division BB of the Consolidated  
45.26 Appropriations Act, 2021, which amended Title XXVII of the Public Health Service Act,  
45.27 Public Law 116-260, and any amendments to and any federal guidance or regulations issued  
45.28 under this act.

46.1 Sec. 23. Minnesota Statutes 2022, section 62Q.021, is amended by adding a subdivision  
46.2 to read:

46.3 Subd. 3. **Compliance with 2021 federal law.** Each health plan company, health provider,  
46.4 and health facility shall comply with the No Surprises Act, including any federal regulations  
46.5 adopted under the act, to the extent that the act imposes requirements that apply in this state  
46.6 but are not required under the laws of this state. This subdivision does not require compliance  
46.7 with any provision of the No Surprises Act before the effective date provided for that  
46.8 provision in the No Surprises Act. The commissioner shall enforce this subdivision.

46.9 Sec. 24. Minnesota Statutes 2022, section 62Q.55, subdivision 5, is amended to read:

46.10 Subd. 5. **Coverage restrictions or limitations.** If emergency services are provided by  
46.11 a nonparticipating provider, with or without prior authorization, the health plan company  
46.12 shall not impose coverage restrictions or limitations that are more restrictive than apply to  
46.13 emergency services received from a participating provider. Cost-sharing requirements that  
46.14 apply to emergency services received out-of-network must be the same as the cost-sharing  
46.15 requirements that apply to services received in-network and shall count toward the in-network  
46.16 deductible. All coverage and charges for emergency services must comply with the No  
46.17 Surprises Act.

46.18 Sec. 25. Minnesota Statutes 2022, section 62Q.556, is amended to read:

46.19 **62Q.556 UNAUTHORIZED PROVIDER SERVICES CONSUMER**  
46.20 **PROTECTIONS AGAINST BALANCE BILLING.**

46.21 Subdivision 1. ~~Unauthorized provider services~~ **Nonparticipating provider balance**  
46.22 **billing prohibition.** (a) Except as provided in paragraph (e), ~~unauthorized provider services~~  
46.23 ~~or~~ (b), balance billing is prohibited when an enrollee receives services from:

46.24 (1) ~~from a nonparticipating provider at a participating hospital or ambulatory surgical~~  
46.25 ~~center, when the services are rendered:~~ as described by the No Surprises Act, including any  
46.26 federal regulations adopted under that act;

46.27 (i) ~~due to the unavailability of a participating provider;~~

46.28 (ii) ~~by a nonparticipating provider without the enrollee's knowledge; or~~

46.29 (iii) ~~due to the need for unforeseen services arising at the time the services are being~~  
46.30 ~~rendered; or~~

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

47.4 (3) a nonparticipating provider or facility providing emergency services as defined in  
 47.5 section 62Q.55, subdivision 3, and other services as described in the requirements of the  
 47.6 No Surprises Act.

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

47.9 ~~(e)~~ (b) The services described in paragraph (a), ~~clause (2)~~ clauses (1), (2), and (3), as  
 47.10 defined in the No Surprises Act, and any federal regulations adopted under that act, are not  
 47.11 ~~unauthorized provider services~~ subject to balance billing if the enrollee gives advance written  
 47.12 provides informed consent to prior to receiving services from the nonparticipating provider  
 47.13 acknowledging that the use of a provider, or the services to be rendered, may result in costs  
 47.14 not covered by the health plan. The informed consent must comply with all requirements  
 47.15 of the No Surprises Act, including any federal regulations adopted under that act.

47.16 Subd. 2. **Prohibition Cost-sharing requirements and independent dispute**  
 47.17 **resolution.** (a) An enrollee's financial responsibility for the ~~unauthorized~~ nonparticipating  
 47.18 provider services described in subdivision 1, paragraph (a), shall be the same cost-sharing  
 47.19 requirements, including co-payments, deductibles, coinsurance, coverage restrictions, and  
 47.20 coverage limitations, as those applicable to services received by the enrollee from a  
 47.21 participating provider. A health plan company must apply any enrollee cost sharing  
 47.22 requirements, including co-payments, deductibles, and coinsurance, for unauthorized  
 47.23 nonparticipating provider services to the enrollee's annual out-of-pocket limit to the same  
 47.24 extent payments to a participating provider would be applied.

47.25 (b) A health plan company must attempt to negotiate the reimbursement, less any  
 47.26 applicable enrollee cost sharing under paragraph (a), for the ~~unauthorized~~ nonparticipating  
 47.27 provider services with the nonparticipating provider. If a health plan company's and  
 47.28 ~~nonparticipating provider's attempts~~ the attempt to negotiate reimbursement for the health  
 47.29 ~~care~~ nonparticipating provider services ~~do~~ does not result in a resolution, ~~the health plan~~  
 47.30 ~~company or provider may elect to refer the matter for binding arbitration, chosen in~~  
 47.31 ~~accordance with paragraph (c). A nondisclosure agreement must be executed by both parties~~  
 47.32 ~~prior to engaging an arbitrator in accordance with this section. The cost of arbitration must~~  
 47.33 ~~be shared equally between the parties.~~ either party may initiate the federal independent

48.1 dispute resolution process pursuant to the No Surprises Act, including any federal regulations  
48.2 adopted under that act.

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

48.8 ~~(d) The arbitrator must consider relevant information, including the health plan company's~~  
48.9 ~~payments to other nonparticipating providers for the same services, the circumstances and~~  
48.10 ~~complexity of the particular case, and the usual and customary rate for the service based on~~  
48.11 ~~information available in a database in a national, independent, not-for-profit corporation,~~  
48.12 ~~and similar fees received by the provider for the same services from other health plans in~~  
48.13 ~~which the provider is nonparticipating, in reaching a decision.~~

48.14 Subd. 3. Annual data reporting. (a) Beginning April 1, 2024, a health plan company  
48.15 must report annually to the commissioner of health:

48.16 (1) the total number of claims and total billed and paid amount for nonparticipating  
48.17 provider services, by service and provider type, submitted to the health plan in the prior  
48.18 calendar year; and

48.19 (2) the total number of enrollee complaints received regarding the rights and protections  
48.20 established by the No Surprises Act in the prior calendar year.

48.21 (b) The commissioners of commerce and health shall develop the form and manner for  
48.22 health plan companies to comply with paragraph (a).

48.23 Subd. 4. Enforcement. (a) Any provider or facility, including a health care provider or  
48.24 facility pursuant to section 62A.63, subdivision 2, or 62J.03, subdivision 8, that is subject  
48.25 to the relevant provisions of the No Surprises Act is subject to the requirements of this  
48.26 section and section 62J.811.

48.27 (b) The commissioner of commerce or health shall enforce this section.

48.28 (c) If a health-related licensing board has cause to believe that a provider has violated  
48.29 this section, it may further investigate and enforce the provisions of this section pursuant  
48.30 to chapter 214.



49.1 Sec. 26. Minnesota Statutes 2022, section 62Q.56, subdivision 2, is amended to read:

49.2 Subd. 2. **Change in health plans.** (a) If an enrollee is subject to a change in health plans,  
49.3 the enrollee's new health plan company must provide, upon request, authorization to receive  
49.4 services that are otherwise covered under the terms of the new health plan through the  
49.5 enrollee's current provider:

49.6 (1) for up to 120 days if the enrollee is engaged in a current course of treatment for one  
49.7 or more of the following conditions:

49.8 (i) an acute condition;

49.9 (ii) a life-threatening mental or physical illness;

49.10 (iii) pregnancy ~~beyond the first trimester of pregnancy;~~

49.11 (iv) a physical or mental disability defined as an inability to engage in one or more major  
49.12 life activities, provided that the disability has lasted or can be expected to last for at least  
49.13 one year, or can be expected to result in death; or

49.14 (v) a disabling or chronic condition that is in an acute phase; or

49.15 (2) for the rest of the enrollee's life if a physician certifies that the enrollee has an expected  
49.16 lifetime of 180 days or less.

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

49.20 (b) The health plan company shall prepare a written plan that provides a process for  
49.21 coverage determinations regarding continuity of care of up to 120 days for new enrollees  
49.22 who request continuity of care with their former provider, if the new enrollee:

49.23 (1) is receiving culturally appropriate services and the health plan company does not  
49.24 have a provider in its preferred provider network with special expertise in the delivery of  
49.25 those culturally appropriate services within the time and distance requirements of section  
49.26 62D.124, subdivision 1; or

49.27 (2) does not speak English and the health plan company does not have a provider in its  
49.28 preferred provider network who can communicate with the enrollee, either directly or through  
49.29 an interpreter, within the time and distance requirements of section 62D.124, subdivision  
49.30 1.

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

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

50.3 Sec. 27. Minnesota Statutes 2022, section 62Q.73, subdivision 1, is amended to read:

50.4 Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

50.5 (1) for individual health plans, a complaint decision relating to a health care service or  
50.6 claim that is partially or wholly adverse to the complainant;

50.7 (2) an individual health plan that is grandfathered plan coverage may instead apply the  
50.8 definition of adverse determination for group coverage in clause (3);

50.9 (3) for group health plans, a complaint decision relating to a health care service or claim  
50.10 that has been appealed in accordance with section 62Q.70 and the appeal decision is partially  
50.11 or wholly adverse to the complainant;

50.12 (4) any adverse determination, as defined in section 62M.02, subdivision 1a, that has  
50.13 been appealed in accordance with section 62M.06 and the appeal did not reverse the adverse  
50.14 determination;

50.15 (5) a decision relating to a health care service made by a health plan company licensed  
50.16 under chapter 60A that denies the service on the basis that the service was not medically  
50.17 necessary; ~~or~~

50.18 (6) the enrollee has met the requirements of subdivision 6, paragraph (e); or

50.19 (7) a decision relating to a health plan's coverage of nonparticipating provider services  
50.20 as described in and subject to section 62Q.556, subdivision 1, paragraph (a).

50.21 An adverse determination does not include complaints relating to fraudulent marketing  
50.22 practices or agent misrepresentation.

50.23 Sec. 28. Minnesota Statutes 2022, section 62Q.73, subdivision 7, is amended to read:

50.24 Subd. 7. **Standards of review.** (a) For an external review of any issue in an adverse  
50.25 determination that does not require a medical necessity determination, the external review  
50.26 must be based on whether the adverse determination was in compliance with the enrollee's  
50.27 health benefit plan or section 62Q.556, subdivision 1, paragraph (a).

50.28 (b) For an external review of any issue in an adverse determination by a health plan  
50.29 company licensed under chapter 62D that requires a medical necessity determination, the  
50.30 external review must determine whether the adverse determination was consistent with the  
50.31 definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.

51.1 (c) For an external review of any issue in an adverse determination by a health plan  
 51.2 company, other than a health plan company licensed under chapter 62D, that requires a  
 51.3 medical necessity determination, the external review must determine whether the adverse  
 51.4 determination was consistent with the definition of medically necessary care in section  
 51.5 62Q.53, subdivision 2.

51.6 (d) For an external review of an adverse determination involving experimental or  
 51.7 investigational treatment, the external review entity must base its decision on all documents  
 51.8 submitted by the health plan company and enrollee, including:

51.9 (1) medical records;

51.10 (2) the recommendation of the attending physician, advanced practice registered nurse,  
 51.11 physician assistant, or health care professional;

51.12 (3) consulting reports from health care professionals;

51.13 (4) the terms of coverage;

51.14 (5) federal Food and Drug Administration approval; and

51.15 (6) medical or scientific evidence or evidence-based standards.

51.16 Sec. 29. Minnesota Statutes 2022, section 62U.04, subdivision 4, is amended to read:

51.17 Subd. 4. **Encounter data.** (a) All health plan companies and third-party administrators  
 51.18 shall submit encounter data on a monthly basis to a private entity designated by the  
 51.19 commissioner of health. The data shall be submitted in a form and manner specified by the  
 51.20 commissioner subject to the following requirements:

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

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

51.27 ~~(3) except for the identifier described in clause (2), the data must not include information~~  
 51.28 ~~that is not included in a health care claim or equivalent encounter information transaction~~  
 51.29 ~~that is required under section 62J.536. (3) effective January 1, 2023, data collected must~~  
 51.30 include enrollee race and ethnicity, to the extent available; and

52.1 (4) except for the data described in clauses (2) and (3), the data must not include  
52.2 information that is not included in a health care claim, dental care claim, or equivalent  
52.3 encounter information transaction that is required under section 62J.536.

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

52.10 (c) Data on providers collected under this subdivision are private data on individuals or  
52.11 nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data  
52.12 in section 13.02, subdivision 19, summary data prepared under this subdivision may be  
52.13 derived from nonpublic data. The commissioner or the commissioner's designee shall  
52.14 establish procedures and safeguards to protect the integrity and confidentiality of any data  
52.15 that it maintains.

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

52.18 (e) The commissioner shall compile summary information on the data submitted under  
52.19 this subdivision. The commissioner shall work with its vendors to assess the data submitted  
52.20 in terms of compliance with the data submission requirements and the completeness of the  
52.21 data submitted by comparing the data with summary information compiled by the  
52.22 commissioner and with established and emerging data quality standards to ensure data  
52.23 quality.

52.24 Sec. 30. Minnesota Statutes 2022, section 62U.04, subdivision 5, is amended to read:

52.25 Subd. 5. **Pricing data.** (a) All health plan companies, dental plan companies, and  
52.26 third-party administrators shall submit, on a monthly basis, data on their contracted prices  
52.27 with health care providers and dental care providers to a private entity designated by the  
52.28 commissioner of health for the purposes of performing the analyses required under this  
52.29 subdivision. The data shall be submitted in the form and manner specified by the  
52.30 commissioner of health.

52.31 (b) The commissioner or the commissioner's designee shall only use the data submitted  
52.32 under this subdivision to carry out the commissioner's responsibilities under this section,  
52.33 including supplying the data to providers so they can verify their results of the peer grouping

53.1 process consistent with the recommendations developed pursuant to subdivision 3c, paragraph  
 53.2 (d), and adopted by the commissioner and, if necessary, submit comments to the  
 53.3 commissioner or initiate an appeal.

53.4 (c) Data collected under this subdivision are nonpublic data as defined in section 13.02.  
 53.5 Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary  
 53.6 data prepared under this section may be derived from nonpublic data. The commissioner  
 53.7 shall establish procedures and safeguards to protect the integrity and confidentiality of any  
 53.8 data that it maintains.

53.9 Sec. 31. Minnesota Statutes 2022, section 62U.04, subdivision 6, is amended to read:

53.10 Subd. 6. **Contracting.** The commissioner may contract with a private entity or consortium  
 53.11 of entities to develop the standards. The private entity or consortium must be nonprofit and  
 53.12 have governance that includes representatives from the following stakeholder groups: health  
 53.13 care providers, dental care providers, health plan companies, dental plan companies, hospitals,  
 53.14 consumers, employers or other health care purchasers, and state government. The entity or  
 53.15 consortium must ensure that the representatives of stakeholder groups in the aggregate  
 53.16 reflect all geographic areas of the state. No one stakeholder group shall have a majority of  
 53.17 the votes on any issue or hold extraordinary powers not granted to any other governance  
 53.18 stakeholder.

53.19 Sec. 32. **[115.7411] ADVISORY COUNCIL ON WATER SUPPLY SYSTEMS AND**  
 53.20 **WASTEWATER TREATMENT FACILITIES.**

53.21 Subdivision 1. **Purpose; membership.** The Advisory Council on Water Supply Systems  
 53.22 and Wastewater Treatment Facilities shall advise the commissioners of health and the  
 53.23 Pollution Control Agency regarding classification of water supply systems and wastewater  
 53.24 treatment facilities, qualifications and competency evaluation of water supply system  
 53.25 operators and wastewater treatment facility operators, and additional laws, rules, and  
 53.26 procedures that may be desirable for regulating the operation of water supply systems and  
 53.27 of wastewater treatment facilities. The advisory council is composed of 11 voting members,  
 53.28 of whom:

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

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

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

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

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

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

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

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

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

54.23 Sec. 33. Minnesota Statutes 2022, section 121A.335, subdivision 3, is amended to read:

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

54.29 ~~(b) A school district or charter school that finds lead at a specific location providing~~  
 54.30 ~~cooking or drinking water within a facility must formulate, make publicly available, and~~  
 54.31 ~~implement a plan that is consistent with established guidelines and recommendations to~~  
 54.32 ~~ensure that student exposure to lead is minimized. This includes, when a school district or~~  
 54.33 ~~charter school finds the presence of lead at a level where action should be taken as set by~~

55.1 ~~the guidance in any water source that can provide cooking or drinking water, immediately~~  
55.2 ~~shutting off the water source or making it unavailable until the hazard has been minimized.~~

55.3 Sec. 34. Minnesota Statutes 2022, section 121A.335, subdivision 5, is amended to read:

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

55.14 (b) Results of testing, and any planned remediation steps, shall be made available within  
55.15 30 days of receiving results.

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

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

55.22 (e) Beginning July 1, 2024, school districts and charter schools must report their test  
55.23 results and remediation activities to the commissioner of health annually on or before July  
55.24 1 of each year.

55.25 Sec. 35. Minnesota Statutes 2022, section 121A.335, is amended by adding a subdivision  
55.26 to read:

55.27 Subd. 6. **Remediation.** (a) A school district or charter school that finds lead above five  
55.28 parts per billion at a specific location providing cooking or drinking water within a facility  
55.29 must formulate, make publicly available, and implement a plan to remediate the lead in  
55.30 drinking water. The plan must be consistent with established guidelines and recommendations  
55.31 to ensure exposure to lead is remediated.

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

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

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

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

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

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

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

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

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

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



57.1 Sec. 37. [144.0526] COMPREHENSIVE DRUG OVERDOSE AND MORBIDITY  
57.2 PREVENTION ACT.

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

57.8 Subd. 2. Establishment. (a) The commissioner of health shall establish a comprehensive  
57.9 drug overdose and morbidity program to conduct comprehensive drug overdose and morbidity  
57.10 prevention, epidemiologic investigations and surveillance, and evaluation to monitor, address  
57.11 and prevent drug overdose statewide through eight integrated strategies that include efforts  
57.12 to:

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

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

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

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

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

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

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

57.29 (i) promote medication-assisted treatment options;

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

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

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

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

58.8 (i) systematically collect data to identify, analyze, and interpret the impact, incidence,  
58.9 incidence trends, conditions, treatments, and health, educational, and developmental outcomes  
58.10 associated with in utero exposure to maternal substance use; and

58.11 (ii) collect data, including on diagnosis, management, interventions, and outcomes, from  
58.12 relevant sources identified by the commissioner, including hospitals, clinics, laboratory  
58.13 settings, and other entities and providers involved in the care or treatment of infants, children,  
58.14 and those who are pregnant, and may do so in collaboration with other prenatal, newborn,  
58.15 and child-related public health data collection systems;

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

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

58.21 (b) Individually identifiable data collected or maintained by the Department of Health  
58.22 under this subdivision is subject to the provisions of subdivision 9, paragraph (a).

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

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

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

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

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

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

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

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

59.16 (7) working collaboratively with sovereign Tribal nations, care providers, nonprofit  
59.17 organizations, for-profit organizations, government entities, community-based organizations,  
59.18 and other entities to implement substance misuse and drug overdose prevention strategies  
59.19 within their communities; and

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

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

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

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

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

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

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

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

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

60.17 Subd. 8. **Measurement.** The commissioner of health shall assess and evaluate grants  
60.18 and contracts awarded using available data sources, including but not limited to the Minnesota  
60.19 All Payer Claims Database (MN APCD), the Minnesota Behavioral Risk Factor Surveillance  
60.20 System (BRFSS), the Minnesota Student Survey, vital records, hospitalization data,  
60.21 syndromic surveillance, and the Minnesota Electronic Health Record Consortium.

60.22 Subd. 9. **Classification of Data.** (a) Individually identifiable data collected or maintained  
60.23 by the comprehensive drug overdose and morbidity program under subdivision 2, clause  
60.24 (8), are classified as private data on individuals, as defined in section 13.02, subdivision 3.

60.25 (b) Private data identified in paragraph (a) shall not be introduced into evidence in any  
60.26 administrative, civil, or criminal proceeding, or disclosed in response to discovery requests,  
60.27 subpoenas, or investigative demands. These disclosure and evidentiary restrictions only  
60.28 apply to data collected or maintained by the comprehensive drug overdose and morbidity  
60.29 program and do not apply to data obtained from alternative sources.

60.30 Sec. 38. **[144.0551] SENTINEL EVENT REVIEW COMMITTEE.**

60.31 Subdivision 1. **Definitions.** (a) For purposes of this section and section 144.0552, the  
60.32 following terms have the meanings given.

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

61.2 (c) "Law-enforcement-involved deadly force encounter" refers to any death where all  
61.3 of the following criteria are met:

61.4 (1) the death was sustained during an encounter between one or more law enforcement  
61.5 officials, including peace officers, state troopers, sheriffs, active military, national guard,  
61.6 correctional officers, federal agents, DNR officers, and private security guards, enforcement  
61.7 personnel brought in from other jurisdictions, and one or more civilians;

61.8 (2) the death occurred during the officer's use of force while the officer is on duty or off  
61.9 duty but performing activities that are within the scope of the officer's law enforcement  
61.10 duties;

61.11 (3) the law enforcement official, whether on or off duty, was acting with the intention  
61.12 of arresting individuals that break the law, suppressing disturbances, maintaining order, or  
61.13 performing another legal action; and

61.14 (4) the injury leading to death took place outside of a jail or prison setting within the  
61.15 state.

61.16 (d) "Use of force" refers to the effort required by police to compel compliance by an  
61.17 unwilling subject. Use of force is the means of compelling compliance or overcoming  
61.18 resistance to an officer's command or commands to protect life or property or to take a  
61.19 person into custody. Types of force may include but are not limited to verbal, physical,  
61.20 chemical, impact, electronic device, use of restraints, firearm or other weapons, and deaths  
61.21 from use of vehicles or from police chase.

61.22 Subd. 2. **Duties of the commissioner.** (a) The commissioner shall routinely collect and  
61.23 analyze data on the prevalence and incidence of law-enforcement-involved deadly force  
61.24 encounters in Minnesota. The commissioner shall routinely report findings to the legislature  
61.25 and to the public.

61.26 (b) Notwithstanding any law to the contrary, data on an individual collected by the  
61.27 commissioner in conducting an investigation to reduce law enforcement-involved deadly  
61.28 force encounters morbidity or mortality are not subject to discovery in a legal action.

61.29 (c) The commissioner shall convene the Sentinel Event Review Committee (SERC) with  
61.30 representation from the following:

61.31 (1) Bureau of Criminal Apprehension;

61.32 (2) Board of Peace Officer Standards and Training;

62.1 (3) Department of Health;

62.2 (4) Department of Human Rights;

62.3 (5) Department Of Corrections;

62.4 (6) Department of Human Services;

62.5 (7) A Minnesota medical examiner or coroner; and

62.6 (8) two appointed members at large.

62.7 (d) Members will be appointed to two-year terms, with up to two consecutive  
62.8 reappointments but not more than six years served consecutively. Local jurisdiction  
62.9 participation will be determined by the commissioner in consultation with local officials  
62.10 where the event occurred and organizations that provided services to the decedent, with up  
62.11 to five participants appointed per case. Participants must include but not be limited to law  
62.12 enforcement, public health officials, medical and social service providers, and community  
62.13 members. A member may not be a current or former employee of the agency that is the  
62.14 subject of the team's review.

62.15 (e) The commissioner shall convene the SERC no later than March 1, 2024, and provide  
62.16 meeting space and administrative assistance necessary for the SERC to conduct its work,  
62.17 including documentation of convenings and findings in collaboration and coordination of  
62.18 committee members and submission of required reports. The commissioner's staff must  
62.19 facilitate the convenings and establish the sentinel event review process.

62.20 Subd. 3. **Sentinel event review.** (a) Initial review by the commissioner's staff will be  
62.21 completed within 90 days of the event to determine any immediate action, appropriate local  
62.22 representation, and timeline for review by the SERC.

62.23 (b) The SERC is charged with identifying and analyzing the root causes of the incident.  
62.24 Following the analysis, the SERC must prepare a report that recommends policy and system  
62.25 changes to reduce and prevent future incidents across jurisdictions, agencies, and systems.

62.26 (c) The full review needs to be completed within six months of the event, or as soon as  
62.27 is practicable, and the report must be filed with the commissioner of health and agency that  
62.28 employed the peace officer involved in the event within 60 days of completion of the review.  
62.29 The commissioner of health must post the report on the Department of Health public website.  
62.30 The posted report must comply with chapter 13, and any data that is not public data must  
62.31 be redacted.

63.1 (d) By June 15 of each year, the SERC shall report to the chairs and ranking minority  
63.2 members of the house of representatives and senate committees and divisions with jurisdiction  
63.3 over public safety on the number of reviews performed under this subdivision, aggregate  
63.4 data on those reviews, the number of reviews that included a recommendation that the  
63.5 agency under review implement a corrective action plan, a description of any  
63.6 recommendations made to the commissioner of public safety statewide training of peace  
63.7 officers, and recommendations for legislative action.

63.8 Subd. 4. **Access to data.** (a) The SERC team shall collect, review, and analyze data  
63.9 related to the decedent and law enforcement official involved.

63.10 Data may include death certificates and death data, including investigative reports,  
63.11 medical and counseling records, victim service records, employment records, survivor  
63.12 interviews and surveys, witness accounts of incident, or other pertinent information  
63.13 concerning decedent's life and access to services as determined by the SERC.

63.14 Data may include law enforcement official's employment record, employment institution's  
63.15 standard operating procedures, and other pertinent information concerning law enforcement  
63.16 officer and law enforcement agency.

63.17 (b) The review team has access to the following not public data, as defined in section  
63.18 13.02, subdivision 8a, relating to a case being reviewed by the SERC: inactive law  
63.19 enforcement investigative data under section 13.82; autopsy records and coroner or medical  
63.20 examiner investigative data under section 13.83; hospital, public health, or other medical  
63.21 records of the victim under section 13.384; records under section 13.46, created by social  
63.22 service agencies that provided services to the victim, the alleged perpetrator, or another  
63.23 victim who experienced use of force or was threatened by the peace officer; and data relating  
63.24 to the victim or a family or household member of the victim. Access to medical records  
63.25 under this paragraph also includes records governed by sections 144.291 to 144.298. The  
63.26 SERC has access to corrections and detention data as provided in section 13.85.

63.27 (c) As part of any review, the SERC may compel the production of other records by  
63.28 applying to the district court for a subpoena, which will be effective throughout the state  
63.29 according to the Rules of Civil Procedure.

63.30 Subd. 5. **Confidentiality and data privacy.** A person attending a SERC meeting may  
63.31 not disclose what transpired at the meeting, except to carry out the purposes of the review  
63.32 or as otherwise provided in this subdivision. The SERC may disclose the names of the  
63.33 victims in the cases it reviewed. The proceedings and records of the SERC are confidential  
63.34 data as defined in section 13.02, subdivision 3, or protected nonpublic data as defined in

64.1 section 13.02, subdivision 13, regardless of their classification in the hands of the person  
 64.2 who provided the data, and are not subject to discovery or introduction into evidence in a  
 64.3 civil or criminal action against a professional, the state, or a county agency, arising out of  
 64.4 the matters the team is reviewing. Information, documents, and records otherwise available  
 64.5 from other sources are not immune from discovery or use in a civil or criminal action solely  
 64.6 because they were presented during proceedings of the SERC. This section does not limit  
 64.7 a person who presented information before the SERC or who is a member of the panel from  
 64.8 testifying about matters within the person's knowledge. However, in a civil or criminal  
 64.9 proceeding, a person may not be questioned about the person's good faith presentation of  
 64.10 information to the SERC or opinions formed by the person as a result of the SERC meetings.

64.11 Subd. 6. **Violation; misdemeanor.** Any data disclosure other than as provided for in  
 64.12 this section is a misdemeanor and punishable as such.

64.13 Subd. 7. **Immunity.** Members of the SERC are immune from claims and are not subject  
 64.14 to any suits, liability, damages, or any other recourse, civil or criminal, arising from any  
 64.15 act, proceeding, decision, or determination undertaken or performed or recommendation  
 64.16 made by the SERC, provided they acted in good faith and without malice in carrying out  
 64.17 their responsibilities. Good faith is presumed unless proven otherwise and the complainant  
 64.18 has the burden of proving malice or a lack of good faith. No organization, institution, or  
 64.19 person furnishing information, data, testimony, reports, or records to the domestic fatality  
 64.20 review team as part of an investigation is civilly or criminally liable or subject to any other  
 64.21 recourse for providing the information.

64.22 Subd. 8. **Community-based grant programs.** The commissioner shall establish a grant  
 64.23 program to fund community grants to implement actionable recommendations developed  
 64.24 by the SERC.

64.25 Sec. 39. **[144.0552] LAW ENFORCEMENT-INVOLVED DEADLY FORCE**  
 64.26 **ENCOUNTERS COMMUNITY ADVISORY COMMITTEE.**

64.27 Subdivision 1. **Establishment.** The commissioner shall establish an 18-member law  
 64.28 enforcement-involved deadly force encounters community advisory committee. The  
 64.29 commissioner shall provide the advisory committee with staff support, office space, and  
 64.30 access to office equipment and services. Members appointed by the commissioner are  
 64.31 appointed for a three-year term and may be reappointed. Nonstate employee members of  
 64.32 the advisory committee will be compensated at the rate of \$55 per day spent on committee  
 64.33 activities, plus expenses, when authorized by the committee as described in section 15.059,



65.1 subdivision 3. Meetings must be held twice yearly, with additional meetings scheduled as  
 65.2 necessary.

65.3 Subd. 2. **Membership.** (a) The commissioner shall appoint up to 18 members, none of  
 65.4 whom may be lobbyists registered under chapter 10A, including:

65.5 (1) at least nine members from Minnesota-based nongovernmental organizations that  
 65.6 advocate on behalf of relevant community groups in Minnesota;

65.7 (2) at least one academic partner with experience studying racial equity in health; and

65.8 (3) up to eight representatives from relevant state agencies.

65.9 (b) The advisory committee may also invite other relevant persons to serve on an ad hoc  
 65.10 basis and participate as full members of the review team for a particular review. These  
 65.11 persons may include but are not limited to:

65.12 (1) individuals with expertise that would be helpful to the review panel; or

65.13 (2) representatives of organizations or agencies that had contact with or provided services  
 65.14 to the decedent.

65.15 Subd. 3. **Duties.** The advisory committee shall:

65.16 (1) advise the commissioner and other state agencies on:

65.17 (i) health outcomes related to law-enforcement-involved deadly force encounters and  
 65.18 priorities for data collection and public health research;

65.19 (ii) specific communities and geographic areas on which to focus prevention efforts;

65.20 (iii) opportunities for community partnerships and sources of additional funding;

65.21 (2) review and discuss reports and recommendations drafted by the Sentinel Event  
 65.22 Review Committee; and

65.23 (3) review applications for community-based grants as described in section 144.0551,  
 65.24 subdivision 8, and advise the department on which applications should be funded.

65.25 Sec. 40. **[144.0752] CULTURAL COMMUNICATIONS.**

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

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

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

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

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

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

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

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

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

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

66.23 Sec. 41. [144.0753] IMPROVING THE HEALTH AND WELLBEING OF PEOPLE  
 66.24 WITH DISABILITIES.

66.25 Subdivision 1. Goal and establishment. The commissioner of health shall support  
 66.26 collaboration and coordination between state and community partners to improve the health  
 66.27 and wellbeing of people with disabilities by addressing health disparities and equity barriers  
 66.28 to health care and preventative services for chronic diseases and other social determinants  
 66.29 of health. The commissioner, in consultation with the Olmstead Implementation Office,  
 66.30 Department of Human Services, Board on Aging, Minnesota Council on Disability, health  
 66.31 care professionals, local public health agencies, and other community organizations that  
 66.32 serve people with disabilities, shall routinely identify priorities and action steps to address  
 66.33 identified gaps in services, resources, and tools.

67.1 Subd. 2. **Assessment and tracking.** The commissioner shall conduct a community needs  
 67.2 assessment and establish a health surveillance and tracking plan in collaboration with  
 67.3 community and organizational partners to identify and address disability health disparities.  
 67.4 The commissioner shall sponsor a public disability data dashboard to report on health  
 67.5 outcomes for people with disabilities. The data shall inform comprehensive disability health  
 67.6 planning, complete with health goals and wellness benchmarks, to prioritize public health  
 67.7 programming for people with disabilities.

67.8 Subd. 3. **Grants authorized.** The commissioner shall establish community-based grants  
 67.9 to support establishment of inclusive evidence-based chronic disease prevention and  
 67.10 management services to address identified gaps and disparities in services.

67.11 Subd. 4. **Technical assistance.** The commissioner shall provide and evaluate training  
 67.12 and capacity-building technical assistance on disability inclusion health training, complete  
 67.13 with accessible preventive health care for public health and health care providers of chronic  
 67.14 disease prevention and management programs and services.

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

67.17 Subd. 6. **Advisory group.** The commissioner shall convene an external disability  
 67.18 community advisory group comprised of people with disabilities, community organizations,  
 67.19 and other partners and stakeholders to advise the department on disability health equity  
 67.20 programs and initiatives through an intersectional disability justice lens. The advisory group  
 67.21 shall also provide guidance regarding the accessibility of department programming and  
 67.22 operations for people with disabilities.

67.23 Sec. 42. **[144.0754] OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES.**

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

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

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

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

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

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

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

68.17 **Sec. 43. [144.0755] AFRICAN AMERICAN HEALTH STATE ADVISORY**  
 68.18 **COUNCIL.**

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

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

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

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

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

68.29 (4) African American secondary or college students;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

70.17 **Subd. 8. Reimbursement.** Compensation or reimbursement for travel and expenses, or  
 70.18 both, incurred for council activities is governed in accordance with section 15.059,  
 70.19 subdivision 3.

70.20 **Sec. 44. [144.0756] AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT**  
 70.21 **PROGRAM.**

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

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

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

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

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

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

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

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

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

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

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

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

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

71.28 Sec. 45. **[144.0757] OFFICE OF AMERICAN INDIAN HEALTH .**

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

71.31 (1) coordinate with Minnesota's Tribal Nations and urban American Indian  
 71.32 community-based organizations to identify underlying causes of health disparities, address

72.1 unique health needs of Minnesota's Tribal communities, and develop public health approaches  
 72.2 to achieve health equity;

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

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

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

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

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

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

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

72.21 Sec. 46. **[144.0758] AMERICAN INDIAN SPECIAL EMPHASIS GRANTS.**

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

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

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

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

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



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

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

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

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

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

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

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

73.17 Subd. 4. **Strategic consideration and priority of proposals; grant awards.** In  
 73.18 developing the proposals and awarding the grants, the commissioner shall consider building  
 73.19 upon the existing capacity of Minnesota's Tribal Nations and urban American Indian  
 73.20 community-based organizations and on developing capacity where it is lacking. Proposals  
 73.21 should focus on addressing health equity issues specific to Tribal and urban American Indian  
 73.22 communities; addressing the health impact of historical trauma; reducing health disparities  
 73.23 experienced by American Indian communities; and incorporating a multisector approach  
 73.24 to addressing identified disparities.

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

73.27 Sec. 47. **[144.0759] PUBLIC HEALTH AMERICORPS.**

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

74.1 Sec. 48. **[144.078] TELEHEALTH IN LIBRARIES PILOT PROGRAM.**

74.2 Subdivision 1. **Grant program.** The commissioner shall administer a grant program  
74.3 for up to six Minnesota libraries to establish and manage telehealth locations to improve  
74.4 access to health care for individuals who currently lack access to health services, do not  
74.5 have adequate technology resources in their homes to access health care or mental health  
74.6 services from their home, or lack technology literacy. The program will monitor progress,  
74.7 conduct an overall evaluation of effectiveness, and report results to the commissioner who  
74.8 may make recommendations for future or continuing program investments.

74.9 Subd. 2. **Expiration.** This section expires June 31, 2027.

74.10 Sec. 49. Minnesota Statutes 2022, section 144.122, is amended to read:

74.11 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

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

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

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

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

75.7	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
75.8	Healthcare Organizations (JCAHO) and	
75.9	American Osteopathic Association (AOA)	
75.10	hospitals	
75.11	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
75.12	Nursing home	\$183 plus \$91 per bed until June 30, 2018.
75.13		\$183 plus \$100 per bed between July 1, 2018,
75.14		and June 30, 2020. \$183 plus \$105 per bed
75.15		beginning July 1, 2020.

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

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

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

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

75.30	Prospective payment surveys for hospitals	\$	900
75.31	Swing bed surveys for nursing homes	\$	1,200
75.32	Psychiatric hospitals	\$	1,400
75.33	Rural health facilities	\$	1,100
75.34	Portable x-ray providers	\$	500
75.35	Home health agencies	\$	1,800
75.36	Outpatient therapy agencies	\$	800
75.37	End stage renal dialysis providers	\$	2,100

76.1	Independent therapists	\$	800
76.2	Comprehensive rehabilitation outpatient facilities	\$	1,200
76.3	Hospice providers	\$	1,700
76.4	Ambulatory surgical providers	\$	1,800
76.5	Hospitals	\$	4,200
76.6	Other provider categories or additional		Actual surveyor costs: average surveyor cost x number of hours for the survey process.
76.7	resurveys required to complete initial		
76.8	certification		

76.9        These fees shall be submitted at the time of the application for federal certification and  
76.10 shall not be refunded. All fees collected after the date that the imposition of fees is not  
76.11 prohibited by federal law shall be deposited in the state treasury and credited to the state  
76.12 government special revenue fund.

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

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

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

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

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

77.1 Sec. 50. **[144.1462] COMMUNITY HEALTH WORKERS; GRANTS AUTHORIZED.**

77.2 Subdivision 1. **Establishment.** The commissioner of health shall support collaboration  
77.3 and coordination between state and community partners to develop, refine, and expand the  
77.4 community health workers (CHW) profession in Minnesota; equipping community health  
77.5 workers to address health needs; and to improve health outcomes. This work addresses the  
77.6 social conditions that impact community health and well-being in public safety, social  
77.7 services, youth and family services, schools, and neighborhood associations.

77.8 Subd. 2. **Grants and contracts authorized; eligibility.** The commissioner of health  
77.9 shall establish grants and contracts to expand and strengthen the community health worker  
77.10 workforce across Minnesota. The recipients shall include at least one not-for-profit  
77.11 community organization serving, convening, and supporting community health workers  
77.12 statewide.

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

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

77.22 Sec. 51. **[144.1463] COMMUNITY MENTAL HEALTH AND WELL-BEING GRANT**  
77.23 **PROGRAM.**

77.24 Subdivision 1. **Establishment.** The commissioner of health shall establish the community  
77.25 mental health and well-being grant program. The purposes of the program are to:

77.26 (1) improve outcomes related to the well-being of Black, nonwhite Latino(a), American  
77.27 Indians, LGBTQIA+, and disability communities, including but not limited to health and  
77.28 well-being; economic security; and safe, stable, nurturing relationships and environments  
77.29 by funding community-based solutions for challenges that are identified by the affected  
77.30 community;

77.31 (2) reduce health inequities related to mental health and well-being; and

77.32 (3) promote racial and geographic equity.

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

78.2 (1) develop a request for proposals for the community mental health well-being grant  
78.3 program in consultation with community stakeholders, local public health organizations  
78.4 and Tribal nations;

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

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

78.11 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,  
78.12 Minnesota Council on Disability and the governor's office on the request for proposal  
78.13 process;

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

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

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

78.19 (8) contract with an independent third-party entity to evaluate the success of the grant  
78.20 program and to build the evidence base for effective community solutions in reducing mental  
78.21 health disparities related to mental health and well-being.

78.22 Subd. 3. Eligible grantees. Organizations eligible to receive grant funding under this  
78.23 section include:

78.24 (1) organizations or entities that work with Black, nonwhite Latino(a), and American  
78.25 Indian communities;

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

78.28 (3) organizations or entities focused on supporting mental health and community healing.

78.29 Subd. 4. Strategic consideration and priority of proposals; eligible populations;  
78.30 grant awards. (a) The commissioner, in consultation with community stakeholders, local  
78.31 public health organizations and Tribal nations, shall develop a request for proposals for  
78.32 mental health, community healing and well-being grants. In developing the proposals and

79.1 awarding the grants, the commissioner shall consider building on the capacity of communities  
 79.2 to promote well-being and support holistic health. Proposals must focus on increasing health  
 79.3 equity and community healing and reducing health disparities experienced by Black, nonwhite  
 79.4 Latino(a), American Indians, LGBTQIA+, and disability communities.

79.5 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
 79.6 give priority to proposals from: organizations or entities led by populations of color,  
 79.7 American Indians and those serving communities of color, American Indians; LGBTQIA+,  
 79.8 and disability communities. The advisory council may recommend additional strategic  
 79.9 considerations and priorities to the commissioner.

79.10 Subd. 5. **Geographic distribution of grants.** The commissioner shall ensure that grant  
 79.11 funds are prioritized and awarded to organizations and entities that are within counties that  
 79.12 have a higher proportion of Black or African American, nonwhite Latino(a), American  
 79.13 Indians, LGBTQIA+, and disability communities to the extent possible.

79.14 Subd. 6. **Report.** Grantees must report grant program outcomes to the commissioner on  
 79.15 the forms and according to the timelines established by the commissioner.

79.16 Sec. 52. **[144.1504] EMPLOYEE RECRUITMENT EDUCATION LOAN**  
 79.17 **FORGIVENESS PROGRAM.**

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

79.20 (b) "Designated rural area" means a statutory and home rule charter city or township  
 79.21 that is outside the seven-county metropolitan area as defined in section 473.121, subdivision  
 79.22 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

79.23 (c) "Emergency circumstances" means those conditions that make it impossible for the  
 79.24 participant to fulfill the service commitment, including death, total and permanent disability,  
 79.25 or temporary disability lasting more than two years.

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

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

79.30 (f) "Physician assistant" means a person licensed under chapter 147A.

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

80.4 Subd. 2. **Creation of account.** (a) A health professional employee education loan  
80.5 forgiveness program account is established. The commissioner of health shall use money  
80.6 from the account to make grants to eligible providers for a loan forgiveness recruitment and  
80.7 retention program. Nominations for loan forgiveness through a grant shall be available to  
80.8 employees who are nurse practitioners, physicians, or physician assistants who agree to  
80.9 practice in designated rural areas that are included in a health profession's shortage area,  
80.10 where the provider rate per 10,000 population is less than ten and the vacancy rate has  
80.11 reached a level determined by the commissioner.

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

80.16 Subd. 3. **Eligibility.** (a) Eligible providers must provide services in designated rural  
80.17 areas that are included in a health profession's shortage area where the provider rate per  
80.18 10,000 population is less than ten and the vacancy rate has reached a level determined by  
80.19 the commissioner for nurse practitioners, physicians, or physician assistants.

80.20 (b) Employees, as described in subdivision 2, paragraph (a), selected to receive loan  
80.21 forgiveness must agree to work a minimum average of 30 hours per week for a minimum  
80.22 of five years for a qualifying provider organization to maintain eligibility for loan forgiveness  
80.23 under this section.

80.24 Subd. 4. **Request for proposals.** The commissioner shall publish request for proposals  
80.25 that specify qualifying provider eligibility requirements; criteria for a qualifying employee  
80.26 loan forgiveness recruitment program; provider selection criteria; documentation required  
80.27 for program participation; maximum number of loan forgiveness slots available per eligible  
80.28 provider; and methods of evaluation. The commissioner must publish additional requests  
80.29 for proposals each year in which funding is available for this purpose.

80.30 Subd. 5. **Application requirements.** (a) Eligible providers seeking loan forgiveness for  
80.31 employees shall submit an application to the commissioner. Applications from eligible  
80.32 providers must contain a complete description of the employee loan forgiveness program  
80.33 being proposed by the applicant, the process for determining which employees are eligible  
80.34 for loan forgiveness, and any special circumstances related to the provider that make it



81.1 difficult to recruit and retain qualified employees. Eligible providers must submit the names  
81.2 of their employees to be considered for loan forgiveness.

81.3 (b) An employee whose name has been submitted to the commissioner and who wishes  
81.4 to apply for loan forgiveness must submit an application to the commissioner that must  
81.5 include employee practice site information and verification of employee qualified educational  
81.6 loan debt. The employee is responsible for securing the employee's qualified educational  
81.7 loans.

81.8 Subd. 6. **Selection process.** The commissioner shall determine a maximum number of  
81.9 loan forgiveness slots available per eligible provider and shall make selections based on the  
81.10 information provided in the grant application, including the demonstrated need for an  
81.11 applicant provider to enhance the retention of its workforce, the proposed employee loan  
81.12 forgiveness selection process, and other criteria as determined by the commissioner.

81.13 Subd. 7. **Reporting requirements.** (a) Participating providers whose employees receive  
81.14 loan forgiveness shall submit a report to the commissioner on a schedule determined by the  
81.15 commissioner and on a form supplied by the commissioner. The report must include the  
81.16 number of employees receiving loan forgiveness and, for each employee receiving loan  
81.17 forgiveness, the employee's name, current position, and average number of hours worked  
81.18 per week. During the loan forgiveness period, the commissioner may require and collect  
81.19 from participating providers and employees receiving loan forgiveness other information  
81.20 necessary to evaluate the program and ensure ongoing eligibility.

81.21 (b) Before receiving loan repayment disbursements, the employee must complete and  
81.22 return to the commissioner a confirmation of practice form provided by the commissioner  
81.23 verifying that the employee is practicing as required in subdivision 3. The employee must  
81.24 provide the commissioner with verification that the full amount of loan repayment  
81.25 disbursement received by the employee has been applied toward the designated loans. After  
81.26 each disbursement, verification must be received by the commissioner and approved before  
81.27 the next loan repayment disbursement is made. Employees who move to a different eligible  
81.28 provider remain eligible for loan repayment as long as they practice as required in subdivision  
81.29 3.

81.30 Subd. 8. **Penalty for nonfulfillment.** If an employee does not fulfill the required  
81.31 minimum service commitment in subdivision 3, the commissioner shall collect from the  
81.32 employee the total amount paid to the employee under the loan forgiveness program, plus  
81.33 interest at a rate established according to section 270C.40. The commissioner shall deposit  
81.34 the money collected in an account in the special revenue fund and money in that account

82.1 is annually appropriated to the commissioner for purposes of this section. The commissioner  
 82.2 may allow waivers of all or part of the money owed to the commissioner as a result of a  
 82.3 nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum  
 82.4 service commitment.

82.5 Subd. 9. Rules. The commissioner may adopt rules to implement this section.

82.6 Sec. 53. Minnesota Statutes 2022, section 144.1505, is amended to read:

82.7 **144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION**  
 82.8 **AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT PROGRAM**  
 82.9 **PROGRAMS.**

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

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

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

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

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

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

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

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

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

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

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

83.7 ~~(7)~~ (9) "project" means a project to establish or expand clinical training for physician  
 83.8 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced  
 83.9 dental therapists, or mental health professionals in Minnesota.

83.10 Subd. 2. ~~Program Programs.~~ (a) For advanced practice provider clinical training  
 83.11 expansion grants, the commissioner of health shall award health professional training site  
 83.12 grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental  
 83.13 therapy, and mental health professional programs to plan and implement expanded clinical  
 83.14 training. A planning grant shall not exceed \$75,000, and a training grant shall not exceed  
 83.15 \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for the third year per  
 83.16 program.

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

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

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

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

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

83.33 (4) travel and lodging for students;

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

84.2 (6) development and implementation of cultural competency training;

84.3 (7) evaluations;

84.4 (8) training site improvements, fees, equipment, and supplies required to establish,

84.5 maintain, or expand ~~a physician assistant, advanced practice registered nurse, pharmacy,~~

84.6 ~~dental therapy, or mental health professional~~ training program; and

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

84.8 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,  
84.9 pharmacy, dental therapy, and mental health professional programs and physician and dental

84.10 programs seeking a grant shall apply to the commissioner. Applications must include a

84.11 description of the number of additional students who will be trained using grant funds;

84.12 attestation that funding will be used to support an increase in the number of clinical training

84.13 slots; a description of the problem that the proposed project will address; a description of

84.14 the project, including all costs associated with the project, sources of funds for the project,

84.15 detailed uses of all funds for the project, and the results expected; and a plan to maintain or

84.16 operate any component included in the project after the grant period. The applicant must

84.17 describe achievable objectives, a timetable, and roles and capabilities of responsible

84.18 individuals in the organization. Applicants applying under subdivision 2, paragraph (b),

84.19 must include information about length of training and training site settings, geographic

84.20 location of rural sites, and rural populations expected to be served.

84.21 Subd. 4. **Consideration of applications.** The commissioner shall review each application

84.22 to determine whether or not the application is complete and whether the program and the

84.23 project are eligible for a grant. In evaluating applications, the commissioner shall score each

84.24 application based on factors including, but not limited to, the applicant's clarity and

84.25 thoroughness in describing the project and the problems to be addressed, the extent to which

84.26 the applicant has demonstrated that the applicant has made adequate provisions to ensure

84.27 proper and efficient operation of the training program once the grant project is completed,

84.28 the extent to which the proposed project is consistent with the goal of increasing access to

84.29 primary care and mental health services for rural and underserved urban communities, the

84.30 extent to which the proposed project incorporates team-based primary care, and project

84.31 costs and use of funds.

84.32 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant

84.33 to be given to an eligible program based on the relative score of each eligible program's

84.34 application, including rural locations as applicable under subdivision 2, paragraph (b), other

85.1 relevant factors discussed during the review, and the funds available to the commissioner.  
 85.2 Appropriations made to the program do not cancel and are available until expended. During  
 85.3 the grant period, the commissioner may require and collect from programs receiving grants  
 85.4 any information necessary to evaluate the program.

85.5 Sec. 54. [144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT  
 85.6 PROGRAM.

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

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

85.10 (1) is located in Minnesota;

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

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

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

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

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

85.27 Subd. 2. Rural residency training program. (a) The commissioner of health shall  
 85.28 award rural residency training program grants to eligible programs to plan, implement, and  
 85.29 sustain rural residency training programs. A rural residency training program grant shall  
 85.30 not exceed \$250,000 per year for up to three years for planning and development, and  
 85.31 \$225,000 per resident per year for each year thereafter to sustain the program.

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

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

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

86.4 (3) establishing new rural residency training programs;

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

86.7 (5) travel and lodging for new residents;

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

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

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

86.13 Subd. 3. **Applications for rural residency training program grants.** Eligible programs  
86.14 seeking a grant shall apply to the commissioner. Applications must include the number of  
86.15 new primary care rural residency training program slots planned, under development or  
86.16 under contract; a description of the training program, including location of the established  
86.17 residency program and rural training sites; a description of the project, including all costs  
86.18 associated with the project; all sources of funds for the project; detailed uses of all funds  
86.19 for the project; the results expected; proof of eligibility for federal graduate medical education  
86.20 funding, if applicable; and a plan to seek the funding. The applicant must describe achievable  
86.21 objectives, a timetable, and the roles and capabilities of responsible individuals in the  
86.22 organization.

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

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

87.1 section 16A.28, subdivision 6, encumbrances for grants under this section issued by June  
87.2 30 of each year may be certified for a period of up to three years beyond the year in which  
87.3 the funds were originally appropriated.

87.4 Sec. 55. [144.1508] CLINICAL HEALTH CARE TRAINING.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

88.24 (3) for each applicant, the type and specialty orientation of trainees in the program; the  
88.25 name, entity address, medical assistance provider number, and national provider identification  
88.26 number of each training site used in the program, as appropriate; the federal tax identification  
88.27 number of each training site, where available; the total number of eligible trainee FTEs at  
88.28 each site; and

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

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



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

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

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

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

89.21 Sec. 56. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

89.22 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision  
89.23 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record  
89.24 and for a certification that the vital record cannot be found. The state registrar or local  
89.25 issuance office shall forward this amount to the commissioner of management and budget  
89.26 each month following the collection of the surcharge for deposit into the account for the  
89.27 children's trust fund for the prevention of child abuse established under section 256E.22.  
89.28 This surcharge shall not be charged under those circumstances in which no fee for a certified  
89.29 birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification  
89.30 by the commissioner of management and budget that the assets in that fund exceed  
89.31 \$20,000,000, this surcharge shall be discontinued.

89.32 (b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable  
89.33 surcharge of \$10 for each certified birth record. The state registrar or local issuance office

90.1 shall forward this amount to the commissioner of management and budget each month  
90.2 following the collection of the surcharge for deposit in the general fund.

90.3 Sec. 57. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

90.4 Subd. 4. **Vital records surcharge.** In addition to any fee prescribed under subdivision  
90.5 1, there is a nonrefundable surcharge of \$4 for each certified and noncertified birth, stillbirth,  
90.6 or death record, and for a certification that the record cannot be found. The local issuance  
90.7 office or state registrar shall forward this amount to the commissioner of management and  
90.8 budget each month following the collection of the surcharge to be deposited into the state  
90.9 government special revenue fund.

90.10 Sec. 58. Minnesota Statutes 2022, section 144.383, is amended to read:

90.11 **144.383 AUTHORITY OF COMMISSIONER.**

90.12 In order to insure safe drinking water in all public water supplies, the commissioner has  
90.13 the ~~following~~ powers to:

90.14 ~~(a) To~~ (1) approve the site, design, and construction and alteration of all public water  
90.15 supplies and, for community and nontransient noncommunity water systems as defined in  
90.16 Code of Federal Regulations, title 40, section 141.2, to approve documentation that  
90.17 demonstrates the technical, managerial, and financial capacity of those systems to comply  
90.18 with rules adopted under this section;

90.19 ~~(b) To~~ (2) enter the premises of a public water supply, or part thereof, to inspect the  
90.20 facilities and records kept pursuant to rules promulgated by the commissioner, to conduct  
90.21 sanitary surveys and investigate the standard of operation and service delivered by public  
90.22 water supplies;

90.23 ~~(c) To~~ (3) contract with community health boards as defined in section 145A.02,  
90.24 subdivision 5, for routine surveys, inspections, and testing of public water supply quality;

90.25 ~~(d) To~~ (4) develop an emergency plan to protect the public when a decline in water  
90.26 quality or quantity creates a serious health risk, and to issue emergency orders if a health  
90.27 risk is imminent;

90.28 ~~(e) To~~ (5) promulgate rules, pursuant to chapter 14 but no less stringent than federal  
90.29 regulation, which may include the granting of variances and exemptions; and

91.1 (6) maintain a database of lead service lines, provide technical assistance to community  
 91.2 systems, and ensure the lead service line inventory data is accessible to the public with  
 91.3 relevant educational materials about health risks related to lead and ways to reduce exposure.

91.4 **Sec. 59. [144.3832] PUBLIC WATER SYSTEM INFRASTRUCTURE**  
 91.5 **STRENGTHENING GRANTS.**

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

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

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

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

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

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

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

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

91.28 **Sec. 60. [144.9282] ADVANCING EQUITY THROUGH COMMUNITY**  
 91.29 **ENGAGEMENT AND SYSTEMS TRANSFORMATION GRANTS.**

91.30 Subdivision 1. **Grant establishment.** The commissioner of health shall establish a grant  
 91.31 program to advance equitable and inclusive community engagement by cultivating a

92.1 community of practice and building community engagement capacity within the department's  
 92.2 system and local public health organizations to:

92.3 (1) ensure that capacity building efforts are translated into practice and that community  
 92.4 relationships and partnerships are strengthened, and avenues for meaningful participation  
 92.5 of Minnesota's diverse communities such as populations of color, American Indians,  
 92.6 LGBTQIA+, and those with disabilities in metro and rural communities in public health  
 92.7 programs are created;

92.8 (2) ensure that current and future policies, procedures, and strategies facilitate meaningful  
 92.9 engagement of communities and focus to create their own healthy futures;

92.10 (3) identify new strategies and actions to support efforts to listen authentically to, and  
 92.11 partner with, Minnesotans most impacted by inequities;

92.12 (4) reduce health inequities; and

92.13 (5) promote racial and geographic equity.

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

92.15 (1) develop a request for proposals for the community engagement capacity building  
 92.16 grant program in consultation with community stakeholders, and local public health  
 92.17 organizations;

92.18 (2) provide outreach, technical assistance, and program development support to increase  
 92.19 capacity for staff, local public health organizations, and communities of practice;

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

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

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

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

92.27 (8) establish a process or mechanism to evaluate the success of the grant program and  
 92.28 to build the evidence base for effective community engagement in reducing health disparities.

92.29 Subd. 3. Eligible grantees. Organizations eligible to receive grant funding under this  
 92.30 section include: organizations or entities that work with diverse communities such as

93.1 populations of color, American Indians, LGBTQIA+, and those with disabilities in metro  
 93.2 and rural communities.

93.3 **Subd. 4. Strategic consideration and priority of proposals; eligible populations;**  
 93.4 **grant awards.** (a) The commissioner, in consultation with community stakeholders, local  
 93.5 public health organizations, and Tribal nations, shall develop a request for proposals to  
 93.6 advance equitable and inclusive community engagement by cultivating a community of  
 93.7 practice and building capacity within their system, service providers, and local public health  
 93.8 organizations.

93.9 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
 93.10 give priority to proposals from local public health departments and other service providers:

93.11 (1) with significant emphasis on serving populations of color, LGBTQIA+, and disability  
 93.12 communities; and

93.13 (2) partnering with organizations or entities led by populations of color and those serving  
 93.14 communities of color, American Indians, LGBTQIA+, and disabilities in metro and rural  
 93.15 communities.

93.16 **Subd. 5. Geographic distribution of grants.** The commissioner shall ensure that grant  
 93.17 funds are prioritized and awarded to organizations and entities that are within counties that  
 93.18 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,  
 93.19 and disability communities to the extent possible.

93.20 **Subd. 6. Report.** Grantees must report grant program outcomes to the commissioner on  
 93.21 the forms and according to the timelines established by the commissioner.

93.22 **Sec. 61. [144.9821] ADVANCING HEALTH EQUITY THROUGH CAPACITY**  
 93.23 **BUILDING AND RESOURCE ALLOCATION.**

93.24 **Subdivision 1. Establishment of grant program.** The commissioner of health shall:

93.25 (1) establish an annual grant program to award infrastructure capacity building grants  
 93.26 to help metro and rural community and faith-based organizations serving populations of  
 93.27 color, American Indian, LGBTQIA+, and those with disabilities in Minnesota who have  
 93.28 been disproportionately impacted by health and other inequities to be better equipped and  
 93.29 prepared for success in procuring grants and contracts at the department and addressing  
 93.30 inequities; and

94.1 (2) create a framework at the department to maintain equitable practices in grantmaking  
94.2 to ensure that internal grantmaking and procurement policies and practices prioritize equity,  
94.3 transparency, and accessibility to include:

94.4 (i) a tracking system for the department to better monitor and evaluate equitable  
94.5 procurement and grantmaking processes and their impacts; and

94.6 (ii) technical assistance and coaching to department leadership in grantmaking and  
94.7 procurement processes and programs and providing tools and guidance to ensure equitable  
94.8 and transparent competitive grantmaking processes and award distribution across  
94.9 communities most impacted by inequities and develop measures to track progress over time.

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

94.11 (1) in consultation with community stakeholders, community health boards and Tribal  
94.12 nations, develop a request for proposals for infrastructure capacity building grant program  
94.13 to help community-based organizations, including faith-based organizations, to be better  
94.14 equipped and prepared for success in procuring grants and contracts at the department and  
94.15 beyond;

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

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

94.22 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,  
94.23 Minnesota Council on Disability, and the governor's office on the request for proposal  
94.24 process;

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

94.27 (6) maintain data on outcomes reported by grantees; and

94.28 (7) establish a process or mechanism to evaluate the success of the capacity building  
94.29 grant program and to build the evidence base for effective community-based organizational  
94.30 capacity building in reducing disparities.

94.31 Subd. 3. Eligible grantees. Organizations eligible to receive grant funding under this  
94.32 section include: organizations or entities that work with diverse communities such populations

95.1 of color, American Indian, LGBTQIA+, and those with disabilities in metro and rural  
 95.2 communities.

95.3 **Subd. 4. Strategic consideration and priority of proposals; eligible populations;**  
 95.4 **grant awards.** (a) The commissioner, in consultation with community stakeholders, shall  
 95.5 develop a request for proposals for equity in procurement and grantmaking capacity building  
 95.6 grant program to help community-based organizations, including faith-based organizations  
 95.7 to be better equipped and prepared for success in procuring grants and contracts at the  
 95.8 department and addressing inequities.

95.9 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
 95.10 give priority to proposals from organizations or entities led by populations of color, American  
 95.11 Indians and those serving communities of color, American Indians; LGBTQIA+, and  
 95.12 disability communities.

95.13 **Subd. 5. Geographic distribution of grants.** The commissioner shall ensure that grant  
 95.14 funds are prioritized and awarded to organizations and entities that are within counties that  
 95.15 have a higher proportion of Black or African American, nonwhite Latino(a), LGBTQIA+,  
 95.16 and disability communities to the extent possible.

95.17 **Subd. 6. Report.** Grantees must report grant program outcomes to the commissioner on  
 95.18 the forms and according to the timelines established by the commissioner.

95.19 **Sec. 62. [144.9981] CLIMATE RESILIENCY.**

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

95.22 (1) increase awareness of climate change;

95.23 (2) track the public health impacts of climate change and extreme weather events;

95.24 (3) provide technical assistance and tools that support climate resiliency to local public  
 95.25 health, Tribal health, soil and water conservation districts, and other local governmental  
 95.26 and nongovernmental organizations; and

95.27 (4) coordinate with the commissioners of the pollution control agency, natural resources,  
 95.28 and agriculture and other state agencies in climate resiliency related planning and  
 95.29 implementation.

95.30 **Subd. 2. Grants authorized; allocation.** (a) The commissioner of health shall manage  
 95.31 a grant program for the purpose of climate resiliency planning. The commissioner shall  
 95.32 award grants through a request for proposals process to local public health, Tribal health,

96.1 soil and water conservation districts, or other local organizations for planning for the health  
 96.2 impacts of extreme weather events and developing adaptation actions. Priority shall be given  
 96.3 to organizations that serve communities that are disproportionately impacted by climate  
 96.4 change.

96.5 (b) Grantees must use the funds to develop a plan or implement strategies that will reduce  
 96.6 the risk of health impacts from extreme weather events. The grant application must include:

96.7 (1) a description of the plan or project for which the grant funds will be used;

96.8 (2) a description of the pathway between the plan or project and its impacts on health;

96.9 (3) a description of the objectives, a work plan, and a timeline for implementation; and

96.10 (4) the community or group the grant proposes to focus on.

96.11 Sec. 63. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

96.12 Subd. 7. **Fines and penalties.** (a) The fee fine for failure to comply with the notification  
 96.13 requirements in section 144G.52, subdivision 7, is \$1,000.

96.14 (b) Fines and penalties collected under this section shall be deposited in a dedicated  
 96.15 special revenue account. On an annual basis, the balance in the special revenue account  
 96.16 shall be appropriated to the commissioner to implement the recommendations of the advisory  
 96.17 council established in section 144A.4799.

96.18 Sec. 64. Minnesota Statutes 2022, section 144G.18, is amended to read:

96.19 **144G.18 NOTIFICATION OF CHANGES IN INFORMATION.**

96.20 Subdivision 1. Notification. A provisional licensee or licensee shall notify the  
 96.21 commissioner in writing prior to a change in the manager or authorized agent and within  
 96.22 60 calendar days after any change in the information required in section 144G.12, subdivision  
 96.23 1, clause (1), (3), (4), (17), or (18).

96.24 Subd. 2. Fines and penalties. (a) The fine for failure to comply with the notification  
 96.25 requirements of this section is \$1,000.

96.26 (b) Fines and penalties collected under this subdivision shall be deposited in a dedicated  
 96.27 special revenue account. On an annual basis, the balance in the special revenue account  
 96.28 shall be appropriated to the commissioner to implement the recommendations of the advisory  
 96.29 council established in section 144A.4799.



97.1 Sec. 65. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

97.2 Subd. 8. ~~Fine~~ **Fines and penalties.** (a) The commissioner may impose a fine for failure  
97.3 to follow the requirements of this section.

97.4 (b) The fine for failure to comply with this section is \$1,000.

97.5 (c) Fines and penalties collected under this section shall be deposited in a dedicated  
97.6 special revenue account. On an annual basis, the balance in the special revenue account  
97.7 shall be appropriated to the commissioner to implement the recommendations of the advisory  
97.8 council established in section 144A.4799.

97.9 Sec. 66. **[145.361] LONG COVID.**

97.10 Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health  
97.11 problems that people experience four or more weeks after being infected with SARS-CoV-2,  
97.12 the virus that causes COVID-19. Long COVID is also called post COVID conditions,  
97.13 long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19  
97.14 (PASC).

97.15 Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct  
97.16 community assessments and epidemiologic investigations to monitor and address impacts  
97.17 of long COVID. The purposes of these activities are to:

97.18 (1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care  
97.19 management and costs; changes in disability status, employment, and quality of life; and  
97.20 service needs of individuals with long COVID and to detect potential public health problems,  
97.21 predict risks, and assist in investigating long COVID health inequities;

97.22 (2) more accurately target information and resources for communities and patients and  
97.23 their families;

97.24 (3) inform health professionals and citizens about risks, early detection, and treatment  
97.25 of long COVID known to be elevated in their communities; and

97.26 (4) promote evidence-based practices around long COVID prevention and management  
97.27 and to address public concerns and questions about long COVID.

97.28 Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health  
97.29 care professionals, the Department of Human Services, local public health, health insurers,  
97.30 employers, schools, long COVID survivors, and community organizations serving people  
97.31 at high risk of long COVID, identify priority actions and activities to address the needs for

98.1 communication, services, resources, tools, strategies, and policies to support long COVID  
98.2 survivors and their families.

98.3 Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and  
98.4 collaborate with community and organizational partners to implement evidence-informed  
98.5 priority actions through community-based grants and contracts. The commissioner of health  
98.6 shall award contracts and grants to organizations that serve communities disproportionately  
98.7 impacted by COVID-19 and long COVID, including but not limited to rural and low-income  
98.8 areas, Black and African Americans, African immigrants, American Indians, Asian  
98.9 American-Pacific Islanders, Latino(a), LGBTQ+, and persons with disabilities. Organizations  
98.10 may also address intersectionality within the groups. The commissioner shall award grants  
98.11 and contracts to eligible organizations to plan, construct, and disseminate resources and  
98.12 information to support survivors of long COVID, including caregivers, health care providers,  
98.13 ancillary health care workers, workplaces, schools, communities, and local and Tribal public  
98.14 health.

98.15 Sec. 67. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

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

98.20 (d) "988" means the universal telephone number designated as the universal telephone  
98.21 number within the United States for the purpose of the national suicide prevention and  
98.22 mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline,  
98.23 or its successor, maintained by the Assistant Secretary for Mental Health and Substance  
98.24 Use under section 520E-3 of the Public Health Service Act (United States Code, title 42,  
98.25 sections 290bb-36c).

98.26 (e) "988 administrator" means the administrator of the national 988 Suicide and Crisis  
98.27 Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under  
98.28 section 520E-3 of the Public Health Service Act.

98.29 (f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system  
98.30 within the United States via modalities offered including call, chat, or text.

98.31 (g) "988 Lifeline Center" means a state identified center that is a member of the Suicide  
98.32 and Crisis Lifeline network that responds to statewide or regional 988 contacts.

99.1 (h) "988 Suicide and Crisis Lifeline (988 Lifeline)" means the national suicide prevention  
99.2 and mental health crisis hotline system maintained by the Assistant Secretary for Mental  
99.3 Health and Substance Use under section 520E-3 of the Public Health Service Act (United  
99.4 States Code, title 42, sections 290bb-36c).

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

99.7 Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and  
99.8 oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts  
99.9 from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the  
99.10 state 24 hours per day, seven days per week.

99.11 (b) The designated 988 Lifeline Center must:

99.12 (1) have an active agreement with the 988 Suicide and Crisis Lifeline program for  
99.13 participation in the network and the department;

99.14 (2) meet the 988 Lifeline program requirements and best practice guidelines for  
99.15 operational and clinical standards;

99.16 (3) provide data and reports, and participate in evaluations and related quality  
99.17 improvement activities as required by the 988 Lifeline program and the department;

99.18 (4) identify or adapt technology that is demonstrated to be interoperable across Mobile  
99.19 Crisis and Public Safety Answering Points used in the state for the purpose of crisis care  
99.20 coordination;

99.21 (5) facilitate crisis and outgoing services, including mobile crisis teams in accordance  
99.22 with guidelines established by the 988 Lifeline program and the department;

99.23 (6) actively collaborate and coordinate service linkages with mental health and substance  
99.24 use disorder treatment providers, local community mental health centers including certified  
99.25 community behavioral health clinics and community behavioral health centers, mobile crisis  
99.26 teams, and community based and hospital emergency departments;

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

99.29 (8) meet the requirements set by the 988 Lifeline program and the department for serving  
99.30 at-risk and specialized populations.

99.31 (c) The department shall adopt rules and regulations to allow appropriate information  
99.32 sharing and communication between and across crisis and emergency response systems.

100.1 (d) The department, having primary oversight of suicide prevention, shall work with the  
100.2 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the  
100.3 purpose of ensuring consistency of public messaging about 988 services. The department  
100.4 may use funds under this section or provide grants to organizations in order to publicize  
100.5 and raise awareness about 988 services.

100.6 (e) The department shall work with representatives from 988 Lifeline Centers and public  
100.7 safety answering points, other public safety agencies and the commissioner of public safety  
100.8 to facilitate the development of protocols and procedures for interactions between 988 and  
100.9 911 services across Minnesota. Protocols and procedures shall be developed following  
100.10 available national standards and guidelines.

100.11 (f) The department shall provide an annual report of the 988 Lifeline usage including  
100.12 answer rates, abandoned calls, and referrals to 911 emergency response.

100.13 Subd. 3. **988 special revenue account established.** (a) There is established a dedicated  
100.14 account in the special revenue fund to create and maintain a statewide 988 suicide and crisis  
100.15 lifeline system pursuant to the National Suicide Hotline Designation Act of 2020, the Federal  
100.16 Communications Commission's rules adopted July 16, 2020, and national guidelines for  
100.17 crisis care.

100.18 (b) The account shall consist of:

100.19 (1) a 988 telecommunications fee imposed;

100.20 (2) a prepaid wireless 988 fee imposed under section 403.161;

100.21 (3) appropriations made by the state legislature;

100.22 (4) grants and gifts intended for deposit;

100.23 (5) interest, premiums, gains, or other earnings on the account; and

100.24 (6) money from any other source that is deposited in or transferred to the account.

100.25 (c) The fund shall be administered by the department and money in the account shall be  
100.26 expended to offset costs that are or can be reasonably attributed to:

100.27 (1) implementing, maintaining, and improving the 988 suicide and crisis lifeline including  
100.28 staffing and technological infrastructure enhancements necessary to achieve operational  
100.29 standards and best practices set by the 988 lifeline and the department;

100.30 (2) personnel for 988 lifeline centers;

101.1 (3) data collection, reporting, participation in evaluations, public promotion, and related  
101.2 quality improvement activities as required by the 988 administrator and the department;  
101.3 and

101.4 (4) administration, oversight, and evaluation of the fund.

101.5 (d) Money in the fund:

101.6 (1) does not revert at the end of any state fiscal year but remains available for the purposes  
101.7 of the fund in subsequent state fiscal years;

101.8 (2) is not subject to transfer to any other fund or to transfer, assignment, or reassignment  
101.9 for any other use or purpose; and

101.10 (3) is continuously appropriated to the commissioner for the purposes of the account.

101.11 (e) An annual report of funds, deposits, and expenditures shall be made to the Federal  
101.12 Communications Commission.

101.13 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide  
101.14 Hotline Designation Act of 2020, the department shall impose a monthly statewide fee on  
101.15 each subscriber of a wireline, wireless, and IP-enabled voice service at a rate that provides  
101.16 for the robust creation, operation, and maintenance of a statewide 988 suicide prevention  
101.17 and crisis system.

101.18 (b) The commissioner shall annually recommend to the Public Utilities Commission an  
101.19 adequate and appropriate fee to implement sections of 145.561. The commissioner shall  
101.20 provide telecommunication service providers and carriers a minimum of 30 days' notice of  
101.21 each fee change.

101.22 (c) The amount of the 988 telecommunication fee must not be less than 12 cents and no  
101.23 more than 25 cents a month on or after January 1, 2024, for each consumer access line,  
101.24 including trunk equivalents as designated by the commission pursuant to section 403.11,  
101.25 subdivision 1. The 988 telecommunication fee must be the same for all subscribers.

101.26 (d) Each wireline, wireless, and IP-enabled voice telecommunications service provider  
101.27 shall collect the 988 telecommunication fee and transfer the amounts collected to the  
101.28 commissioner of public safety in the same manner as provided in section 403.11, subdivision  
101.29 1, paragraph (d).

101.30 (e) The commissioner of public safety shall deposit the money collected from the 988  
101.31 telecommunication fee to the 988 account to be expended only in support of 988 services,  
101.32 or enhancements of such services.

102.1 (f) Consistent with United States Code, title 47, section 251(a), the revenue generated  
102.2 by a 988 telecommunication fee must only be used to offset costs that are or will be  
102.3 reasonably attributed to:

102.4 (1) ensuring the efficient and effective routing and handling of calls, chats, and texts  
102.5 made to the 988 Suicide and Crisis Lifeline centers including staffing and technological  
102.6 infrastructure enhancements necessary to achieve operational, performance, and clinical  
102.7 standards and best practices set by the 988 Lifeline program and the department; and

102.8 (2) personnel and providing acute mental health and crisis outreach services by directly  
102.9 responding to the 988 Suicide and Crisis Lifeline.

102.10 (g) All 988 telecommunications fee revenue must be used to supplement, not supplant,  
102.11 any federal, state, or local funding for suicide prevention.

102.12 (h) The 988 telecommunications fee amount shall be adjusted as needed to provide for  
102.13 continuous operation, volume increases, and maintenance of the 988 service.

102.14 (i) The commissioner shall report on revenue generated by the 988 telecommunications  
102.15 fee to the Federal Communications Commission.

102.16 Subd. 5. 988 fee for prepaid wireless telecommunications services. (a) The 988  
102.17 telecommunications fee established in subdivision 4 does not apply to prepaid wireless  
102.18 telecommunications services. Prepaid wireless telecommunications services are subject to  
102.19 the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

102.20 (b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by  
102.21 sections 403.161 and 403.162.

102.22 Sec. 68. [145.57] ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS  
102.23 AUTHORIZED.

102.24 Subdivision 1. Goal and establishment. (a) It is the goal of the state to increase protective  
102.25 factors for mental well-being and decrease disparities in rates of mental health issues among  
102.26 adolescent populations. The commissioner of health shall administer grants to  
102.27 community-based organizations to facilitate mental health promotion programs for  
102.28 adolescents, particularly those from populations that report higher rates of specific mental  
102.29 health needs.

102.30 (b) The commissioner of health shall coordinate with other efforts at the local, state, or  
102.31 national level to avoid duplication and promote complementary efforts in mental health  
102.32 promotion among adolescents.

103.1 Subd. 2. Grants authorized. (a) The commissioner of health shall award grants to  
103.2 eligible community organizations, including nonprofit organizations, community health  
103.3 boards, and Tribal public health entities, to implement community-based mental health  
103.4 promotion programs for adolescents in community settings to improve adolescent mental  
103.5 health and reduce disparities between adolescent populations in reported rates of mental  
103.6 health needs.

103.7 (b) The commissioner of health, in collaboration with community and professional  
103.8 stakeholders, shall establish criteria for review of applications received under this subdivision  
103.9 to ensure funded programs operate using best practices such as trauma-informed care and  
103.10 positive youth development principles.

103.11 (c) Grant funds distributed under this subdivision shall be used to support new or existing  
103.12 community-based mental health promotion programs that include but are not limited to:

103.13 (1) training community-based members to facilitate discussions or courses on adolescent  
103.14 mental health promotion skills;

103.15 (2) training trusted community members to model positive mental health skills and  
103.16 practices in their existing roles;

103.17 (3) training and supporting adolescents to provide peer support; and

103.18 (4) supporting community dialogue on mental health promotion and collective stress or  
103.19 trauma.

103.20 Subd. 3. Evaluation. The commissioner shall conduct an evaluation of the  
103.21 community-based grant programs funded under this section. Grant recipients shall cooperate  
103.22 with the commissioner in the evaluation, and at the direction of the commissioner, shall  
103.23 provide the commissioner with the information needed to conduct the evaluation.

103.24 Sec. 69. [145.903] SCHOOL-BASED HEALTH CENTERS.

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

103.27 (b) "School-based health center" or "comprehensive school-based health center" means  
103.28 a safety net health care delivery model that is located in or near a school facility and that  
103.29 offers comprehensive health care, including preventive and behavioral health services,  
103.30 provided by licensed and qualified health professionals in accordance with federal, state,  
103.31 and local law. When not located on school property, the school-based health center must

104.1 have an established relationship with one or more schools in the community and operate to  
104.2 primarily serve those student groups.

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

104.5 (1) health care providers;

104.6 (2) community clinics;

104.7 (3) hospitals;

104.8 (4) federally qualified health centers and look-alikes as defined in section 145.9269;

104.9 (5) health care foundations or nonprofit organizations;

104.10 (6) higher education institutions; or

104.11 (7) local health departments.

104.12 Subd. 2. Expansion of Minnesota school-based health centers. (a) The commissioner  
104.13 of health shall administer a program to provide grants to school districts and school-based  
104.14 health centers to support existing centers and facilitate the growth of school-based health  
104.15 centers in Minnesota.

104.16 (b) Grant funds distributed under this subdivision shall be used to support new or existing  
104.17 school-based health centers that:

104.18 (1) operate in partnership with a school or school district and with the permission of the  
104.19 school or school district board;

104.20 (2) provide health services through a sponsoring organization that meets the requirements  
104.21 in subdivision 1, paragraph (c); and

104.22 (3) provide health services to all students and youth within a school or school district,  
104.23 regardless of ability to pay, insurance coverage, or immigration status, and in accordance  
104.24 with federal, state, and local law.

104.25 (c) The commissioner of health shall administer a grant to a nonprofit organization to  
104.26 facilitate a community of practice among school-based health centers to improve quality,  
104.27 equity, and sustainability of care delivered through school-based health centers; encourage  
104.28 cross-sharing among school-based health centers; support existing clinics; and expand  
104.29 school-based health centers in new communities in Minnesota.

104.30 (d) Grant recipients shall report their activities and annual performance measures as  
104.31 defined by the commissioner in a format and time specified by the commissioner.



105.1 (e) The commissioners of health and of education shall coordinate the projects and  
 105.2 initiatives funded under this section with other efforts at the local, state, or national level  
 105.3 to avoid duplication and promote coordinated efforts.

105.4 Subd. 3. **School-based health center services.** Services provided by a school-based  
 105.5 health center may include but are not limited to:

105.6 (1) preventive health care;

105.7 (2) chronic medical condition management, including diabetes and asthma care;

105.8 (3) mental health care and crisis management;

105.9 (4) acute care for illness and injury;

105.10 (5) oral health care;

105.11 (6) vision care;

105.12 (7) nutritional counseling;

105.13 (8) substance abuse counseling;

105.14 (9) referral to a specialist, medical home, or hospital for care;

105.15 (10) additional services that address social determinants of health; and

105.16 (11) emerging services such as mobile health and telehealth.

105.17 Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate  
 105.18 a school-based health center must enter into a memorandum of agreement with the school  
 105.19 or school district. The memorandum of agreement must require the sponsoring organization  
 105.20 to be financially responsible for the operation of school-based health centers in the school  
 105.21 or school district and must identify the costs that are the responsibility of the school or  
 105.22 school district, such as Internet access, custodial services, utilities, and facility maintenance.  
 105.23 To the greatest extent possible, a sponsoring organization must bill private insurers, medical  
 105.24 assistance, and other public programs for services provided in the school-based health  
 105.25 centers in order to maintain the financial sustainability of school-based health centers.

105.26 Sec. 70. Minnesota Statutes 2022, section 145.925, is amended to read:

105.27 **145.925 FAMILY PLANNING GRANTS.**

105.28 Subdivision 1. ~~Eligible organizations; purpose~~ Goal and establishment. The  
 105.29 ~~commissioner of health may make special grants to cities, counties, groups of cities or~~  
 105.30 ~~counties, or nonprofit corporations to provide pre-pregnancy family planning services.~~ (a)

106.1 It is the goal of the state to increase access to sexual and reproductive health services for  
 106.2 people who experience barriers, whether geographic, cultural, financial, or other, in access  
 106.3 to such services. The commissioner of health shall administer grants to facilitate access to  
 106.4 sexual and reproductive health services for people of reproductive age, particularly those  
 106.5 from populations that experience barriers to these services.

106.6 (b) The commissioner of health shall coordinate with other efforts at the local, state, or  
 106.7 national level to avoid duplication and promote complementary efforts in reproductive and  
 106.8 sexual health service promotion among people of reproductive age.

106.9 ~~Subd. 1a. **Family planning services; defined.** "Family planning services" means~~  
 106.10 ~~counseling by trained personnel regarding family planning; distribution of information~~  
 106.11 ~~relating to family planning, referral to licensed physicians or local health agencies for~~  
 106.12 ~~consultation, examination, medical treatment, genetic counseling, and prescriptions for the~~  
 106.13 ~~purpose of family planning; and the distribution of family planning products, such as charts,~~  
 106.14 ~~thermometers, drugs, medical preparations, and contraceptive devices. For purposes of~~  
 106.15 ~~sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals~~  
 106.16 ~~to prevent or aid conception but does not include the performance, or make referrals for~~  
 106.17 ~~encouragement of voluntary termination of pregnancy.~~

106.18 ~~Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this~~  
 106.19 ~~section to any nonprofit corporation which performs abortions. No state funds shall be used~~  
 106.20 ~~under contract from a grantee to any nonprofit corporation which performs abortions. This~~  
 106.21 ~~provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or~~  
 106.22 ~~health maintenance organizations certified pursuant to chapter 62D.~~

106.23 Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section,  
 106.24 "sexual and reproductive health services" means services that promote a state of complete  
 106.25 physical, mental, and social well-being in relation to sexuality and reproduction, and not  
 106.26 merely the absence of disease or infirmity, in all matters relating to the reproductive system,  
 106.27 its functions and processes, and to sexuality. These services must be provided in accord  
 106.28 with nationally recognized standards and include but are not limited to sexual and  
 106.29 reproductive health counseling, voluntary and informed decision-making on sexual and  
 106.30 reproductive health, information on and provision of contraceptive methods, sexual and  
 106.31 reproductive health screenings and treatment, pregnancy testing and counseling, and other  
 106.32 preconception services.

106.33 ~~Subd. 3. **Minors Grants authorized.** No funds provided by grants made pursuant to~~  
 106.34 ~~this section shall be used to support any family planning services for any unemancipated~~

107.1 ~~minor in any elementary or secondary school building.~~ (a) The commissioner of health shall  
107.2 award grants to eligible community organizations, including nonprofit organizations,  
107.3 community health boards, and Tribal communities in rural and metropolitan areas of the  
107.4 state to support, sustain, expand, or implement reproductive and sexual health programs for  
107.5 people of reproductive age to increase access to and availability of medically accurate sexual  
107.6 and reproductive health services.

107.7 (b) The commissioner of health shall establish application scoring criteria in the evaluation  
107.8 of applications submitted for award under this section. These criteria include but are not  
107.9 limited to the degree to which applicants' programming responds to demographic factors  
107.10 relevant to subdivision 1, paragraph (a), and paragraph (f).

107.11 (c) When determining whether to award a grant or the amount of a grant under this  
107.12 section, the commissioner of health may identify and stratify geographic regions based on  
107.13 the region's need for sexual and reproductive health services. In this stratification, the  
107.14 commissioner may consider data on the prevalence of poverty and other factors relevant to  
107.15 a geographic region's need for sexual and reproductive health services.

107.16 (d) The commissioner of health may consider geographic and Tribal communities'  
107.17 representation in the award of grants.

107.18 (e) Current recipients of funding under this section shall not be afforded priority over  
107.19 new applicants.

107.20 (f) Grant funds shall be used to support new or existing sexual and reproductive health  
107.21 programs that provide person-centered, accessible services; that are culturally and  
107.22 linguistically appropriate, inclusive of all people, and trauma-informed; that protect the  
107.23 dignity of the individual; and that ensure equitable, quality services consistent with nationally  
107.24 recognized standards of care. These services include:

107.25 (i) education and outreach on medically accurate sexual and reproductive health  
107.26 information;

107.27 (ii) contraceptive counseling, provision of contraceptive methods, and follow-up;

107.28 (iii) screening, testing, and treatment of sexually transmitted infections and other sexual  
107.29 or reproductive concerns; and

107.30 (iv) referral and follow-up for medical, financial, mental health, and other services in  
107.31 accord with a service recipient's needs.

107.32 ~~Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342,~~  
107.33 ~~any person employed to provide family planning services who is paid in whole or in part~~

108.1 ~~from funds provided under this section who advises an abortion or sterilization to any~~  
 108.2 ~~unemancipated minor shall, following such a recommendation, so notify the parent or~~  
 108.3 ~~guardian of the reasons for such an action.~~

108.4 Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans  
 108.5 and budgets of prospective grant recipients, for the submission of annual financial and  
 108.6 statistical reports, and the maintenance of statements of source and application of funds by  
 108.7 grant recipients. The commissioner of health may not require that any home rule charter or  
 108.8 statutory city or county apply for or receive grants under this subdivision as a condition for  
 108.9 the receipt of any state or federal funds unrelated to family planning services.

108.10 Subd. 6. **Public services; individual and employee rights.** The request of any person  
 108.11 for family planning sexual and reproductive health services or the refusal to accept any  
 108.12 service shall in no way affect the right of the person to receive public assistance, public  
 108.13 health services, or any other public service. Nothing in this section shall abridge the right  
 108.14 of the individual person to make decisions concerning family planning sexual and  
 108.15 reproductive health, nor shall any individual person be required to state a reason for refusing  
 108.16 any offer of family planning sexual and reproductive health services.

108.17 ~~Any employee of the agencies engaged in the administration of the provisions of this~~  
 108.18 ~~section may refuse to accept the duty of offering family planning services to the extent that~~  
 108.19 ~~the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal,~~  
 108.20 ~~suspension, demotion, or any other discrimination in employment. The directors or~~  
 108.21 ~~supervisors of the agencies shall reassign the duties of employees in order to carry out the~~  
 108.22 ~~provisions of this section.~~

108.23 All information gathered by any agency, entity, or individual conducting programs in  
 108.24 family planning sexual and reproductive health is private data on individuals within the  
 108.25 meaning of section 13.02, subdivision 12. For any person or entity meeting the definition  
 108.26 of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and  
 108.27 reproductive health services information provided to, gathered about, or received from a  
 108.28 person under this section is also subject to the Minnesota Health Records Act, in sections  
 108.29 144.291 to 144.298.

108.30 Subd. 7. **Family planning services; information required.** ~~A grant recipient shall~~  
 108.31 ~~inform any person requesting counseling on family planning methods or procedures of:~~

108.32 ~~(1) Any methods or procedures which may be followed, including identification of any~~  
 108.33 ~~which are experimental or any which may pose a health hazard to the person;~~

109.1 ~~(2) A description of any attendant discomforts or risks which might reasonably be~~  
 109.2 ~~expected;~~

109.3 ~~(3) A fair explanation of the likely results, should a method fail;~~

109.4 ~~(4) A description of any benefits which might reasonably be expected of any method;~~

109.5 ~~(5) A disclosure of appropriate alternative methods or procedures;~~

109.6 ~~(6) An offer to answer any inquiries concerning methods or procedures; and~~

109.7 ~~(7) An instruction that the person is free either to decline commencement of any method~~  
 109.8 ~~or procedure or to withdraw consent to a method or procedure at any reasonable time.~~

109.9 ~~Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under~~  
 109.10 ~~any program receiving financial assistance under this section, who coerces or endeavors to~~  
 109.11 ~~coerce any person to undergo an abortion or sterilization procedure by threatening the person~~  
 109.12 ~~with the loss of or disqualification for the receipt of any benefit or service under a program~~  
 109.13 ~~receiving state or federal financial assistance shall be guilty of a misdemeanor.~~

109.14 **Subd. 9. Amount of grant; rules.** Notwithstanding any rules to the contrary, including  
 109.15 rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant  
 109.16 funds for family planning special projects, shall not limit the total amount of funds that can  
 109.17 be allocated to an organization. The commissioner shall allocate to an organization receiving  
 109.18 grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999  
 109.19 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the  
 109.20 organization submits an application that meets grant funding criteria. This subdivision does  
 109.21 not affect any procedure established in rule for allocating special project money to the  
 109.22 different regions. The commissioner shall revise the rules for family planning special project  
 109.23 grants so that they conform to the requirements of this subdivision. In adopting these  
 109.24 revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but  
 109.25 is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph  
 109.26 (b), does not apply to these rules.

109.27 **Sec. 71. [145.9257] COMMUNITY SOLUTIONS FOR HEALTHY CHILD**  
 109.28 **DEVELOPMENT GRANT PROGRAM.**

109.29 Subdivision 1. **Establishment.** The commissioner of health shall establish a grant  
 109.30 program to improve child development outcomes and the well-being of children of color  
 109.31 and American Indian children from prenatal to grade 3 and their families. The purposes of  
 109.32 the program are to:

110.1 (1) improve child development outcomes related to the well-being of children of color  
 110.2 and American Indian children from prenatal to grade 3 and their families, including but not  
 110.3 limited to the goals outlined by the Department of Human Services' early childhood systems  
 110.4 reform effort: early learning; health and well-being; economic security; and safe, stable,  
 110.5 nurturing relationships and environments by funding community-based solutions for  
 110.6 challenges that are identified by the affected community;

110.7 (2) reduce racial disparities in children's health and development from prenatal to grade  
 110.8 3; and

110.9 (3) promote racial and geographic equity.

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

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

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

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

110.19 (4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council,  
 110.20 and the governor's early learning council on the request for proposal process;

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

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

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

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

110.29 Subd. 3. Community solutions advisory council; establishment; duties;

110.30 compensation. (a) No later than October 1, 2023, the commissioner shall have convened  
 110.31 a 12-member community solutions advisory council as follows:

110.32 (1) two members representing the African Heritage community;

- 111.1 (2) two members representing the Latino community;
- 111.2 (3) two members representing the Asian-Pacific Islander community;
- 111.3 (4) two members representing the American Indian community;
- 111.4 (5) two parents of children of Black, nonwhite people of color, or that are American
- 111.5 Indian with children under nine years of age;
- 111.6 (6) one member with research or academic expertise in racial equity and healthy child
- 111.7 development; and
- 111.8 (7) one member representing an organization that advocates on behalf of communities
- 111.9 of color or American Indians.
- 111.10 (b) At least three of the 12 members of the advisory council must come from outside
- 111.11 the seven-county metropolitan area.
- 111.12 (c) The community solutions advisory council shall:
- 111.13 (1) advise the commissioner on the development of the request for proposals for
- 111.14 community solutions healthy child development grants. In advising the commissioner, the
- 111.15 council must consider how to build on the capacity of communities to promote child and
- 111.16 family well-being and address social determinants of healthy child development;
- 111.17 (2) review responses to requests for proposals and advise the commissioner on the
- 111.18 selection of grantees and grant awards;
- 111.19 (3) advise the commissioner on the establishment of a transparent and objective
- 111.20 accountability process focused on outcomes the grantees agree to achieve;
- 111.21 (4) advise the commissioner on ongoing oversight and necessary support in the
- 111.22 implementation of the program; and
- 111.23 (5) support the commissioner on other racial equity and early childhood grant efforts.
- 111.24 (d) Each advisory council member shall be compensated in accordance with section
- 111.25 15.059, subdivision 3.
- 111.26 Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this
- 111.27 section include: (1) organizations or entities that work with Black, non-white communities
- 111.28 of color, and American Indian communities;
- 111.29 (2) Tribal nations and Tribal organizations as defined in section 658P of the Child Care
- 111.30 and Development Block Grant Act of 1990; and
- 111.31 (3) organizations or entities focused on supporting healthy child development.

112.1 Subd. 5. Strategic consideration and priority of proposals; eligible populations;  
112.2 grant awards. (a) The commissioner, in consultation with the community solutions advisory  
112.3 council, shall develop a request for proposals for healthy child development grants. In  
112.4 developing the proposals and awarding the grants, the commissioner shall consider building  
112.5 on the capacity of communities to promote child and family well-being and address social  
112.6 determinants of healthy child development. Proposals must focus on increasing racial equity  
112.7 and healthy child development and reducing health disparities experienced by children of  
112.8 Black, nonwhite people of color, and American Indian children from prenatal to grade 3  
112.9 and their families.

112.10 (b) In awarding the grants, the commissioner shall provide strategic consideration and  
112.11 give priority to proposals from:

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

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

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

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

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

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

112.24 The advisory council may recommend additional strategic considerations and priorities  
112.25 to the commissioner.

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

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



113.1 Sec. 72. [145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE  
113.2 SETTINGS GRANT PROGRAM.

113.3 Subdivision 1. Establishment; purpose. The commissioner of health shall develop a  
113.4 grant program for the purpose of remediating identified sources of lead in drinking water  
113.5 in schools and licensed child care settings.

113.6 Subd. 2. Grants authorized. The commissioner shall award grants through a request  
113.7 for proposals process to schools and licensed child care settings. Priority shall be given to  
113.8 schools and licensed child care settings with higher levels of lead detected in water samples,  
113.9 evidence of lead service lines, or lead plumbing materials and school districts that serve  
113.10 disadvantaged communities.

113.11 Subd. 3. Grant allocation. Grantees must use the funds to address sources of lead  
113.12 contamination in their facilities including but not limited to service connections, premise  
113.13 plumbing, and implementing best practices for water management within the building.

113.14 Sec. 73. [145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD  
113.15 CARE SETTINGS.

113.16 Subdivision 1. Requirement to test. By July 1, 2024, licensed child care providers must  
113.17 develop a plan to accurately and efficiently test for the presence of lead in drinking water  
113.18 in child care facilities following either the Department of Health's document "Reducing  
113.19 Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care  
113.20 Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action"  
113.21 guidance materials.

113.22 Subd. 2. Scope and frequency of testing. The plan under subdivision 1 must include  
113.23 testing every building serving children and all water fixtures used for consumption of water,  
113.24 including water used in food preparation. All taps must be tested at least once every five  
113.25 years. A licensed child care provider must begin testing in buildings by July 1, 2024, and  
113.26 complete testing in all buildings that serve students within five years.

113.27 Subd. 3. Remediation of lead in drinking water. The plan under subdivision 1 must  
113.28 include steps to remediate if lead is present in drinking water. A licensed child care provider  
113.29 that finds lead at concentrations at or exceeding five parts per billion at a specific location  
113.30 providing water to children within its facilities must take action to reduce lead exposure  
113.31 following guidance and verify the success of remediation by retesting the location for lead.  
113.32 Remediation actions are actions that reduce lead levels from the drinking water fixture as  
113.33 demonstrated by testing. This includes using certified filters, implementing, and documenting

114.1 a building-wide flushing program, and replacing or removing fixtures with elevated lead  
114.2 levels.

114.3 Subd. 4. **Reporting results.** (a) A licensed child care provider that tested its buildings  
114.4 for the presence of lead shall make the results of the testing and any remediation steps taken  
114.5 available to parents and staff and notify them of the availability of results. Reporting shall  
114.6 occur no later than 30 days from receipt of results and annually thereafter.

114.7 (b) Beginning July 1, 2024, a licensed child care provider must report the provider's test  
114.8 results and remediation activities to the commissioner of health annually on or before July  
114.9 1 of each year.

114.10 Sec. 74. **[145.9571] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

114.11 Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act  
114.12 is to build equitable, inclusive, and culturally and linguistically responsive systems that  
114.13 ensure the health and well-being of young children and their families by supporting the  
114.14 Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent  
114.15 infant mortality, increasing access to culturally relevant developmental and social-emotional  
114.16 screening with follow-up, and sustaining and expanding the model jail practices for children  
114.17 of incarcerated parents in Minnesota jails.

114.18 Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality  
114.19 collaborative is established to improve pregnancy outcomes for pregnant people and  
114.20 newborns through efforts to:

114.21 (1) advance evidence-based and evidence-informed clinics and other health service  
114.22 practices and processes through quality care review, chart audits, and continuous quality  
114.23 improvement initiatives that enable equitable outcomes;

114.24 (2) review current data, trends, and research on best practices to inform and prioritize  
114.25 quality improvement initiatives;

114.26 (3) identify methods that incorporate antiracism into individual practice and organizational  
114.27 guidelines in the delivery of perinatal health services;

114.28 (4) support quality improvement initiatives to address substance use disorders in pregnant  
114.29 people and infants with neonatal abstinence syndrome or other effects of substance use;

114.30 (5) provide a forum to discuss state-specific system and policy issues to guide quality  
114.31 improvement efforts that improve population-level perinatal outcomes;

115.1 (6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated  
115.2 effort across system organizations to reinforce a continuum of care model; and

115.3 (7) support health care facilities in monitoring interventions through rapid data collection  
115.4 and applying system changes to provide improved care in perinatal health.

115.5 Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a  
115.6 nonprofit organization to create or sustain a multidisciplinary network of representatives  
115.7 of health care systems, health care providers, academic institutions, local and state agencies,  
115.8 and community partners that will collaboratively improve pregnancy and infant outcomes  
115.9 through evidence-based, population-level quality improvement initiatives.

115.10 Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit  
115.11 organization to support efforts that improve maternal and infant health outcomes aligned  
115.12 with the purpose outlined in subdivision 2. The commissioner shall give preference to a  
115.13 nonprofit organization that has the ability to provide these services throughout the state.  
115.14 The commissioner shall provide content expertise to the grant recipient to further the  
115.15 accomplishment of the purpose.

115.16 Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The  
115.17 commissioner of health shall establish the Minnesota partnership to prevent infant mortality  
115.18 program that is a statewide partnership program to engage communities, exchange best  
115.19 practices, share summary data on infant health, and promote policies to improve birth  
115.20 outcomes and eliminate preventable infant mortality.

115.21 (b) The goal of the Minnesota partnership to prevent infant mortality program is to:

115.22 (1) build a statewide multisectoral partnership including the state government, local  
115.23 public health agencies, Tribes, private sector, and community nonprofit organizations with  
115.24 the shared goal of decreasing infant mortality rates among populations with significant  
115.25 disparities, including among Black, American Indian, other nonwhite communities, and  
115.26 rural populations;

115.27 (2) address the leading causes of poor infant health outcomes such as premature birth,  
115.28 infant sleep-related deaths, and congenital anomalies through strategies to change social  
115.29 and environmental determinants of health; and

115.30 (3) promote the development, availability, and use of data-informed, community-driven  
115.31 strategies to improve infant health outcomes.

115.32 Subd. 5a. **Grants authorized.** (a) The commissioner of health shall award grants to  
115.33 eligible applicants to convene, coordinate, and implement data-driven strategies and culturally

116.1 relevant activities to improve infant health by reducing preterm birth, sleep-related infant  
116.2 deaths, and congenital malformations and address social and environmental determinants  
116.3 of health. Grants shall be awarded to support community nonprofit organizations, Tribal  
116.4 governments, and community health boards. In accordance with available funding, grants  
116.5 shall be noncompetitively awarded to the eleven sovereign Tribal governments if their  
116.6 respective proposals demonstrate the ability to implement programs designed to achieve  
116.7 the purposes in subdivision 2 and meet other requirements of this section. An eligible  
116.8 applicant must submit a complete application to the commissioner of health by the deadline  
116.9 established by the commissioner. The commissioner shall award all other grants competitively  
116.10 to eligible applicants in metropolitan and rural areas of the state and may consider geographic  
116.11 representation in grant awards.

116.12 (b) Grantee activities shall:

116.13 (1) address the leading cause or causes of infant mortality;

116.14 (2) be based on community input;

116.15 (3) focus on policy, systems, and environmental changes that support infant health; and

116.16 (4) address the health disparities and inequities that are experienced in the grantee's  
116.17 community.

116.18 (c) The commissioner shall review each application to determine whether the application  
116.19 is complete and whether the applicant and the project are eligible for a grant. In evaluating  
116.20 applications according to subdivision 2, the commissioner shall establish criteria including  
116.21 but not limited to: the eligibility of the applicant's project under this section; the applicant's  
116.22 thoroughness and clarity in describing the infant health issues grant funds are intended to  
116.23 address; a description of the applicant's proposed project; the project's likelihood to achieve  
116.24 the grant's purposes as described in this section; a description of the population demographics  
116.25 and service area of the proposed project; and evidence of efficiencies and effectiveness  
116.26 gained through collaborative efforts.

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

116.29 Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise,  
116.30 technical expertise, training to grant recipients, and advice on data-driven strategies.

116.31 (b) For the purposes of carrying out the grant program under subdivision 5, including  
116.32 for administrative purposes, the commissioner shall award contracts to appropriate entities  
116.33 to assist in training and provide technical assistance to grantees.

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

117.3 (1) partnership development and capacity building;

117.4 (2) Tribal support;

117.5 (3) implementation support for specific infant health strategies;

117.6 (4) communications by convening and sharing lessons learned; and

117.7 (5) health equity.

117.8 Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of  
117.9 the developmental and social-emotional screening is to identify young children at risk for  
117.10 developmental and behavioral concerns and provide follow-up services to connect families  
117.11 and young children to appropriate community-based resources and programs. The  
117.12 commissioner of health shall work with the commissioners of human services and education  
117.13 to implement this section and promote interagency coordination with other early childhood  
117.14 programs including those that provide screening and assessment.

117.15 Subd. 6a. **Duties.** The commissioner shall:

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

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

117.20 (3) provide screening for developmental and social-emotional delays based on current  
117.21 recommended best practices;

117.22 (4) review and share the results of the screening with the parent or guardian. Support  
117.23 families in their role as caregivers by providing anticipatory guidance around typical growth  
117.24 and development;

117.25 (5) ensure children and families are referred to and linked with appropriate  
117.26 community-based services and resources when any developmental or social-emotional  
117.27 concerns are identified through screening; and

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

118.1 Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based  
118.2 organizations, community health boards, and Tribal nations to support follow-up services  
118.3 for children with developmental or social-emotional concerns identified through screening  
118.4 in order to link children and their families to appropriate community-based services and  
118.5 resources. Grants shall also be awarded to community-based organizations to train and  
118.6 utilize cultural liaisons to help families navigate the screening and follow-up process in a  
118.7 culturally and linguistically responsive manner. The commissioner shall provide technical  
118.8 assistance, content expertise, and training to grant recipients to ensure that follow-up services  
118.9 are effectively provided.

118.10 Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health  
118.11 may make special grants to counties and groups of counties to implement model jail practices  
118.12 and to county governments, Tribal governments, or nonprofit organizations in corresponding  
118.13 geographic areas to build partnerships with county jails to support children of incarcerated  
118.14 parents and their caregivers.

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

118.19 Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health  
118.20 shall award grants to eligible county jails to implement model jail practices and separate  
118.21 grants to county governments, Tribal governments, or nonprofit organizations in  
118.22 corresponding geographic areas to build partnerships with county jails to support children  
118.23 of incarcerated parents and their caregivers.

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

118.25 (1) parenting classes or groups;

118.26 (2) family-centered intake and assessment of inmate programs;

118.27 (3) family notification, information, and communication strategies;

118.28 (4) correctional staff training;

118.29 (5) policies and practices for family visits; and

118.30 (6) family-focused reentry planning.

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

119.1 Subd. 7b. Technical assistance and oversight; model jail practices. (a) The  
 119.2 commissioner shall provide content expertise, training to grant recipients, and advice on  
 119.3 evidence-based strategies, including evidence-based training to support incarcerated parents.

119.4 (b) For the purposes of carrying out the grant program under subdivision 7a, including  
 119.5 for administrative purposes, the commissioner shall award contracts to appropriate entities  
 119.6 to assist in training and provide technical assistance to grantees.

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

119.9 (1) evidence-based training for incarcerated parents;

119.10 (2) partnership building and community engagement;

119.11 (3) evaluation of process and outcomes of model jail practices; and

119.12 (4) expert guidance on reducing the harm caused to children of incarcerated parents and  
 119.13 application of model jail practices.

119.14 Sec. 75. [145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL)  
 119.15 COUNCIL.

119.16 Subdivision 1. Establishment; composition of advisory council. The commissioner  
 119.17 shall establish and appoint a health equity advisory and leadership (HEAL) council to  
 119.18 provide guidance to the commissioner of health regarding strengthening and improving the  
 119.19 health of communities most impacted by health inequities across the state. The council shall  
 119.20 consist of 18 members who will provide representation from the following groups:

119.21 (1) African American and African heritage communities;

119.22 (2) Asian American and Pacific Islander communities;

119.23 (3) Latina/o/x communities;

119.24 (4) American Indian communities and Tribal governments and nations;

119.25 (5) disability communities;

119.26 (6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

119.27 (7) representatives who reside outside the seven-county metropolitan area.

119.28 Subd. 2. Organization and meetings. The advisory council shall be organized and  
 119.29 administered under section 15.059. Meetings shall be held at least quarterly and hosted by

120.1 the department. Subcommittees may be convened as necessary. Advisory council meetings  
 120.2 are subject to the open meeting law under chapter 13D.

120.3 Subd. 3. **Duties.** The advisory council shall:

120.4 (1) advise the commissioner on health equity issues and the health equity priorities and  
 120.5 concerns of the populations specified in subdivision 1;

120.6 (2) assist the agency in efforts to advance health equity, including consulting in specific  
 120.7 agency policies and programs, providing ideas and input about potential budget and policy  
 120.8 proposals, and recommending review of agency policies, standards, or procedures that may  
 120.9 create or perpetuate health inequities; and

120.10 (3) assist the agency in developing and monitoring meaningful performance measures  
 120.11 related to advancing health equity.

120.12 Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities  
 120.13 in the state are eliminated. Health inequities will be considered eliminated when race,  
 120.14 ethnicity, income, gender, gender identity, geographic location, or other identity or social  
 120.15 marker will no longer be predictors of health outcomes in the state. Section 145.928 describes  
 120.16 nine health disparities that must be considered when determining whether health inequities  
 120.17 have been eliminated in the state.

120.18 Sec. 76. **[145.988] COMPREHENSIVE AND COLLABORATIVE RESOURCE AND**  
 120.19 **REFERRAL SYSTEM FOR CHILDREN.**

120.20 Subdivision 1. **Establishment; purpose.** The commissioner shall establish the  
 120.21 Comprehensive and Collaborative Resource and Referral System for Children to support a  
 120.22 comprehensive, collaborative resource and referral system for children from prenatal through  
 120.23 age eight, and their families. The commissioner of health shall work collaboratively with  
 120.24 the commissioners of human services and education to implement this section.

120.25 Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across  
 120.26 sectors, including child health, early learning and education, child welfare, and family  
 120.27 supports by:

120.28 (1) providing early childhood provider outreach to support knowledge of and access to  
 120.29 local resources that provide early detection and intervention services;

120.30 (2) identifying and providing access to early childhood and family support navigation  
 120.31 specialists that can support families and their children's needs; and

120.32 (3) linking children and families to appropriate community-based services.



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

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

121.10 (d) The Help Me Connect system shall collect data to increase understanding of the  
121.11 current and ongoing system of support and resources for expectant families and children  
121.12 through age eight and their families, including identification of gaps in service, barriers to  
121.13 finding and receiving appropriate services, and lack of resources.

121.14 Sec. 77. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

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

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

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

121.31 (d) The State Community Health Advisory Committee may recommend a formula to  
121.32 the commissioner to use in distributing funds to community health boards.

122.1 (e) Notwithstanding any adjustment in paragraph (b), community health boards, all or  
122.2 a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota,  
122.3 Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive  
122.4 an increase equal to ten percent of the grant award to the community health board under  
122.5 paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for  
122.6 the last six months of the year. For calendar years beginning on or after January 1, 2016,  
122.7 the amount distributed under this paragraph shall be adjusted each year based on available  
122.8 funding and the number of eligible community health boards.

122.9 (f) Funding for foundational public health responsibilities must be distributed based on  
122.10 a formula determined by the commissioner in consultation with the State Community Health  
122.11 Services Advisory Committee. A portion of these funds may be used to fund new  
122.12 organizational models, including multijurisdictional and regional partnerships. These funds  
122.13 shall be used in accordance with subdivision 5.

122.14 Sec. 78. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

122.15 Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their  
122.16 local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address  
122.17 the areas of public health responsibility and local priorities developed through the community  
122.18 health assessment and community health improvement planning process.

122.19 (b) Funding for foundational public health responsibilities as outlined in subdivision 1,  
122.20 paragraph (f), must be used to fulfill foundational public health responsibilities as defined  
122.21 by the commissioner in consultation with the State Community Health Service Advisory  
122.22 Committee unless a community health board can demonstrate fulfillment of foundational  
122.23 public health responsibilities. If a community health board can demonstrate foundational  
122.24 public health responsibilities are fulfilled, funds may be used for local priorities developed  
122.25 through the community health assessment and community health improvement planning  
122.26 process.

122.27 (c) By July 1, 2028, all local public health grant funds must be used first to fulfill  
122.28 foundational public health responsibilities. Once a community health board can demonstrate  
122.29 foundational public health responsibilities are fulfilled, funds can be used for local priorities  
122.30 developed through the community health assessment and community health improvement  
122.31 planning process.

123.1 Sec. 79. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision  
123.2 to read:

123.3 Subd. 2b. Grants to Tribes. The commissioner shall distribute grants to Tribal  
123.4 governments for foundational public health responsibilities as defined by each Tribal  
123.5 government.

123.6 Sec. 80. Minnesota Statutes 2022, section 403.161, is amended to read:

123.7 **403.161 PREPAID WIRELESS FEES IMPOSED; COLLECTION; REMITTANCE.**

123.8 Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail  
123.9 transaction is imposed on prepaid wireless telecommunications service until the fee is  
123.10 adjusted as an amount per retail transaction under subdivision 7.

123.11 (b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the  
123.12 monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail  
123.13 transaction for prepaid wireless telecommunications service until the fee is adjusted as an  
123.14 amount per retail transaction under subdivision 7.

123.15 (c) A prepaid wireless 988 fee, in the amount of the monthly charge, is imposed on each  
123.16 retail transaction for prepaid wireless telecommunications service until the fee is adjusted  
123.17 as an amount per retail transaction under subdivision 7.

123.18 Subd. 2. **Exemption.** The fees established under subdivision 1 are not imposed on a  
123.19 minimal amount of prepaid wireless telecommunications service that is sold with a prepaid  
123.20 wireless device and is charged a single nonitemized price, and a seller may not apply the  
123.21 fees to such a transaction. For purposes of this subdivision, a minimal amount of service  
123.22 means an amount of service denominated as either ten minutes or less or \$5 or less.

123.23 Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~, telecommunications access  
123.24 Minnesota, and 988 fees must be collected by the seller from the consumer for each retail  
123.25 transaction occurring in this state. The amount of each fee must be combined into one  
123.26 amount, which must be separately stated on an invoice, receipt, or other similar document  
123.27 that is provided to the consumer by the seller.

123.28 Subd. 4. **Sales and use tax treatment.** For purposes of this section, a retail transaction  
123.29 conducted in person by a consumer at a business location of the seller must be treated as  
123.30 occurring in this state if that business location is in this state, and any other retail transaction  
123.31 must be treated as occurring in this state if the retail transaction is treated as occurring in  
123.32 this state for purposes of the sales and use tax as specified in section 297A.669, subdivision  
123.33 3, paragraph (c).

124.1 Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~<sub>2</sub> telecommunications access  
 124.2 Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any  
 124.3 provider, except that the seller is liable to remit all fees as provided in section 403.162.

124.4 Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid  
 124.5 wireless E911 ~~and~~<sub>2</sub> telecommunications access Minnesota, and 988 fees collected by a seller  
 124.6 from a consumer must not be included in the base for measuring any tax, fee, surcharge, or  
 124.7 other charge that is imposed by this state, any political subdivision of this state, or any  
 124.8 intergovernmental agency.

124.9 Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~<sub>2</sub> telecommunications access  
 124.10 Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change  
 124.11 to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013,  
 124.12 ~~or~~ the fee imposed under section 237.52, subdivision 2, as applicable.

124.13 (b) The department shall post notice of any fee changes on its website at least 30 days  
 124.14 in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor  
 124.15 the department's website for notice of fee changes.

124.16 (c) Fee changes are effective 60 days after the first day of the first calendar month after  
 124.17 the commissioner of public safety or the Public Utilities Commission, as applicable, changes  
 124.18 the fee.

124.19 Sec. 81. Minnesota Statutes 2022, section 403.162, is amended to read:

124.20 **403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.**

124.21 Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~<sub>2</sub> telecommunications access  
 124.22 Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue  
 124.23 at the times and in the manner provided by chapter 297A with respect to the general sales  
 124.24 and use tax. The commissioner of revenue shall establish registration and payment procedures  
 124.25 that substantially coincide with the registration and payment procedures that apply in chapter  
 124.26 297A.

124.27 Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid  
 124.28 wireless E911 ~~and~~<sub>2</sub> telecommunications access Minnesota, and 988 fees collected by the  
 124.29 seller from consumers.

124.30 Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection,  
 124.31 refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and  
 124.32 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed  
 124.33 under section 403.161.

125.1 Subd. 4. **Procedures for resale transactions.** The commissioner of revenue shall  
125.2 establish procedures by which a seller of prepaid wireless telecommunications service may  
125.3 document that a sale is not a retail transaction. These procedures must substantially coincide  
125.4 with the procedures for documenting sale for resale transactions as provided in chapter  
125.5 297A.

125.6 Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative  
125.7 proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications  
125.8 access Minnesota fee, and the prepaid wireless 988 fee, imposed per retail transaction, divide  
125.9 the fees collected in corresponding proportions. Within 30 days of receipt of the collected  
125.10 fees, the commissioner shall:

125.11 (1) deposit the proportion of the collected fees attributable to the prepaid wireless E911  
125.12 fee in the 911 emergency telecommunications service account in the special revenue fund;  
125.13 ~~and~~

125.14 (2) deposit the proportion of collected fees attributable to the prepaid wireless  
125.15 telecommunications access Minnesota fee in the telecommunications access fund established  
125.16 in section 237.52, subdivision 1; and

125.17 (3) deposit the proportion of the collected fees attributable to the prepaid wireless 988  
125.18 fee in the 988 special revenue fund established.

125.19 (b) The commissioner of revenue may deduct and deposit in a special revenue account  
125.20 an amount not to exceed two percent of collected fees. Money in the account is annually  
125.21 appropriated to the commissioner of revenue to reimburse its direct costs of administering  
125.22 the collection and remittance of prepaid wireless E911 fees, ~~and~~ prepaid wireless  
125.23 telecommunications access Minnesota fees, and prepaid wireless 988 fees.

125.24 Sec. 82. Laws 2022, chapter 99, article 1, section 46, is amended to read:

125.25 Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

125.26 Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant  
125.27 program to award grants to health care entities, including but not limited to health care  
125.28 systems, hospitals, nursing facilities, community health clinics or consortium of clinics,  
125.29 federally qualified health centers, rural health clinics, or health professional associations  
125.30 for the purpose of establishing or expanding programs focused on improving the mental  
125.31 health of health care professionals.

126.1 (b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed  
126.2 and are focused on addressing the mental health of health care professionals by:

126.3 (1) identifying and addressing the barriers to and stigma among health care professionals  
126.4 associated with seeking self-care, including mental health and substance use disorder services;

126.5 (2) encouraging health care professionals to seek support and care for mental health and  
126.6 substance use disorder concerns;

126.7 (3) identifying risk factors associated with suicide and other mental health conditions;

126.8 ~~or~~

126.9 (4) developing and making available resources to support health care professionals with  
126.10 self-care and resiliency; and

126.11 (5) identifying and modifying structural barriers in health care delivery that create  
126.12 unnecessary stress in the workplace.

126.13 Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit  
126.14 an application to the commissioner by the deadline established by the commissioner. An  
126.15 application must be on a form and contain information as specified by the commissioner  
126.16 and at a minimum must contain:

126.17 (1) a description of the purpose of the program for which the grant funds will be used;

126.18 (2) a description of the achievable objectives of the program and how these objectives  
126.19 will be met; and

126.20 (3) a process for documenting and evaluating the results of the program.

126.21 (b) The commissioner shall give priority to programs that involve peer-to-peer support.

126.22 Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision  
126.23 6, encumbrances for grants under this section issued by June 30 of each year may be certified  
126.24 for a period of up to three years beyond the year in which the funds were originally  
126.25 appropriated.

126.26 Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the  
126.27 grant program by conducting a periodic evaluation of the impact and outcomes of the grant  
126.28 program on health care professional burnout and retention. The commissioner shall submit  
126.29 the results of the evaluation and any recommendations for improving the grant program to  
126.30 the chairs and ranking minority members of the legislative committees with jurisdiction  
126.31 over health care policy and finance by October 15, 2024.

127.1 Sec. 83. Laws 2022, chapter 99, article 3, section 9, is amended to read:

127.2 Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE**  
127.3 **PROFESSIONALS.**

127.4 \$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner  
127.5 of health for the health care professionals mental health grant program. This is a onetime  
127.6 appropriation and is available until June 30, 2027.

127.7 Sec. 84. **COVID-19 PANDEMIC DELAYED PREVENTIVE CARE.**

127.8 Subdivision 1. Establishment. The commissioner of health shall develop a  
127.9 comprehensive program to increase access and utilization of preventive care and ongoing  
127.10 disease management to improve the health and well-being of all Minnesotans and contribute  
127.11 to reducing health care costs. The purpose is to:

127.12 (1) address disparities in health outcomes focused on the leading causes of morbidity  
127.13 and mortality, including but not limited to cardiovascular disease, stroke, diabetes, cancer,  
127.14 asthma, mental health, and oral health for residents statewide;

127.15 (2) promote use of community-led programs to meet local needs;

127.16 (3) promote partnerships between local communities, Tribal and local public health  
127.17 agencies and health care providers;

127.18 (4) address how underlying determinants of health including food, housing, and economic  
127.19 insecurity impact health outcomes;

127.20 (5) ensure programs use innovative and evidence-based and practice informed strategies  
127.21 including but not limited to telehealth and use of paraprofessionals such as community  
127.22 health workers and use of community locations outside of medical settings including but  
127.23 not limited to libraries and mobile sites; and

127.24 (6) support implementation of state plans to improve health outcomes for Minnesotans.

127.25 Subd. 2. Partnerships. The commissioner of health shall consult and collaborate with  
127.26 organizations and agencies including but not limited to health care, local public health, and  
127.27 community organizations that serve people who are disproportionately experiencing health  
127.28 inequities, to assess, prioritize and implement strategies and policies that will improve  
127.29 health.

127.30 Subd. 3. Grants and contracts. The commissioner of health shall coordinate and  
127.31 collaborate with community and organizational partners to implement health improvement

128.1 strategies. The commissioner of health shall award contracts and grants to organizations  
 128.2 including but not limited to community-led organizations, Tribal and local public health  
 128.3 agencies, and health care organizations that serve communities disproportionately impacted  
 128.4 by health inequities. The commissioner of health shall award grants and contracts to eligible  
 128.5 organizations to assess or implement steps to reduce barriers to implementation of chronic  
 128.6 disease prevention and management programs.

128.7 Subd. 4. **Evaluation.** The commissioner of health shall assess and evaluate grants  
 128.8 awarded to assess changes in access and utilization of screening and disease management  
 128.9 services from statewide data sources.

128.10 Sec. 85. **REPEALER.**

128.11 (a) Minnesota Statutes 2022, sections 62J.84, subdivision 5; and 62U.10, subdivisions  
 128.12 6, 7, and 8, are repealed.

128.13 (b) Minnesota Statutes 2022, sections 145.4235; 145.4241; 145.4242; 145.4243;  
 128.14 145.4244; 145.4245; 145.4246; 145.4247; 145.4248; 145.4249; and 145.925, subdivisions  
 128.15 1a, 3, 4, 7, and 8, are repealed.

### 128.16 ARTICLE 3

#### 128.17 HEALTH BOARDS POLICY

128.18 Section 1. **[148.635] FEE.**

128.19 Subdivision 1. **Nonrefundable fee.** The fee in this section is nonrefundable.

128.20 Subd. 2. **Licensure verification fee.** The fee for verification of licensure is \$20.

128.21 Sec. 2. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

128.22 Subd. 2. **Licensure and application fees.** Licensure and application fees established  
 128.23 by the board shall not exceed the following amounts:

128.24 (1) application fee for national examination is ~~\$110~~ \$150;

128.25 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination  
 128.26 is ~~\$110~~ \$150;

128.27 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

128.28 (4) annual renewal fee for LMFT license is ~~\$125~~ \$225;

128.29 (5) late fee for LMFT license renewal is ~~\$50~~ \$100;



- 129.1 (6) application fee for LMFT licensure by reciprocity is ~~\$220~~ \$300;
- 129.2 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license  
129.3 is ~~\$75~~ \$100;
- 129.4 (8) annual renewal fee for LAMFT license is ~~\$75~~ \$100;
- 129.5 (9) late fee for LAMFT renewal is ~~\$25~~ \$50;
- 129.6 (10) fee for reinstatement of license is \$150;
- 129.7 (11) fee for emeritus status is ~~\$125~~ \$225; and
- 129.8 (12) fee for temporary license for members of the military is \$100.
- 129.9 Sec. 3. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:
- 129.10 Subdivision 1. **Application fees.** Application fees for licensure and registration are as  
129.11 follows:
- 129.12 (1) pharmacist licensed by examination, ~~\$175~~ \$210;
- 129.13 (2) pharmacist licensed by reciprocity, ~~\$275~~ \$300;
- 129.14 (3) pharmacy intern, ~~\$50~~ \$75;
- 129.15 (4) pharmacy technician, ~~\$50~~ \$60;
- 129.16 (5) pharmacy, ~~\$260~~ \$300;
- 129.17 (6) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;
- 129.18 (7) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 129.19 (8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;
- 129.20 (9) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300  
129.21 for each additional facility;
- 129.22 (10) third-party logistics provider, ~~\$260~~ \$300;
- 129.23 (11) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;
- 129.24 (12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;
- 129.25 (13) drug manufacturer, nonlegend or veterinary legend drugs, ~~\$5,260~~ \$5,300;
- 129.26 (14) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~  
129.27 \$300 for each additional facility;
- 129.28 (15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;

130.1 (16) drug manufacturer of opiate-containing controlled substances listed in section  
 130.2 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;

130.3 (17) medical gas dispenser, \$260;

130.4 (18) controlled substance researcher, ~~\$75~~ \$150; and

130.5 (19) pharmacy professional corporation, \$150.

130.6 Sec. 4. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

130.7 Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~\$175~~ \$210.

130.8 Sec. 5. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

130.9 Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as  
 130.10 follows:

130.11 (1) pharmacist, ~~\$175~~ \$210;

130.12 (2) pharmacy technician, ~~\$50~~ \$60;

130.13 (3) pharmacy, ~~\$260~~ \$300;

130.14 (4) drug wholesaler, legend drugs only, ~~\$5,260~~ \$5,300;

130.15 (5) drug wholesaler, legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

130.16 (6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;

130.17 (7) drug wholesaler, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~ \$300

130.18 for each additional facility;

130.19 (8) third-party logistics provider, ~~\$260~~ \$300;

130.20 (9) drug manufacturer, nonopiate legend drugs only, ~~\$5,260~~ \$5,300;

130.21 (10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~\$5,260~~ \$5,300;

130.22 (11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~\$5,260~~ \$5,300;

130.23 (12) drug manufacturer, medical gases, ~~\$5,260~~ \$5,300 for the first facility and ~~\$260~~

130.24 \$300 for each additional facility;

130.25 (13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~\$5,260~~ \$5,300;

130.26 (14) drug manufacturer of opiate-containing controlled substances listed in section  
 130.27 152.02, subdivisions 3 to 5, ~~\$55,260~~ \$55,300;

130.28 (15) medical gas dispenser, \$260;

131.1 (16) controlled substance researcher, ~~\$75~~ \$150; and

131.2 (17) pharmacy professional corporation, ~~\$100~~ \$150.

131.3 Sec. 6. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

131.4 Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and  
131.5 certificates are as follows:

131.6 (1) intern affidavit, ~~\$20~~ \$30;

131.7 (2) duplicate small license, ~~\$20~~ \$30; and

131.8 (3) duplicate large certificate, \$30.

131.9 Sec. 7. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

131.10 Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license  
131.11 to lapse may reinstate the license with board approval and upon payment of any fees and  
131.12 late fees in arrears, up to a maximum of \$1,000.

131.13 (b) A pharmacy technician who has allowed the technician's registration to lapse may  
131.14 reinstate the registration with board approval and upon payment of any fees and late fees  
131.15 in arrears, up to a maximum of ~~\$90~~ \$250.

131.16 (c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics  
131.17 provider, or a medical gas dispenser who has allowed the license of the establishment to  
131.18 lapse may reinstate the license with board approval and upon payment of any fees and late  
131.19 fees in arrears.

131.20 (d) A controlled substance researcher who has allowed the researcher's registration to  
131.21 lapse may reinstate the registration with board approval and upon payment of any fees and  
131.22 late fees in arrears.

131.23 (e) A pharmacist owner of a professional corporation who has allowed the corporation's  
131.24 registration to lapse may reinstate the registration with board approval and upon payment  
131.25 of any fees and late fees in arrears.

132.1

**ARTICLE 4**

132.2

**MNSURE POLICY**

132.3 Section 1. Minnesota Statutes 2022, section 62K.15, is amended to read:

132.4 **62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT**  
132.5 **PERIODS.**

132.6 (a) Health carriers offering individual health plans must limit annual enrollment in the  
132.7 individual market to the annual open enrollment periods for MNsure. Nothing in this section  
132.8 limits the application of special or limited open enrollment periods as defined under the  
132.9 Affordable Care Act.

132.10 (b) Health carriers offering individual health plans must inform all applicants at the time  
132.11 of application and enrollees at least annually of the open and special enrollment periods as  
132.12 defined under the Affordable Care Act.

132.13 (c) Health carriers offering individual health plans must provide a special enrollment  
132.14 period for enrollment in the individual market by employees of a small employer that offers  
132.15 a qualified small employer health reimbursement arrangement in accordance with United  
132.16 States Code, title 26, section 9831(d). The special enrollment period shall be available only  
132.17 to employees newly hired by a small employer offering a qualified small employer health  
132.18 reimbursement arrangement, and to employees employed by the small employer at the time  
132.19 the small employer initially offers a qualified small employer health reimbursement  
132.20 arrangement. For employees newly hired by the small employer, the special enrollment  
132.21 period shall last for 30 days after the employee's first day of employment. For employees  
132.22 employed by the small employer at the time the small employer initially offers a qualified  
132.23 small employer health reimbursement arrangement, the special enrollment period shall last  
132.24 for 30 days after the date the arrangement is initially offered to employees.

132.25 (d) The commissioner of commerce shall enforce this section.

132.26 (e) Health carriers offering individual health plans through MNsure must provide a  
132.27 special enrollment period as required under the easy enrollment health insurance outreach  
132.28 program under section 62V.12.

132.29 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
132.30 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

133.1 Sec. 2. **[62V.12] EASY ENROLLMENT HEALTH INSURANCE OUTREACH**  
133.2 **PROGRAM.**

133.3 **Subdivision 1. Establishment.** The board, in cooperation with the commissioner of  
133.4 revenue, must establish the easy enrollment health insurance outreach program to:

133.5 (1) reduce the number of uninsured Minnesotans and increase access to affordable health  
133.6 insurance coverage;

133.7 (2) allow the commissioner of revenue to provide return information, at the request of  
133.8 the taxpayer, to MNsure to provide the taxpayer with information about the potential  
133.9 eligibility for financial assistance and health insurance enrollment options through MNsure;

133.10 (3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for  
133.11 health insurance coverage; and

133.12 (4) allow MNsure to conduct targeted outreach to assist interested taxpayer households  
133.13 in applying for and enrolling in affordable health insurance options through MNsure,  
133.14 including connecting interested taxpayer households with a navigator or broker for free  
133.15 enrollment assistance.

133.16 **Subd. 2. Screening for eligibility for insurance assistance.** Upon receipt of and based  
133.17 on return information received from the commissioner of revenue under section 270B.14,  
133.18 subdivision 22, MNsure may make a projected assessment on whether the interested  
133.19 taxpayer's household may qualify for a financial assistance program for health insurance  
133.20 coverage.

133.21 **Subd. 3. Outreach letter and special enrollment period.** (a) MNsure must provide a  
133.22 written letter of the projected assessment under subdivision 2 to a taxpayer who indicates  
133.23 to the commissioner of revenue that the taxpayer is interested in obtaining information on  
133.24 access to health insurance.

133.25 (b) MNsure must allow a special enrollment period for taxpayers who receive the outreach  
133.26 letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through  
133.27 MNsure. The triggering event for the special enrollment period is the day the outreach letter  
133.28 under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents,  
133.29 have 65 days from the triggering event to select a qualifying health plan and coverage for  
133.30 the qualifying health plan is effective the first day of the month after plan selection.

133.31 (c) Taxpayers who have a member of the taxpayer's household currently enrolled in a  
133.32 qualified health plan through MNsure are not eligible for the special enrollment under  
133.33 paragraph (b).

134.1 (d) MNsure must provide information about the easy enrollment health insurance outreach  
134.2 program and the special enrollment period described in this subdivision to the general public.

134.3 Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under  
134.4 this section are not appealable.

134.5 (b) Qualification for the special enrollment period under this section is appealable to  
134.6 MNsure under this chapter and Minnesota Rules, chapter 7700.

134.7 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
134.8 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

134.9 Sec. 3. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to  
134.10 read:

134.11 Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or  
134.12 return information to the MNsure board if a taxpayer makes the designation under section  
134.13 290.433 on an income tax return filed with the commissioner. The commissioner must only  
134.14 disclose data necessary to provide the taxpayer with information about the potential eligibility  
134.15 for financial assistance and health insurance enrollment options under section 62V.12.

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

134.17 Sec. 4. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH**  
134.18 **PROGRAM CHECKOFF.**

134.19 Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return  
134.20 may designate on their original return a request that the commissioner provide their return  
134.21 information to the MNsure board for purposes of providing the individual with information  
134.22 about potential eligibility for financial assistance and health insurance enrollment options  
134.23 under section 62V.12, to the extent necessary to administer the easy enrollment health  
134.24 insurance outreach program.

134.25 Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the  
134.26 designation in subdivision 1 on their income tax return.

134.27 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December  
134.28 31, 2023.

134.29 Sec. 5. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

134.30 The MNsure board and the commissioner of the Department of Revenue must develop  
134.31 and implement systems, policies, and procedures that encourage, facilitate, and streamline

- 135.1 data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose  
135.2 of the easy enrollment health insurance outreach program under Minnesota Statutes, section  
135.3 62V.12, for operation beginning with tax year 2023.

**62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.**

Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning January 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information described in paragraph (b) for each newly acquired prescription drug for which the price was \$100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for a newly acquired brand name drug where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in price over the previous 24-month period; and

(2) for a newly acquired generic drug where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall submit to the commissioner no later than 60 days after the acquiring manufacturer begins to sell the newly acquired drug, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;

(2) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;

(3) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;

(4) the price of the prescription drug for the previous five years;

(5) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the manufacturer's drug; and

(6) the patent expiration date of the drug if it is under patent.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

**62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.**

Subd. 6. **Projected spending baseline.** Beginning February 15, 2016, and each February 15 thereafter, the commissioner of health shall report the projected impact on spending from specified health indicators related to various preventable illnesses and death. The impacts shall be reported over a ten-year time frame using a baseline forecast of private and public health care and long-term care spending for residents of this state, beginning with calendar year 2009 projected estimates of costs, and updated annually for each of the following health indicators:

(1) costs related to rates of obesity, including obesity-related cancers, coronary heart disease, stroke, and arthritis;

(2) costs related to the utilization of tobacco products;

(3) costs related to hypertension;

(4) costs related to diabetes or prediabetes; and

(5) costs related to dementia and chronic disease among an elderly population over 60, including additional long-term care costs.

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



year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

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

Subd. 8. **Transfers.** When accumulated annual savings accruing to state-administered health care programs, as calculated under subdivision 7, meet or exceed \$50,000,000 for all health indicators in aggregate statewide, the commissioner of health shall certify that event to the commissioner of management and budget, no later than December 15 of each year. In the next fiscal year following the certification, the commissioner of management and budget shall transfer \$50,000,000 from the general fund to the health care access fund. This transfer shall repeat in each fiscal year following subsequent certifications of additional cumulative savings, up to \$50,000,000 per year. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

#### **145.4235 POSITIVE ABORTION ALTERNATIVES.**

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

(1) "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother;

(2) "nondirective counseling" means providing clients with:

(i) a list of health care providers and social service providers that provide prenatal care, childbirth care, infant care, foster care, adoption services, alternatives to abortion, or abortion services; and

(ii) nondirective, nonmarketing information regarding such providers; and

(3) "unborn child" means a member of the species *Homo sapiens* from fertilization until birth.

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

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(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) The commissioner shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information is medically accurate.

**Subd. 3. Privacy protection.** (a) Any program receiving a grant under this section must have a privacy policy and procedures in place to ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program is not made public or shared with any other agency or organization without the written consent of the woman. All communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in sections 144.291 to 144.298 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner has access to any information necessary to monitor and review a grantee's program as required under subdivision 4.

**Subd. 4. Duties of commissioner.** The commissioner shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

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Subd. 5. **Severability.** Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or its application to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are severable.

Subd. 6. **Minnesota Supreme Court jurisdiction.** The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of this section and shall expedite the resolution of the action.

**145.4241 DEFINITIONS.**

Subdivision 1. **Applicability.** As used in sections 145.4241 to 145.4249, the following terms have the meanings given them.

Subd. 2. **Abortion.** "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to intentionally terminate the pregnancy of a female known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. **Attempt to perform an abortion.** "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4249.

Subd. 3a. **Fetal anomaly incompatible with life.** "Fetal anomaly incompatible with life" means a fetal anomaly diagnosed before birth that will with reasonable certainty result in death of the unborn child within three months. Fetal anomaly incompatible with life does not include conditions which can be treated.

Subd. 4. **Medical emergency.** "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 4a. **Perinatal hospice.** (a) "Perinatal hospice" means comprehensive support to the female and her family that includes support from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses.

(b) The availability of perinatal hospice provides an alternative to families for whom elective pregnancy termination is not chosen.

Subd. 5. **Physician.** "Physician" means a person licensed as a physician or osteopathic physician under chapter 147.

Subd. 6. **Probable gestational age of the unborn child.** "Probable gestational age of the unborn child" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the unborn child at the time the abortion is planned to be performed.

Subd. 7. **Stable Internet website.** "Stable Internet website" means a website that, to the extent reasonably practicable, is safeguarded from having its content altered other than by the commissioner of health.

Subd. 8. **Unborn child.** "Unborn child" means a member of the species *Homo sapiens* from fertilization until birth.

**145.4242 INFORMED CONSENT.**

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

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(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed;

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored website, and what the website address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the website, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), item (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

(c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly incompatible with life must be informed of available perinatal hospice services and offered this care as an alternative to abortion. If perinatal hospice services are declined, voluntary and informed consent by the female seeking an abortion is given if the female receives the information required in paragraphs (a), clause (1), and (b). The female must comply with the requirements in paragraph (a), clauses (3) and (4).

**145.4243 PRINTED INFORMATION.**

(a) Within 90 days after July 1, 2003, the commissioner of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, and shall cause to be available on the state website provided for under section 145.4244 the following printed materials in such a way as to ensure that the information is easily comprehensible:

(1) geographically indexed materials designed to inform the female of public and private agencies and services available to assist a female through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer, and a description of the manner, including telephone numbers, in which they might be contacted or, at the option of the commissioner of health, printed materials including a toll-free, 24-hours-a-day telephone number that may be called to obtain, orally or by a tape recorded message tailored to a zip code entered by the caller, such a list and description of agencies in the locality of the caller and of the services they offer;

(2) materials designed to inform the female of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the unborn child's survival and pictures or drawings representing the development of unborn children at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks commonly associated with carrying a child to term; and

(3) materials with the following information concerning an unborn child of 20 weeks gestational age and at two weeks gestational increments thereafter in such a way as to ensure that the information is easily comprehensible:

(i) the development of the nervous system of the unborn child;

(ii) fetal responsiveness to adverse stimuli and other indications of capacity to experience organic pain; and

(iii) the impact on fetal organic pain of each of the methods of abortion procedures commonly employed at this stage of pregnancy.

The material under this clause shall be objective, nonjudgmental, and designed to convey only accurate scientific information.

(b) The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The website provided for under section 145.4244 shall be maintained at a minimum resolution of 70 DPI (dots per inch). All pictures appearing on the website shall be a minimum of 200x300 pixels. All letters on the website shall be a minimum of 11-point font. All information and pictures shall be accessible with an industry standard browser, requiring no additional plug-ins. The materials required under this section must be available at no cost from the commissioner of health upon request and in appropriate number to any person, facility, or hospital.

**145.4244 INTERNET WEBSITE.**

The commissioner of health shall develop and maintain a stable Internet website to provide the information described under section 145.4243. No information regarding who uses the website shall be collected or maintained. The commissioner of health shall monitor the website on a weekly basis to prevent and correct tampering.

**145.4245 PROCEDURE IN CASE OF MEDICAL EMERGENCY.**

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create serious risk of substantial and irreversible impairment of a major bodily function.

**145.4246 REPORTING REQUIREMENTS.**

Subdivision 1. **Reporting form.** Within 90 days after July 1, 2003, the commissioner of health shall prepare a reporting form for physicians containing a reprint of sections 145.4241 to 145.4249 and listing:

(1) the number of females to whom the physician provided the information described in section 145.4242, clause (1); of that number, the number provided by telephone and the number provided in person; and of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion;

(2) the number of females to whom the physician or an agent of the physician provided the information described in section 145.4242, clause (2); of that number, the number provided by telephone and the number provided in person; of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion; and of each of those numbers, the number provided by the physician and the number provided by an agent of the physician;

(3) the number of females who availed themselves of the opportunity to obtain a copy of the printed information described in section 145.4243 other than on the website and the number who did not; and of each of those numbers, the number who, to the best of the reporting physician's information and belief, went on to obtain the abortion; and

(4) the number of abortions performed by the physician in which information otherwise required to be provided at least 24 hours before the abortion was not so provided because an immediate abortion was necessary to avert the female's death and the number of abortions in which such information was not so provided because a delay would create serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 2. **Distribution of forms.** The commissioner of health shall ensure that copies of the reporting forms described in subdivision 1 are provided:

(1) by December 1, 2003, and by December 1 of each subsequent year thereafter to all physicians licensed to practice in this state; and

(2) to each physician who subsequently becomes newly licensed to practice in this state, at the same time as official notification to that physician that the physician is so licensed.

Subd. 3. **Reporting requirement.** By April 1, 2005, and by April 1 of each subsequent year thereafter, each physician who provided, or whose agent provided, information to one or more females in accordance with section 145.4242 during the previous calendar year shall submit to the commissioner of health a copy of the form described in subdivision 1 with the requested data entered accurately and completely.

Subd. 4. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

Subd. 5. **Failure to report as required.** Reports that are not submitted by the end of a grace period of 30 days following the due date shall be subject to a late fee of \$500 for each additional 30-day period or portion of a 30-day period they are overdue. Any physician required to report according to this section who has not submitted a report, or has submitted only an incomplete report, more than one year following the due date, may, in an action brought by the commissioner of health, be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to sanctions for civil contempt.

Subd. 6. **Public statistics.** By July 1, 2005, and by July 1 of each subsequent year thereafter, the commissioner of health shall issue a public report providing statistics for the previous calendar year compiled from all of the reports covering that year submitted according to this section for each of the items listed in subdivision 1. Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner of health shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual providing or provided information according to section 145.4242.

Subd. 7. **Consolidation.** The commissioner of health may consolidate the forms or reports described in this section with other forms or reports to achieve administrative convenience or fiscal savings or to reduce the burden of reporting requirements.

**145.4247 REMEDIES.**

Subdivision 1. **Civil remedies.** Any person upon whom an abortion has been performed without complying with sections 145.4241 to 145.4249 may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. Any person upon whom an abortion has been attempted without complying with sections 145.4241 to 145.4249 may maintain an action against the person who attempted to perform the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. No civil liability may be assessed for failure to comply with section 145.4242, clause (2), item (iii), or that portion of section 145.4242, clause (2), requiring written certification that the female has been informed of her opportunity to review the information referred to in section 145.4242, clause (2), item (iii), unless the commissioner of health has made the printed materials or website address available at the time the physician or the physician's agent is required to inform the female of her right to review them.

Subd. 2. **Suit to compel statistical report.** If the commissioner of health fails to issue the public report required under section 145.4246, subdivision 6, or fails in any way to enforce Laws 2003, chapter 14, any group of ten or more citizens of this state may seek an injunction in a court of competent jurisdiction against the commissioner of health requiring that a complete report be issued within a period stated by court order. Failure to abide by such an injunction shall subject the commissioner to sanctions for civil contempt.

Subd. 3. **Attorney fees.** If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

Subd. 4. **Protection of privacy in court proceedings.** In every civil action brought under sections 145.4241 to 145.4249, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under subdivision 1, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

**145.4248 SEVERABILITY.**

If any one or more provision, section, subsection, sentence, clause, phrase, or word of sections 145.4241 to 145.4249 or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4241 to 145.4249 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4241 to 145.4249, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

**145.4249 SUPREME COURT JURISDICTION.**

The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of sections 145.4241 to 145.4249 and shall expedite the resolution of the action.

**145.925 FAMILY PLANNING GRANTS.**

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

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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. 3. **Minors.** 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.

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. 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 or 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.