This Document can be made available in alternative formats upon request

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-THIRD SESSION

H. F. No. 2930

03/16/2023 Authored by Liebling
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration
03/20/2023 Adoption of Report: Re-referred to the Committee on Health Finance and Policy

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**

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

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**

	Appropriations by Fund		
2.32	General	240,491,000	230,169,000

3.1 State Government 3.2 Special Revenue	12,392,000	12,682,000
3.3 Health Care Access	52,207,000	56,921,000
3.4 Federal TANF	11,713,000	11,713,000

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 $2,182,00 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**

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

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 Subd. 2. **Board of Behavioral Health and** 16.2 **Therapy**	1,022,000	1,044,000
16.3 Subd. 3. **Board of Chiropractic Examiners**	773,000	790,000
16.4 Subd. 4. **Board of Dentistry**	4,100,000	4,163,000

16.5 (a) **Administrative services unit; operating**
16.6 **costs.** Of this appropriation, $1,936,000 in
16.7 fiscal year 2024 and $1,960,000 in fiscal year
16.8 2025 are for operating costs of the
16.9 administrative services unit. The
16.10 administrative services unit may receive and
16.11 expend reimbursements for services it
16.12 performs for other agencies.

16.13 (b) **Administrative services unit; volunteer**
16.14 **health care provider program.** Of this
16.15 appropriation, $150,000 in fiscal year 2024
16.16 and $150,000 in fiscal year 2025 are to pay
16.17 for medical professional liability coverage
16.18 required under Minnesota Statutes, section
16.19 214.40.

16.20 (c) **Administrative services unit; retirement**
16.21 **costs.** Of this appropriation, $237,000 in fiscal
16.22 year 2024 and $237,000 in fiscal year 2025
16.23 are for the administrative services unit to pay
16.24 for the retirement costs of health-related board
16.25 employees. This funding may be transferred
16.26 to the health board incurring retirement costs.
16.27 Any board that has an unexpended balance for
16.28 an amount transferred under this paragraph
16.29 shall transfer the unexpended amount to the
16.30 administrative services unit. If the amount
16.31 appropriated in the first year of the biennium
16.32 is not sufficient, the amount from the second
16.33 year of the biennium is available.

16.34 (d) **Administrative services unit; contested**
16.35 **cases and other legal proceedings.** Of this

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

18.1 Appropriations by Fund

18.2 State Government 18.3 Special Revenue	5,266,000	5,206,000
18.4 Health Care Access	76,000	38,000

18.5 **Base level adjustment.** The state government
18.6 special revenue fund base is $5,056,000 in
18.7 fiscal year 2026 and $5,056,000 in fiscal year
18.8 2027. The health care access fund base is $0
18.9 in fiscal year 2026 and $0 in fiscal year 2027.

18.10 Subd. 13. **Board of Physical Therapy**	678,000	694,000
18.11 Subd. 14. **Board of Podiatric Medicine**	253,000	257,000
18.12 Subd. 15. **Board of Psychology**	2,618,000	2,734,000

18.13 **Health professionals service program.** This
18.14 appropriation includes $1,234,000 in fiscal
18.15 year 2024 and $1,324,000 in fiscal year 2025
18.16 for the health professional services program.

18.17 Subd. 16. **Board of Social Work**	1,779,000	1,839,000
18.18 Subd. 17. **Board of Veterinary Medicine**	382,000	392,000

18.19 Sec. 4. **EMERGENCY MEDICAL SERVICES** 18.20 **REGULATORY BOARD**	**$ 4,317,000**	**$ 4,376,000**

18.21 (a) **Cooper/Sams Volunteer Ambulance**
18.22 **Program.** $950,000 in fiscal year 2024 and
18.23 $950,000 in fiscal year 2025 are for the
18.24 Cooper/Sams volunteer ambulance program
18.25 under Minnesota Statutes, section 144E.40.

18.26 (1) Of this amount, $861,000 in fiscal year
18.27 2024 and $861,000 in fiscal year 2025 are for
18.28 the ambulance service personnel longevity
18.29 award and incentive program under Minnesota
18.30 Statutes, section 144E.40.

18.31 (2) Of this amount, $89,000 in fiscal year 2024
18.32 and $89,000 in fiscal year 2025 are for
18.33 operations of the ambulance service personnel

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 General	11,095,000	14,296,000
19.34 Health Care Access	800,000	0

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 20.14 Sec. 11. **RARE DISEASE ADVISORY COUNCIL**	**$**	**654,000**	**$**	**602,000**
20.15 Sec. 12. **REVENUE**	**$**	**40,000**	**$**	**4,000**

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,; 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,; 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:

(i) to manufacture the prescription drug;

(ii) to market the prescription drug, including advertising costs; and

(iii) to distribute the prescription drug; and

~~(4)~~ (5) the patent expiration date of the drug if it is under patent.

(b) The manufacturer may submit documentation necessary to support the information reported under this subdivision.

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

Subd. 6. **Public posting of prescription drug price information.** (a) The commissioner shall post on the department's website, or may contract with a private entity or consortium that satisfies the standards of section 62U.04, subdivision 6, to meet this requirement, the following information:

(1) a list of the prescription drugs reported under subdivisions 3~~, 4, and 5,~~ to 6 and 9 to 14 and the manufacturers of those prescription drugs; and

(2) information reported to the commissioner under subdivisions 3~~, 4, and 5~~ to 6 and 9 to 14.

(b) The information must be published in an easy-to-read format and in a manner that identifies the information that is disclosed on a per-drug basis and must not be aggregated in a manner that prevents the identification of the prescription drug.

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing

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

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

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

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

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

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

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

(1) failing to register under subdivision 15;

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

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

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

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

(c) The commissioner shall impose civil penalties under this section as provided in 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~~<u> to 6 and 9 to 14</u>.

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

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

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

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 ~~(c), unauthorized provider services~~
46.23 ~~occur~~ (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~~

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

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

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

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

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

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

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

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

(1) medical records;

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

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

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

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

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

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

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

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

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~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit in the general fund.

Sec. 57. Minnesota Statutes 2022, section 144.226, subdivision 4, is amended to read:

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

Sec. 58. Minnesota Statutes 2022, section 144.383, is amended to read:

144.383 AUTHORITY OF COMMISSIONER.

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

~~(a) To~~ (1) approve the site, design, and construction and alteration of all public water supplies and, for community and nontransient noncommunity water systems as defined in Code of Federal Regulations, title 40, section 141.2, to approve documentation that demonstrates the technical, managerial, and financial capacity of those systems to comply with rules adopted under this section;

~~(b) To~~ (2) enter the premises of a public water supply, or part thereof, to inspect the facilities and records kept pursuant to rules promulgated by the commissioner, to conduct sanitary surveys and investigate the standard of operation and service delivered by public water supplies;

~~(c) To~~ (3) contract with community health boards as defined in section 145A.02, subdivision 5, for routine surveys, inspections, and testing of public water supply quality;

~~(d) To~~ (4) develop an emergency plan to protect the public when a decline in water quality or quantity creates a serious health risk, and to issue emergency orders if a health risk is imminent;

~~(e) To~~ (5) promulgate rules, pursuant to chapter 14 but no less stringent than federal 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

populations of color, American Indians, LGBTQIA+, and those with disabilities in metro and rural communities.

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, local public health organizations, and Tribal nations, shall develop a request for proposals to advance equitable and inclusive community engagement by cultivating a community of practice and building capacity within their system, service providers, and local public health organizations.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from local public health departments and other service providers:

(1) with significant emphasis on serving populations of color, LGBTQIA+, and disability communities; and

(2) partnering with organizations or entities led by populations of color and those serving communities of color, American Indians, LGBTQIA+, and disabilities in metro and rural communities.

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

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

Sec. 61. **[144.9821] ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION.**

Subdivision 1. **Establishment of grant program.** The commissioner of health shall:

(1) establish an annual grant program to award infrastructure capacity building grants to help metro and rural community and faith-based organizations serving populations of color, American Indian, LGBTQIA+, and those with disabilities in Minnesota who have been disproportionately impacted by health and other inequities to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities; and

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 prepregnancy 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~~

~~minor in any elementary or secondary school building.~~ (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal communities in rural and metropolitan areas of the state to support, sustain, expand, or implement reproductive and sexual health programs for people of reproductive age to increase access to and availability of medically accurate sexual and reproductive health services.

(b) The commissioner of health shall establish application scoring criteria in the evaluation of applications submitted for award under this section. These criteria include but are not limited to the degree to which applicants' programming responds to demographic factors relevant to subdivision 1, paragraph (a), and paragraph (f).

(c) When determining whether to award a grant or the amount of a grant under this section, the commissioner of health may identify and stratify geographic regions based on the region's need for sexual and reproductive health services. In this stratification, the commissioner may consider data on the prevalence of poverty and other factors relevant to a geographic region's need for sexual and reproductive health services.

(d) The commissioner of health may consider geographic and Tribal communities' representation in the award of grants.

(e) Current recipients of funding under this section shall not be afforded priority over new applicants.

(f) Grant funds shall be used to support new or existing sexual and reproductive health programs that provide person-centered, accessible services; that are culturally and linguistically appropriate, inclusive of all people, and trauma-informed; that protect the dignity of the individual; and that ensure equitable, quality services consistent with nationally recognized standards of care. These services include:

(i) education and outreach on medically accurate sexual and reproductive health information;

(ii) contraceptive counseling, provision of contraceptive methods, and follow-up;

(iii) screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns; and

(iv) referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

~~Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part~~

~~from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.~~

Subd. 5. **Rules.** The commissioner of health shall promulgate rules for approval of plans and budgets of prospective grant recipients, for the submission of annual financial and statistical reports, and the maintenance of statements of source and application of funds by grant recipients. The commissioner of health may not require that any home rule charter or statutory city or county apply for or receive grants under this subdivision as a condition for the receipt of any state or federal funds unrelated to family planning services.

Subd. 6. **Public services; individual ~~and employee~~ rights.** The request of any person for ~~family planning~~ sexual and reproductive health services or the refusal to accept any service shall in no way affect the right of the person to receive public assistance, public health services, or any other public service. Nothing in this section shall abridge the right of the ~~individual~~ person to make decisions concerning ~~family planning~~ sexual and reproductive health, nor shall any ~~individual~~ person be required to state a reason for refusing any offer of ~~family planning~~ sexual and reproductive health services.

~~Any employee of the agencies engaged in the administration of the provisions of this section may refuse to accept the duty of offering family planning services to the extent that the duty is contrary to personal beliefs. A refusal shall not be grounds for dismissal, suspension, demotion, or any other discrimination in employment. The directors or supervisors of the agencies shall reassign the duties of employees in order to carry out the provisions of this section.~~

All information gathered by any agency, entity, or individual conducting programs in ~~family planning~~ sexual and reproductive health is private data on individuals within the meaning of section 13.02, subdivision 12. For any person or entity meeting the definition of a "provider" under section 144.291, subdivision 2, paragraph (i), all sexual and reproductive health services information provided to, gathered about, or received from a person under this section is also subject to the Minnesota Health Records Act, in sections 144.291 to 144.298.

~~Subd. 7. **Family planning services; information required.** A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:~~

~~(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;~~

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 of 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).

Subd. 5. **Remittance.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees are the liability of the consumer and not of the seller or of any provider, except that the seller is liable to remit all fees as provided in section 403.162.

Subd. 6. **Exclusion for calculating other charges.** The combined amount of the prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by a seller from a consumer must not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

Subd. 7. **Fee changes.** (a) The prepaid wireless E911 ~~and~~, telecommunications access Minnesota ~~fee~~, and 988 fees must be proportionately increased or reduced upon any change to the fee imposed under section 403.11, subdivision 1, paragraph (c), after July 1, 2013, ~~or~~ the fee imposed under section 237.52, subdivision 2, as applicable.

(b) The department shall post notice of any fee changes on its website at least 30 days in advance of the effective date of the fee changes. It is the responsibility of sellers to monitor the department's website for notice of fee changes.

(c) Fee changes are effective 60 days after the first day of the first calendar month after the commissioner of public safety or the Public Utilities Commission, as applicable, changes the fee.

Sec. 81. Minnesota Statutes 2022, section 403.162, is amended to read:

403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.

Subdivision 1. **Remittance.** Prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by sellers must be remitted to the commissioner of revenue at the times and in the manner provided by chapter 297A with respect to the general sales and use tax. The commissioner of revenue shall establish registration and payment procedures that substantially coincide with the registration and payment procedures that apply in chapter 297A.

Subd. 2. **Seller's fee retention.** A seller may deduct and retain three percent of prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees collected by the seller from consumers.

Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection, refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed 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.

(b) Grants shall be awarded for programs that are evidenced-based or evidenced-informed and are focused on addressing the mental health of health care professionals by:

(1) identifying and addressing the barriers to and stigma among health care professionals associated with seeking self-care, including mental health and substance use disorder services;

(2) encouraging health care professionals to seek support and care for mental health and substance use disorder concerns;

(3) identifying risk factors associated with suicide and other mental health conditions; ~~or~~

(4) developing and making available resources to support health care professionals with self-care and resiliency~~.~~; and

(5) identifying and modifying structural barriers in health care delivery that create unnecessary stress in the workplace.

Subd. 2. **Allocation of grants.** (a) To receive a grant, a health care entity must submit an application to the commissioner by the deadline established by the commissioner. An application must be on a form and contain information as specified by the commissioner and at a minimum must contain:

(1) a description of the purpose of the program for which the grant funds will be used;

(2) a description of the achievable objectives of the program and how these objectives will be met; and

(3) a process for documenting and evaluating the results of the program.

(b) The commissioner shall give priority to programs that involve peer-to-peer support.

Subd. 2a. **Grant term.** Notwithstanding Minnesota Statutes, section 16A.28, subdivision 6, encumbrances for grants under this section issued by June 30 of each year may be certified for a period of up to three years beyond the year in which the funds were originally appropriated.

Subd. 3. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program by conducting a periodic evaluation of the impact and outcomes of the grant program on health care professional burnout and retention. The commissioner shall submit the results of the evaluation and any recommendations for improving the grant program to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by October 15, 2024.

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;

(6) application fee for LMFT licensure by reciprocity is ~~$220~~ $300;

(7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT) license is ~~$75~~ $100;

(8) annual renewal fee for LAMFT license is ~~$75~~ $100;

(9) late fee for LAMFT renewal is ~~$25~~ $50;

(10) fee for reinstatement of license is $150;

(11) fee for emeritus status is ~~$125~~ $225; and

(12) fee for temporary license for members of the military is $100.

Sec. 3. Minnesota Statutes 2022, section 151.065, subdivision 1, is amended to read:

Subdivision 1. **Application fees.** Application fees for licensure and registration are as follows:

(1) pharmacist licensed by examination, ~~$175~~ $210;

(2) pharmacist licensed by reciprocity, ~~$275~~ $300;

(3) pharmacy intern, ~~$50~~ $75;

(4) pharmacy technician, ~~$50~~ $60;

(5) pharmacy, ~~$260~~ $300;

(6) drug wholesaler, legend drugs only, ~~$5,260~~ $5,300;

(7) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,300;

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(9) drug wholesaler, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(10) third-party logistics provider, ~~$260~~ $300;

(11) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,300;

(12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,300;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$5,260~~ $5,300;

(14) drug manufacturer, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(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~~ <u>$150</u>; and

131.2 (17) pharmacy professional corporation, ~~$100~~ <u>$150</u>.

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~~ <u>$30</u>;

131.7 (2) duplicate small license, ~~$20~~ <u>$30</u>; 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~~ <u>$250</u>.

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;

(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.

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:

(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

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 of procedures; and

(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.

Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.