

1.1 CONFERENCE COMMITTEE REPORT ON S.F. No. 4699

1.2 A bill for an act

1.3 relating to state government; modifying provisions governing health care, health  
1.4 insurance, health policy, emergency medical services, the Department of Health,  
1.5 the Department of Human Services, MNsure, health care workforce, health-related  
1.6 licensing boards, health care affordability and delivery, background studies, child  
1.7 protection and welfare, child care licensing, behavioral health, economic assistance,  
1.8 housing and homelessness, human services policy, the Minnesota Indian Family  
1.9 Preservation Act, and the Department of Children, Youth, and Families; establishing  
1.10 the Office of Emergency Medical Services; establishing the Minnesota African  
1.11 American Family Preservation and Child Welfare Disproportionality Act; making  
1.12 technical and conforming changes; requiring reports; imposing penalties; providing  
1.13 appointments; making forecast adjustments; appropriating money; amending  
1.14 Minnesota Statutes 2022, sections 16A.055, subdivision 1a, by adding a subdivision;  
1.15 16A.103, by adding a subdivision; 62A.0411; 62A.15, subdivision 4, by adding a  
1.16 subdivision; 62A.28, subdivision 2; 62D.02, subdivisions 4, 7; 62D.03, subdivision  
1.17 1; 62D.05, subdivision 1; 62D.06, subdivision 1; 62D.14, subdivision 1; 62D.19;  
1.18 62D.20, subdivision 1; 62D.22, subdivision 5; 62E.02, subdivision 3; 62J.49,  
1.19 subdivision 1; 62J.61, subdivision 5; 62M.01, subdivision 3; 62Q.097, by adding  
1.20 a subdivision; 62Q.14; 62V.05, subdivision 12; 62V.08; 62V.11, subdivision 4;  
1.21 103I.621, subdivisions 1, 2; 121A.15, subdivision 3, by adding a subdivision;  
1.22 144.05, subdivision 6, by adding a subdivision; 144.058; 144.0724, subdivisions  
1.23 2, 3a, 4, 6, 7, 8, 9, 11; 144.1464, subdivisions 1, 2, 3; 144.1501, subdivision 5;  
1.24 144.1911, subdivision 2; 144.212, by adding a subdivision; 144.216, subdivision  
1.25 2, by adding subdivisions; 144.218, by adding a subdivision; 144.292, subdivision  
1.26 6; 144.293, subdivisions 2, 4, 9, 10; 144.493, by adding a subdivision; 144.494,  
1.27 subdivision 2; 144.551, subdivision 1; 144.555, subdivisions 1a, 1b, 2, by adding  
1.28 subdivisions; 144.605, by adding a subdivision; 144.99, subdivision 3; 144A.10,  
1.29 subdivisions 15, 16; 144A.471, by adding a subdivision; 144A.474, subdivision  
1.30 13; 144A.61, subdivision 3a; 144A.70, subdivisions 3, 5, 6, 7; 144A.71, subdivision  
1.31 2, by adding a subdivision; 144A.72, subdivision 1; 144A.73; 144E.001, subdivision  
1.32 3a, by adding subdivisions; 144E.101, by adding a subdivision; 144E.16,  
1.33 subdivisions 5, 7; 144E.19, subdivision 3; 144E.27, subdivisions 3, 5, 6; 144E.28,  
1.34 subdivisions 3, 5, 6, 8; 144E.285, subdivisions 1, 2, 4, 6, by adding subdivisions;  
1.35 144E.287; 144E.305, subdivision 3; 144G.08, subdivision 29; 144G.10, by adding  
1.36 a subdivision; 144G.16, subdivision 6; 146B.03, subdivision 7a; 146B.10,  
1.37 subdivisions 1, 3; 148.235, subdivision 10; 149A.02, subdivisions 3, 3b, 16, 23,  
1.38 26a, 27, 35, 37c, by adding subdivisions; 149A.03; 149A.65; 149A.70, subdivisions  
1.39 1, 2, 3, 5; 149A.71, subdivisions 2, 4; 149A.72, subdivisions 3, 9; 149A.73,  
1.40 subdivision 1; 149A.74, subdivision 1; 149A.93, subdivision 3; 149A.94,  
1.41 subdivisions 1, 3, 4; 149A.97, subdivision 2; 151.01, subdivisions 23, 27; 151.065,  
1.42 by adding subdivisions; 151.066, subdivisions 1, 2, 3; 151.212, by adding a  
1.43 subdivision; 151.37, by adding a subdivision; 151.74, subdivision 6; 152.22,

2.1 subdivision 14, by adding a subdivision; 152.25, subdivision 2; 152.27, subdivisions  
 2.2 2, 6, by adding a subdivision; 176.175, subdivision 2; 214.025; 214.04, subdivision  
 2.3 2a; 214.29; 214.31; 214.355; 243.166, subdivision 7, as amended; 245.096; 245.462,  
 2.4 subdivision 6; 245.4663, subdivision 2; 245A.04, subdivision 10, by adding a  
 2.5 subdivision; 245A.043, subdivisions 2, 4, by adding subdivisions; 245A.07,  
 2.6 subdivision 6; 245A.10, subdivisions 1, as amended, 2, as amended; 245A.14,  
 2.7 subdivision 17; 245A.144; 245A.175; 245A.52, subdivision 2, by adding a  
 2.8 subdivision; 245A.66, subdivision 2; 245C.05, subdivision 5; 245C.08, subdivision  
 2.9 4; 245C.10, subdivision 18; 245C.14, subdivision 1, by adding a subdivision;  
 2.10 245C.15, subdivisions 3, 4; 245C.22, subdivision 4; 245C.24, subdivisions 2, 5;  
 2.11 245C.30, by adding a subdivision; 245E.08; 245F.09, subdivision 2; 245F.14, by  
 2.12 adding a subdivision; 245F.17; 245G.07, subdivision 4; 245G.08, subdivisions 5,  
 2.13 6; 245G.10, by adding a subdivision; 245G.22, subdivisions 6, 7; 245H.01, by  
 2.14 adding subdivisions; 245H.08, subdivision 1; 245H.14, subdivisions 1, 4; 245I.02,  
 2.15 subdivisions 17, 19; 245I.10, subdivision 9; 245I.11, subdivision 1, by adding a  
 2.16 subdivision; 245I.20, subdivision 4; 245I.23, subdivision 14; 256.01, subdivision  
 2.17 41, by adding a subdivision; 256.029, as amended; 256.045, subdivisions 3b, as  
 2.18 amended, 5, as amended, 7, as amended; 256.0451, subdivisions 1, as amended,  
 2.19 22, 24; 256.046, subdivision 2, as amended; 256.9657, subdivision 8, by adding  
 2.20 a subdivision; 256.969, by adding subdivisions; 256B.056, subdivisions 1a, 10;  
 2.21 256B.0622, subdivisions 2a, 3a, 7a, 7d; 256B.0623, subdivision 5; 256B.0625,  
 2.22 subdivisions 12, 20, 39, by adding subdivisions; 256B.0757, subdivisions 4a, 4d,  
 2.23 by adding a subdivision; 256B.0943, subdivision 12; 256B.0947, subdivision 5;  
 2.24 256B.76, subdivision 6; 256B.795; 256I.04, subdivision 2f; 256J.08, subdivision  
 2.25 34a; 256J.28, subdivision 1; 256K.45, subdivision 2; 256N.22, subdivision 10;  
 2.26 256N.24, subdivision 10; 256N.26, subdivisions 12, 13, 15, 16, 18, 21, 22; 256P.05,  
 2.27 by adding a subdivision; 256R.02, subdivision 20; 259.20, subdivision 2; 259.37,  
 2.28 subdivision 2; 259.52, subdivisions 2, 4; 259.53, by adding a subdivision; 259.79,  
 2.29 subdivision 1; 259.83, subdivision 4; 260.755, subdivisions 2a, 5, 14, 17a, by  
 2.30 adding subdivisions; 260.775; 260.785, subdivisions 1, 3; 260.810, subdivision 3;  
 2.31 260C.007, subdivisions 6, 26b; 260C.141, by adding a subdivision; 260C.178,  
 2.32 subdivisions 1, as amended, 7; 260C.202; 260C.209, subdivision 1; 260C.212,  
 2.33 subdivisions 1, 2; 260C.301, subdivision 1, as amended; 260C.329, subdivisions  
 2.34 3, 8; 260C.4411, by adding a subdivision; 260C.515, subdivision 4; 260C.607,  
 2.35 subdivisions 1, 6; 260C.611; 260C.613, subdivision 1; 260C.615, subdivision 1;  
 2.36 260D.01; 260E.03, subdivision 23, as amended; 260E.30, subdivision 3, as  
 2.37 amended; 260E.33, subdivision 2, as amended; 317A.811, subdivisions 1, 2, 4;  
 2.38 393.07, subdivision 10a; 518.17, by adding a subdivision; 519.05; 524.3-801, as  
 2.39 amended; Minnesota Statutes 2023 Supplement, sections 13.46, subdivision 4, as  
 2.40 amended; 15A.0815, subdivision 2; 43A.08, subdivision 1a; 62J.84, subdivision  
 2.41 10; 62Q.46, subdivision 1; 62Q.473, by adding subdivisions; 62Q.522, subdivision  
 2.42 1; 119B.011, subdivision 15; 119B.16, subdivisions 1a, 1c; 119B.161, subdivision  
 2.43 2; 124D.142, subdivision 2, as amended; 142A.03, by adding a subdivision;  
 2.44 144.0526, subdivision 1; 144.1501, subdivisions 1, 2, 3, 4; 144.1505, subdivision  
 2.45 2; 144.2252, subdivision 2; 144.2253; 144.587, subdivision 4; 144A.4791,  
 2.46 subdivision 10; 144E.101, subdivisions 6, 7, as amended; 145.561, subdivision 4;  
 2.47 151.555, subdivisions 1, 4, 5, 6, 7, 8, 9, 11, 12; 151.74, subdivision 3; 152.126,  
 2.48 subdivision 6; 152.28, subdivision 1; 245.4889, subdivision 1; 245A.02, subdivision  
 2.49 2c; 245A.03, subdivisions 2, as amended, 7, as amended; 245A.043, subdivision  
 2.50 3; 245A.07, subdivision 1, as amended; 245A.11, subdivision 7; 245A.16,  
 2.51 subdivisions 1, as amended, 11; 245A.211, subdivision 4; 245A.242, subdivision  
 2.52 2; 245A.50, subdivisions 3, 4; 245A.66, subdivision 4, as amended; 245C.02,  
 2.53 subdivisions 6a, 13e; 245C.033, subdivision 3; 245C.08, subdivision 1; 245C.10,  
 2.54 subdivision 15; 245C.15, subdivisions 2, 4a; 245C.31, subdivision 1; 245G.22,  
 2.55 subdivisions 2, 17; 245H.06, subdivisions 1, 2; 245H.08, subdivisions 4, 5;  
 2.56 254B.04, subdivision 1a; 256.01, subdivision 12b; 256.043, subdivisions 3, 3a;  
 2.57 256.045, subdivision 3, as amended; 256.046, subdivision 3; 256.0471, subdivision  
 2.58 1, as amended; 256.969, subdivision 2b; 256B.0622, subdivisions 7b, 8; 256B.0625,

3.1 subdivisions 3a, 5m, 9, 13e, as amended, 13f, 13k, 16; 256B.064, subdivision 4;  
3.2 256B.0671, subdivision 5; 256B.0701, subdivision 6; 256B.0947, subdivision 7;  
3.3 256B.764; 256D.01, subdivision 1a; 256E.38, subdivision 4; 256I.05, subdivisions  
3.4 1a, 11; 256L.03, subdivision 1; 256M.42, by adding a subdivision; 256P.06,  
3.5 subdivision 3; 259.83, subdivisions 1, 1b, 3a; 260.014, by adding a subdivision;  
3.6 260.755, subdivisions 1a, 3, 3a, 5b, 20, 22; 260.758, subdivisions 2, 4, 5; 260.761;  
3.7 260.762; 260.763, subdivisions 1, 4, 5; 260.765, subdivisions 2, 3a, 4b; 260.771,  
3.8 subdivisions 1a, 1b, 1c, 2b, 2d, 6, by adding a subdivision; 260.773, subdivisions  
3.9 1, 2, 3, 4, 5, 10, 11; 260.774, subdivisions 1, 2, 3; 260.781, subdivision 1; 260.786,  
3.10 subdivision 2; 260.795, subdivision 1; 342.01, subdivision 63; 342.52, subdivision  
3.11 3; 342.53; 342.54, subdivision 2; 342.55, subdivision 2; 518A.42, subdivision 3;  
3.12 Laws 1987, chapter 404, section 18, subdivision 1; Laws 2023, chapter 22, section  
3.13 4, subdivision 2; Laws 2023, chapter 57, article 1, section 6; Laws 2023, chapter  
3.14 70, article 1, section 35; article 11, section 13, subdivision 8; article 12, section  
3.15 30, subdivisions 2, 3; article 14, section 42, subdivision 6; article 20, sections 2,  
3.16 subdivisions 5, 22, 24, 29, 31; 3, subdivision 2; 12, as amended; 23; Laws 2024,  
3.17 chapter 80, article 1, sections 38, subdivisions 1, 2, 5, 6, 7, 9; 96; article 2, sections  
3.18 5, subdivision 21, by adding a subdivision; 6, subdivisions 2, 3, 3a, by adding a  
3.19 subdivision; 7, subdivision 2; 10, subdivisions 1, 6; 16, subdivision 1, by adding  
3.20 a subdivision; 30, subdivision 2; 31; 74; article 4, section 26; article 6, section 4;  
3.21 article 7, section 4; proposing coding for new law in Minnesota Statutes, chapters  
3.22 62D; 62J; 62Q; 137; 142A; 144; 144A; 144E; 145; 149A; 151; 214; 245C; 245H;  
3.23 256B; 259; 260; 260D; 260E; 524; proposing coding for new law as Minnesota  
3.24 Statutes, chapters 142B; 142F; 332C; repealing Minnesota Statutes 2022, sections  
3.25 62A.041, subdivision 3; 144.218, subdivision 3; 144.497; 144E.001, subdivision  
3.26 5; 144E.01; 144E.123, subdivision 5; 144E.27, subdivisions 1, 1a; 144E.50,  
3.27 subdivision 3; 245A.065; 245C.125; 256.01, subdivisions 12, 12a; 256B.79,  
3.28 subdivision 6; 256D.19, subdivisions 1, 2; 256D.20, subdivisions 1, 2, 3, 4;  
3.29 256D.23, subdivisions 1, 2, 3; 256R.02, subdivision 46; 260.755, subdivision 13;  
3.30 Minnesota Statutes 2023 Supplement, sections 62J.312, subdivision 6; 62Q.522,  
3.31 subdivisions 3, 4; 144.0528, subdivision 5; 245C.08, subdivision 2; Laws 2023,  
3.32 chapter 25, section 190, subdivision 10; Laws 2024, chapter 80, article 1, sections  
3.33 38, subdivisions 3, 4, 11; 39; 43, subdivision 2; article 2, sections 1, subdivision  
3.34 11; 3, subdivision 3; 4, subdivision 4; 6, subdivision 4; 10, subdivision 4; 33; 69;  
3.35 article 7, sections 3; 9; Minnesota Rules, parts 9502.0425, subparts 5, 10;  
3.36 9545.0805, subpart 1; 9545.0845; 9560.0232, subpart 5.

3.37 May 19, 2024

3.38 The Honorable Bobby Joe Champion  
3.39 President of the Senate

3.40 The Honorable Melissa Hortman  
3.41 Speaker of the House of Representatives

3.42 We, the undersigned conferees for S.F. No. 4699 report that we have agreed upon the  
3.43 items in dispute and recommend as follows:

3.44 That the House recede from its amendments and that S.F. No. 4699 be further amended  
3.45 as follows:

3.46 Delete everything after the enacting clause and insert:

4.1 "ARTICLE 1

4.2 DEPARTMENT OF HUMAN SERVICES HEALTH CARE FINANCE

4.3 Section 1. Minnesota Statutes 2023 Supplement, section 256.9631, is amended to read:

4.4 **256.9631 ~~DIRECT PAYMENT SYSTEM~~ ALTERNATIVE CARE DELIVERY**  
4.5 **MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

4.6 Subdivision 1. **Direction to the commissioner.** (a) The commissioner, in order to deliver  
4.7 services to eligible individuals, achieve better health outcomes, and reduce the cost of health  
4.8 care for the state, shall develop an implementation plan plans for a ~~direct payment system~~  
4.9 to deliver services to eligible individuals in order to achieve better health outcomes and  
4.10 reduce the cost of health care for the state. Under this system, at least three care delivery  
4.11 models that:

4.12 (1) are alternatives to the use of commercial managed care plans to deliver health care  
4.13 to Minnesota health care program enrollees; and

4.14 (2) do not shift financial risk to nongovernmental entities.

4.15 (b) One of the alternative models must be a direct payment system under which eligible  
4.16 individuals must receive services through the ~~medical assistance~~ fee-for-service system,  
4.17 county-based purchasing plans, ~~or~~ and county-owned health maintenance organizations. At  
4.18 least one additional model must include county-based purchasing plans and county-owned  
4.19 health maintenance organizations in their design, and must allow these entities to deliver  
4.20 care in geographic areas on a single plan basis, if:

4.21 (1) these entities contract with all providers that agree to contract terms for network  
4.22 participation; and

4.23 (2) the commissioner of human services determines that an entity's provider network is  
4.24 adequate to ensure enrollee access and choice.

4.25 (c) Before determining the alternative models for which implementation plans will be  
4.26 developed, the commissioner shall consult with the chairs and ranking minority members  
4.27 of the legislative committees with jurisdiction over health care finance and policy.

4.28 (d) The commissioner shall present an implementation plan plans for the ~~direct payment~~  
4.29 system selected models to the chairs and ranking minority members of the legislative  
4.30 committees with jurisdiction over health care finance and policy by January 15, 2026. The  
4.31 commissioner may contract for technical assistance in developing the implementation ~~plan~~  
4.32 plans and conducting related studies and analyses.

5.1 ~~(b) For the purposes of the direct payment system, the commissioner shall make the~~  
5.2 ~~following assumptions:~~

5.3 ~~(1) health care providers are reimbursed directly for all medical assistance covered~~  
5.4 ~~services provided to eligible individuals, using the fee-for-service payment methods specified~~  
5.5 ~~in chapters 256, 256B, 256R, and 256S;~~

5.6 ~~(2) payments to a qualified hospital provider are equivalent to the payments that would~~  
5.7 ~~have been received based on managed care direct payment arrangements. If necessary, a~~  
5.8 ~~qualified hospital provider may use a county-owned health maintenance organization to~~  
5.9 ~~receive direct payments as described in section 256B.1973; and~~

5.10 ~~(3) county-based purchasing plans and county-owned health maintenance organizations~~  
5.11 ~~must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.~~

5.12 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the  
5.13 meanings given.

5.14 (b) "Eligible individuals" means qualified all medical assistance enrollees, ~~defined as~~  
5.15 ~~persons eligible for medical assistance as families and children and adults without children~~  
5.16 ~~and MinnesotaCare enrollees.~~

5.17 (c) "Minnesota health care programs" means the medical assistance and MinnesotaCare  
5.18 programs.

5.19 ~~(e)~~ (d) "Qualified hospital provider" means a nonstate government teaching hospital  
5.20 with high medical assistance utilization and a level 1 trauma center, and all of the hospital's  
5.21 owned or affiliated health care professionals, ambulance services, sites, and clinics.

5.22 Subd. 3. **Implementation ~~plan~~ plans.** (a) ~~The~~ Each implementation plan must include:

5.23 (1) a timeline for the development and recommended implementation date of the ~~direct~~  
5.24 ~~payment system~~ alternative model. In recommending a timeline, the commissioner must  
5.25 consider:

5.26 (i) timelines required by the existing contracts with managed care plans and county-based  
5.27 purchasing plans to sunset existing delivery models;

5.28 (ii) in counties that choose to operate a county-based purchasing plan under section  
5.29 256B.692, timelines for any new procurements required for those counties to establish a  
5.30 new county-based purchasing plan or participate in an existing county-based purchasing  
5.31 plan;

6.1 (iii) in counties that choose to operate a county-owned health maintenance organization  
6.2 under section 256B.69, timelines for any new procurements required for those counties to  
6.3 establish a new county-owned health maintenance organization or to continue serving  
6.4 enrollees through an existing county-owned health maintenance organization; and

6.5 (iv) a recommendation on whether the commissioner should contract with a third-party  
6.6 administrator to administer the ~~direct payment system~~ alternative model, and the timeline  
6.7 needed for procuring an administrator;

6.8 (2) the procedures to be used to ensure continuity of care for enrollees who transition  
6.9 from managed care to fee-for-service and any administrative resources needed to carry out  
6.10 these procedures;

6.11 (3) recommended quality measures for health care service delivery;

6.12 (4) any changes to fee-for-service payment rates that the commissioner determines are  
6.13 necessary to ensure provider access and high-quality care and to reduce health disparities;

6.14 (5) recommendations on ensuring effective care coordination under the ~~direct payment~~  
6.15 ~~system~~ alternative model, especially for enrollees who:

6.16 (i) are age 65 or older, blind, or have disabilities;

6.17 (ii) have complex medical conditions, ~~who;~~

6.18 (iii) face socioeconomic barriers to receiving care, ~~or who;~~ or

6.19 (iv) are from underserved populations that experience health disparities;

6.20 (6) recommendations on ~~whether the direct payment system should provide supplemental~~  
6.21 ~~payments~~ payment arrangements for care coordination, including:

6.22 (i) the provider types eligible for ~~supplemental~~ care coordination payments;

6.23 (ii) procedures to coordinate ~~supplemental~~ care coordination payments with existing  
6.24 supplemental or cost-based payment methods or to replace these existing methods; and

6.25 (iii) procedures to align care coordination initiatives funded ~~through supplemental~~  
6.26 ~~payments~~ under this section the alternative model with existing care coordination initiatives;

6.27 (7) recommendations on whether the ~~direct payment system~~ alternative model should  
6.28 include funding to providers for outreach initiatives to patients who, because of mental  
6.29 illness, homelessness, or other circumstances, are unlikely to obtain needed care and  
6.30 treatment;

7.1 (8) recommendations for a supplemental payment to qualified hospital providers to offset  
7.2 any potential revenue losses resulting from the shift from managed care payments; and

7.3 ~~(9) recommendations on whether and how the direct payment system should be expanded~~  
7.4 ~~to deliver services and care coordination to medical assistance enrollees who are age 65 or~~  
7.5 ~~older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and~~

7.6 ~~(10) (9) recommendations for statutory changes necessary to implement the direct~~  
7.7 ~~payment system alternative model.~~

7.8 (b) In developing the each implementation plan, the commissioner shall:

7.9 (1) calculate the projected cost of ~~a direct payment system~~ the alternative model relative  
7.10 to the cost of the current system;

7.11 (2) assess gaps in care coordination under the current medical assistance and  
7.12 MinnesotaCare programs;

7.13 (3) evaluate the effectiveness of approaches other states have taken to coordinate care  
7.14 under a fee-for-service system, including the coordination of care provided to persons who  
7.15 are age 65 or older, are blind, or have disabilities;

7.16 (4) estimate the loss of revenue and cost savings from other payment enhancements  
7.17 based on managed care plan directed payments and pass-throughs;

7.18 (5) estimate cost trends under ~~a direct payment system~~ the alternative model for managed  
7.19 care payments to county-based purchasing plans and county-owned health maintenance  
7.20 organizations;

7.21 (6) estimate the impact of ~~a direct payment system~~ the alternative model on other revenue,  
7.22 including taxes, surcharges, or other federally approved in lieu of services and on other  
7.23 arrangements allowed under managed care;

7.24 (7) consider allowing eligible individuals to opt out of managed care as an alternative  
7.25 approach;

7.26 ~~(8) assess the feasibility of a medical assistance outpatient prescription drug benefit~~  
7.27 ~~carve-out under section 256B.69, subdivision 6d, and in consultation with the commissioners~~  
7.28 ~~of commerce and health, assess the feasibility of including MinnesotaCare enrollees and~~  
7.29 ~~private sector enrollees of health plan companies in the drug benefit carve-out. The~~  
7.30 ~~assessment of feasibility must address and include recommendations related to the process~~  
7.31 ~~and terms by which the commissioner would contract with health plan companies to~~

8.1 ~~administer prescription drug benefits and develop and manage a drug formulary, and the~~  
8.2 ~~impact of the drug-benefit carve-out on health care providers, including small pharmacies;~~

8.3 ~~(9)~~ (8) consult with the commissioners of health and commerce and the contractor or  
8.4 contractors analyzing the Minnesota Health Plan ~~under section 19~~ and other health reform  
8.5 models on plan design and assumptions; and

8.6 ~~(10)~~ (9) conduct other analyses necessary to develop the implementation plan.

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

8.8 Sec. 2. Minnesota Statutes 2022, section 256.9657, is amended by adding a subdivision  
8.9 to read:

8.10 Subd. 2a. **Teaching hospital surcharge.** (a) Each teaching hospital shall pay to the  
8.11 medical assistance account a surcharge equal to 1.41 percent of its fiscal year 2021 net  
8.12 patient revenue for inpatient services. The initial surcharge must not be collected more than  
8.13 30 days before the commissioner makes the first of the payments required under section  
8.14 256.969, subdivision 2g. Subsequent surcharge payments must be paid annually in the form  
8.15 and manner specified by the commissioner. The surcharge must comply with all applicable  
8.16 federal requirements and federal laws, including but not limited to Code of Federal  
8.17 Regulations, title 42, section 433.68.

8.18 (b) Revenue from the surcharge must be used by the commissioner only to pay the  
8.19 nonfederal share of the medical assistance supplemental payments described in section  
8.20 256.969, subdivision 2g, and must be used to supplement, and not supplant, medical  
8.21 assistance reimbursement to teaching hospitals.

8.22 (c) For purposes of this subdivision, "teaching hospital" means any Minnesota hospital  
8.23 with a Centers for Medicare and Medicaid Services designation of "teaching hospital" as  
8.24 reported on form CMS-2552-10, worksheet S-2, line 56, that is eligible for reimbursement  
8.25 under section 256.969, subdivision 2g.

8.26 (d) Notwithstanding paragraph (c), the following hospitals are exempt from paying the  
8.27 surcharge under this section:

8.28 (1) all hospitals in Minnesota designated as a children's hospital under Medicare, including  
8.29 Children's Health Care, doing business as Children's Minnesota, and Gillette Children's  
8.30 Specialty Healthcare, doing business as Gillette Children's;

8.31 (2) teaching hospitals with three or fewer full-time equivalent trainees, based on a  
8.32 Medicare cost report filed for the fiscal year ending in 2022;

9.1 (3) federal Indian Health Service facilities; and

9.2 (4) regional treatment centers.

9.3 (e) The teaching hospital surcharge established under this subdivision must only be  
9.4 assessed if the annual inpatient supplemental payments under section 256.969, subdivision  
9.5 2g, are approved by the Centers for Medicare and Medicaid Services.

9.6 (f) The commissioner must reduce the surcharge percentage in paragraph (a) such that  
9.7 the aggregate amount collected from hospitals under this subdivision does not exceed the  
9.8 total amount needed for the nonfederal share of the annual inpatient supplemental payments  
9.9 authorized by section 256.969, subdivision 2g.

9.10 (g) For purposes of this subdivision, net patient revenue for inpatient services must be  
9.11 calculated by:

9.12 (1) determining gross inpatient hospital facility charges from the hospital's audited  
9.13 statements or, if not contained or segregated within the hospital's audited financial statements,  
9.14 using detailed internal financial income statements or schedules; and

9.15 (2) subtracting from gross inpatient hospital facility charges:

9.16 (i) all professional fee charges, home health charges, skilled nursing facility charges,  
9.17 hospice charges, end-stage renal disease charges, and other nonhospital charges; and

9.18 (ii) applicable contractual allowances.

9.19 (h) Teaching hospitals subject to the surcharge under this subdivision shall submit to  
9.20 the commissioner, in the form and manner specified by the commissioner, all documentation  
9.21 necessary to provide reconciliation of the net patient revenue calculation under paragraph  
9.22 (b).

9.23 (i) This subdivision is effective on the later of July 1, 2025, or 60 days after the end of  
9.24 the first legislative regular session that begins following federal approval for all of the  
9.25 following: (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the  
9.26 amendment in this act to section 256.969, subdivision 2b; and (3) the amendment in this  
9.27 act adding section 256.969, subdivision 2g. The commissioner of human services shall  
9.28 notify the revisor of statutes when federal approval is obtained.

9.29 (j) This subdivision is subject to the implementation requirements in section 9.

9.30 (k) This subdivision expires June 30, 2030, or five years after federal approval is obtained,  
9.31 whichever is later.

10.1 Sec. 3. Minnesota Statutes 2023 Supplement, section 256.969, subdivision 2b, is amended  
10.2 to read:

10.3 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
10.4 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
10.5 to the following:

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

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

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

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

10.14 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
10.15 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
10.16 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
10.17 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
10.18 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
10.19 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
10.20 period as other hospitals.

10.21 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
10.22 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
10.23 area, except for the hospitals paid under the methodologies described in paragraph (a),  
10.24 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
10.25 manner similar to Medicare. The base year or years for the rates effective November 1,  
10.26 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,  
10.27 ensuring that the total aggregate payments under the rebased system are equal to the total  
10.28 aggregate payments that were made for the same number and types of services in the base  
10.29 year. Separate budget neutrality calculations shall be determined for payments made to  
10.30 critical access hospitals and payments made to hospitals paid under the DRG system. Only  
10.31 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being  
10.32 rebased during the entire base period shall be incorporated into the budget neutrality  
10.33 calculation.

11.1 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
11.2 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph  
11.3 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
11.4 a five percent increase or decrease from the base year payments for any hospital. Any  
11.5 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
11.6 shall maintain budget neutrality as described in paragraph (c).

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

11.11 (1) pediatric services;

11.12 (2) behavioral health services;

11.13 (3) trauma services as defined by the National Uniform Billing Committee;

11.14 (4) transplant services;

11.15 (5) obstetric services, newborn services, and behavioral health services provided by  
11.16 hospitals outside the seven-county metropolitan area;

11.17 (6) outlier admissions;

11.18 (7) low-volume providers; and

11.19 (8) services provided by small rural hospitals that are not critical access hospitals.

11.20 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

11.21 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
11.22 admission is standardized by the applicable Medicare wage index and adjusted by the  
11.23 hospital's disproportionate population adjustment;

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

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

11.29 (4) in determining hospital payment rates for discharges occurring on or after the rate  
11.30 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per  
11.31 discharge shall be based on the cost-finding methods and allowable costs of the Medicare

12.1 program in effect during the base year or years. In determining hospital payment rates for  
12.2 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding  
12.3 methods and allowable costs of the Medicare program in effect during the base year or  
12.4 years.

12.5 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
12.6 the rates established under paragraph (c), and any adjustments made to the rates under  
12.7 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
12.8 total aggregate payments for the same number and types of services under the rebased rates  
12.9 are equal to the total aggregate payments made during calendar year 2013.

12.10 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
12.11 thereafter, payment rates under this section shall be rebased to reflect only those changes  
12.12 in hospital costs between the existing base year or years and the next base year or years. In  
12.13 any year that inpatient claims volume falls below the threshold required to ensure a  
12.14 statistically valid sample of claims, the commissioner may combine claims data from two  
12.15 consecutive years to serve as the base year. Years in which inpatient claims volume is  
12.16 reduced or altered due to a pandemic or other public health emergency shall not be used as  
12.17 a base year or part of a base year if the base year includes more than one year. Changes in  
12.18 costs between base years shall be measured using the lower of the hospital cost index defined  
12.19 in subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
12.20 claim. The commissioner shall establish the base year for each rebasing period considering  
12.21 the most recent year or years for which filed Medicare cost reports are available, except  
12.22 that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019.  
12.23 The estimated change in the average payment per hospital discharge resulting from a  
12.24 scheduled rebasing must be calculated and made available to the legislature by January 15  
12.25 of each year in which rebasing is scheduled to occur, and must include by hospital the  
12.26 differential in payment rates compared to the individual hospital's costs.

12.27 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates  
12.28 for critical access hospitals located in Minnesota or the local trade area shall be determined  
12.29 using a new cost-based methodology. The commissioner shall establish within the  
12.30 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
12.31 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed  
12.32 the total cost for critical access hospitals as reflected in base year cost reports. Until the  
12.33 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
12.34 decrease from the base year payments for any hospital, except a hospital that had payments  
12.35 that were greater than 100 percent of the hospital's costs in the base year shall have their

13.1 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
13.2 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
13.3 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
13.4 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
13.5 following criteria:

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

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

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

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

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

13.18 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
13.19 hospital's payments received from the medical assistance program for the care of medical  
13.20 assistance patients;

13.21 (3) the ratio between the hospital's charges to the medical assistance program and the  
13.22 hospital's payments received from the medical assistance program for the care of medical  
13.23 assistance patients;

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

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

13.27 (6) geographic location.

13.28 (k) Subject to subdivision 2g, effective for discharges occurring on or after January 1,  
13.29 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include  
13.30 a rate factor specific to each hospital that qualifies for a medical education and research  
13.31 cost distribution under section 62J.692, subdivision 4, paragraph (a).

14.1 **EFFECTIVE DATE.** (a) This section is effective the later of July 1, 2025, or 60 days  
14.2 after the end of the first legislative session that begins following federal approval of all of  
14.3 the following:

14.4 (1) the amendment in this act to add Minnesota Statutes, section 256.9657, subdivision  
14.5 2a;

14.6 (2) the amendments in this act to Minnesota Statutes, section 256.969, subdivision 2b;  
14.7 and

14.8 (3) the amendment in this act to add Minnesota Statutes, section 256.969, subdivision  
14.9 2g.

14.10 (b) The commissioner of human services shall notify the revisor of statutes when federal  
14.11 approval is obtained.

14.12 Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to  
14.13 read:

14.14 Subd. 2g. **Annual supplemental payment for graduate medical education.** (a) The  
14.15 commissioner and contracted managed care organizations shall annually pay an inpatient  
14.16 supplemental payment to all eligible hospitals for graduate medical education. A hospital  
14.17 must be an eligible hospital to receive an annual supplemental payment under this  
14.18 subdivision. Payments under this subdivision must comply with all applicable federal  
14.19 requirements and federal laws and meet the requirements of Code of Federal Regulations,  
14.20 title 42, section 438.60.

14.21 (b) For purposes of this subdivision, "eligible hospital" means a hospital that:

14.22 (1) is located in Minnesota;

14.23 (2) participates in Minnesota's medical assistance program;

14.24 (3) has received fee-for-service medical assistance payments in the payment year; and

14.25 (4) is either:

14.26 (i) eligible to receive graduate medical education payments from the Medicare program  
14.27 under Code of Federal Regulations, title 42, section 413.75; or

14.28 (ii) a hospital in Minnesota designated as a children's hospital under Medicare, including  
14.29 Children's Health Care, doing business as Children's Minnesota, and Gillette Children's  
14.30 Specialty Healthcare, doing business as Gillette Children's.

14.31 (c) The annual inpatient supplemental payment must be calculated as follows:

15.1 (1) \$425,000 per full-time equivalent trained for each of the first ten full-time equivalents  
15.2 at a hospital;

15.3 (2) \$350,000 per full-time equivalent trained for each full-time equivalent between 11  
15.4 and 20 full-time equivalents at a hospital;

15.5 (3) \$95,000 per full-time equivalent trained for each full-time equivalent between 21  
15.6 and 30 full-time equivalents at a hospital;

15.7 (4) \$70,000 per full-time equivalent trained for each full-time equivalent between 31  
15.8 and 400 full-time equivalents at a hospital; and

15.9 (5) \$50,000 per full-time equivalent trained for each full-time equivalent above 401  
15.10 full-time equivalents at a hospital.

15.11 (d) The data source for the full-time equivalent trained under paragraph (c) must be the  
15.12 Medicare cost report for the fiscal year ending in calendar year 2022. The full-time equivalent  
15.13 is calculated by adding the two values populated on lines 10 and 11 on worksheet E, part  
15.14 A, of the Medicare cost report for that year, except that for eligible hospitals that are children's  
15.15 hospitals, the full-time equivalent is calculated based on interns and residents, as determined  
15.16 by adding form CMS-2552-10, worksheet E-4, lines 6, 10.01, and 15.01, or its equivalent,  
15.17 for that year.

15.18 (e) An eligible hospital must not accept any reimbursement under section 62J.692 if it  
15.19 would result in payments in excess of eligible expenditures. The surcharge paid under section  
15.20 256.9657, subdivision 2a, and the payment received under this section must be reported in  
15.21 the application under section 62J.692.

15.22 (f) The supplemental payments under this subdivision:

15.23 (1) must not be included as public program revenue under section 62J.692; and

15.24 (2) must be deemed permissible pass-through payments for graduate medical education  
15.25 under Code of Federal Regulations, title 42, section 438.6(d), or when the state makes  
15.26 payments directly to teaching hospitals for graduate medical education costs approved under  
15.27 the state plan under Code of Federal Regulations, title 42, section 438.60.

15.28 (g) The total aggregate state and federal supplemental payments for hospitals under this  
15.29 subdivision must not exceed \$203,000,000 per year. The commissioner may reduce the  
15.30 amount paid for each full-time equivalent, as described in paragraph (c), on an equal basis  
15.31 to limit the total cost of all supplemental payments to the total dollar amounts available.

16.1 (h) This subdivision is effective the later of July 1, 2025, or 60 days after the end of the  
16.2 first legislative regular session that begins following federal approval for all of the following:  
16.3 (1) the amendment in this act adding section 256.9657, subdivision 2a; (2) the amendment  
16.4 in this act to section 256.969, subdivision 2b; and (3) the amendment in this act to add  
16.5 section 256.969, subdivision 2g. The commissioner of human services shall notify the revisor  
16.6 of statutes when federal approval is obtained.

16.7 (i) This subdivision is subject to the implementation requirements in section 9.

16.8 (j) This subdivision expires June 30, 2030, or five years after federal approval is obtained,  
16.9 whichever is later.

16.10 Sec. 5. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to  
16.11 read:

16.12 Subd. 32. **Biological products for cell and gene therapy.** (a) Effective July 1, 2025,  
16.13 and upon necessary federal approval of documentation required to enter into a value-based  
16.14 arrangement under section 256B.0625, subdivision 13k, the commissioner may provide  
16.15 separate reimbursement to hospitals for biological products provided in the inpatient hospital  
16.16 setting as part of cell or gene therapy to treat rare diseases, as defined in United States Code,  
16.17 title 21, section 360bb, if the drug manufacturer enters into a value-based arrangement with  
16.18 the commissioner.

16.19 (b) The commissioner shall establish the separate reimbursement rate for biological  
16.20 products provided under paragraph (a) based on the methodology used for drugs administered  
16.21 in an outpatient setting under section 256B.0625, subdivision 13e, paragraph (e).

16.22 **EFFECTIVE DATE.** This section is effective July 1, 2025.

16.23 Sec. 6. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as  
16.24 amended by Laws 2024, chapter 85, section 66, is amended to read:

16.25 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
16.26 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the  
16.27 usual and customary price charged to the public. The usual and customary price means the  
16.28 lowest price charged by the provider to a patient who pays for the prescription by cash,  
16.29 check, or charge account and includes prices the pharmacy charges to a patient enrolled in  
16.30 a prescription savings club or prescription discount club administered by the pharmacy or  
16.31 pharmacy chain. The amount of payment basis must be reduced to reflect all discount  
16.32 amounts applied to the charge by any third-party provider/insurer agreement or contract for

17.1 submitted charges to medical assistance programs. The net submitted charge may not be  
17.2 greater than the patient liability for the service. The professional dispensing fee shall be  
17.3 ~~\$10.77~~ \$11.55 for prescriptions filled with legend drugs meeting the definition of "covered  
17.4 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The  
17.5 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall  
17.6 be ~~\$10.77~~ \$11.55 per claim. The professional dispensing fee for prescriptions filled with  
17.7 over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~\$10.77~~  
17.8 \$11.55 for dispensed quantities equal to or greater than the number of units contained in  
17.9 the manufacturer's original package. The professional dispensing fee shall be prorated based  
17.10 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
17.11 than the number of units contained in the manufacturer's original package. The pharmacy  
17.12 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered  
17.13 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units  
17.14 contained in the manufacturer's original package and shall be prorated based on the  
17.15 percentage of the package dispensed when the pharmacy dispenses a quantity less than the  
17.16 number of units contained in the manufacturer's original package. The National Average  
17.17 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.  
17.18 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient  
17.19 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for  
17.20 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B  
17.21 Drug Pricing Program ceiling price established by the Health Resources and Services  
17.22 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as  
17.23 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in  
17.24 the United States, not including prompt pay or other discounts, rebates, or reductions in  
17.25 price, for the most recent month for which information is available, as reported in wholesale  
17.26 price guides or other publications of drug or biological pricing data. The maximum allowable  
17.27 cost of a multisource drug may be set by the commissioner and it shall be comparable to  
17.28 the actual acquisition cost of the drug product and no higher than the NADAC of the generic  
17.29 product. Establishment of the amount of payment for drugs shall not be subject to the  
17.30 requirements of the Administrative Procedure Act.

17.31 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
17.32 an automated drug distribution system meeting the requirements of section 151.58, or a  
17.33 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
17.34 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
17.35 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
17.36 retrospectively billing pharmacy must submit a claim only for the quantity of medication

18.1 used by the enrolled recipient during the defined billing period. A retrospectively billing  
18.2 pharmacy must use a billing period not less than one calendar month or 30 days.

18.3 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota  
18.4 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost  
18.5 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective  
18.6 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that  
18.7 is less than a 30-day supply.

18.8 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC  
18.9 of the generic product or the maximum allowable cost established by the commissioner  
18.10 unless prior authorization for the brand name product has been granted according to the  
18.11 criteria established by the Drug Formulary Committee as required by subdivision 13f,  
18.12 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in  
18.13 a manner consistent with section 151.21, subdivision 2.

18.14 (e) The basis for determining the amount of payment for drugs administered in an  
18.15 outpatient setting shall be the lower of the usual and customary cost submitted by the  
18.16 provider, 106 percent of the average sales price as determined by the United States  
18.17 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
18.18 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
18.19 set by the commissioner. If average sales price is unavailable, the amount of payment must  
18.20 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
18.21 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
18.22 The commissioner shall discount the payment rate for drugs obtained through the federal  
18.23 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an  
18.24 outpatient setting shall be made to the administering facility or practitioner. A retail or  
18.25 specialty pharmacy dispensing a drug for administration in an outpatient setting is not  
18.26 eligible for direct reimbursement.

18.27 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy  
18.28 products that are lower than the ingredient cost formulas specified in paragraph (a). The  
18.29 commissioner may require individuals enrolled in the health care programs administered  
18.30 by the department to obtain specialty pharmacy products from providers with whom the  
18.31 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are  
18.32 defined as those used by a small number of recipients or recipients with complex and chronic  
18.33 diseases that require expensive and challenging drug regimens. Examples of these conditions  
18.34 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,  
18.35 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of

19.1 cancer. Specialty pharmaceutical products include injectable and infusion therapies,  
19.2 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that  
19.3 require complex care. The commissioner shall consult with the Formulary Committee to  
19.4 develop a list of specialty pharmacy products subject to maximum allowable cost  
19.5 reimbursement. In consulting with the Formulary Committee in developing this list, the  
19.6 commissioner shall take into consideration the population served by specialty pharmacy  
19.7 products, the current delivery system and standard of care in the state, and access to care  
19.8 issues. The commissioner shall have the discretion to adjust the maximum allowable cost  
19.9 to prevent access to care issues.

19.10 (g) Home infusion therapy services provided by home infusion therapy pharmacies must  
19.11 be paid at rates according to subdivision 8d.

19.12 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey  
19.13 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient  
19.14 drugs under medical assistance. The commissioner shall ensure that the vendor has prior  
19.15 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the  
19.16 department to dispense outpatient prescription drugs to fee-for-service members must  
19.17 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under  
19.18 section 256B.064 for failure to respond. The commissioner shall require the vendor to  
19.19 measure a single statewide cost of dispensing for specialty prescription drugs and a single  
19.20 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies  
19.21 to measure the mean, mean weighted by total prescription volume, mean weighted by  
19.22 medical assistance prescription volume, median, median weighted by total prescription  
19.23 volume, and median weighted by total medical assistance prescription volume. The  
19.24 commissioner shall post a copy of the final cost of dispensing survey report on the  
19.25 department's website. The initial survey must be completed no later than January 1, 2021,  
19.26 and repeated every three years. The commissioner shall provide a summary of the results  
19.27 of each cost of dispensing survey and provide recommendations for any changes to the  
19.28 dispensing fee to the chairs and ranking minority members of the legislative committees  
19.29 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section  
19.30 256.01, subdivision 42, this paragraph does not expire.

19.31 (i) The commissioner shall increase the ingredient cost reimbursement calculated in  
19.32 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to  
19.33 the wholesale drug distributor tax under section 295.52.

19.34 **EFFECTIVE DATE.** This section is effective October 1, 2024.

20.1 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13k, is  
20.2 amended to read:

20.3 Subd. 13k. **Value-based purchasing arrangements.** (a) The commissioner may enter  
20.4 into a value-based purchasing arrangement under medical assistance or MinnesotaCare, by  
20.5 written arrangement with a drug manufacturer based on agreed-upon metrics. The  
20.6 commissioner may contract with a vendor to implement and administer the value-based  
20.7 purchasing arrangement. A value-based purchasing arrangement may include but is not  
20.8 limited to rebates, discounts, price reductions, risk sharing, reimbursements, guarantees,  
20.9 shared savings payments, withholds, or bonuses. A value-based purchasing arrangement  
20.10 must provide at least the same value or discount in the aggregate as would claiming the  
20.11 mandatory federal drug rebate under the Federal Social Security Act, section 1927.

20.12 (b) Nothing in this section shall be interpreted as requiring a drug manufacturer or the  
20.13 commissioner to enter into an arrangement as described in paragraph (a).

20.14 (c) Nothing in this section shall be interpreted as altering or modifying medical assistance  
20.15 coverage requirements under the federal Social Security Act, section 1927.

20.16 (d) If the commissioner determines that a state plan amendment is necessary before  
20.17 implementing a value-based purchasing arrangement, the commissioner shall request the  
20.18 amendment and may delay implementing this provision until the amendment is approved.

20.19 (e) The commissioner may provide separate reimbursement to hospitals for drugs provided  
20.20 in the inpatient hospital setting as part of a value-based purchasing arrangement. This  
20.21 payment must be separate from the diagnostic related group reimbursement for the inpatient  
20.22 admission or discharge associated with a stay during which the patient received a drug under  
20.23 this section. For payments made under this section, the hospital must not be reimbursed for  
20.24 the drug under the payment methodology in section 256.969. The commissioner shall  
20.25 establish the separate reimbursement rate for drugs provided under this section based on  
20.26 the methodology used for drugs administered in an outpatient setting under section  
20.27 256B.0625, subdivision 13e, paragraph (e).

20.28 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
20.29 of human services shall notify the revisor of statutes when federal approval is obtained.

20.30 Sec. 8. Minnesota Statutes 2023 Supplement, section 256L.04, subdivision 10, is amended  
20.31 to read:

20.32 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is available to  
20.33 citizens or nationals of the United States; lawfully present noncitizens as defined in Code

21.1 of Federal Regulations, ~~title 8, section 103.12~~ title 45, section 155.20; and undocumented  
21.2 noncitizens. For purposes of this subdivision, an undocumented noncitizen is an individual  
21.3 who resides in the United States without the approval or acquiescence of the United States  
21.4 Citizenship and Immigration Services. Families with children who are citizens or nationals  
21.5 of the United States must cooperate in obtaining satisfactory documentary evidence of  
21.6 citizenship or nationality according to the requirements of the federal Deficit Reduction  
21.7 Act of 2005, Public Law 109-171.

21.8 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and  
21.9 individuals who are ineligible for medical assistance by reason of immigration status and  
21.10 who have incomes equal to or less than 200 percent of federal poverty guidelines, except  
21.11 that these persons may be eligible for emergency medical assistance under section 256B.06,  
21.12 subdivision 4.

21.13 **EFFECTIVE DATE.** This section is effective November 1, 2024.

21.14 **Sec. 9. IMPLEMENTATION OF TEACHING HOSPITAL SURCHARGE AND**  
21.15 **GRADUATE MEDICAL EDUCATION SUPPLEMENTAL PAYMENT.**

21.16 (a) The commissioner of human services shall submit to the Centers for Medicare and  
21.17 Medicaid Services a request for federal approval to implement the teaching hospital surcharge  
21.18 under Minnesota Statutes, section 256.9657, subdivision 2a, and the graduate medical  
21.19 education supplemental payments under Minnesota Statutes, section 256.969, subdivisions  
21.20 2b and 2g. At least 60 days before submitting the request for approval, the commissioner  
21.21 of human services shall make available to the public the draft surcharge requirements, draft  
21.22 supplemental payment rates, and an estimate of each nonexempt hospital's surcharge amount.  
21.23 The commissioner shall provide at least 60 days for public comment.

21.24 (b) During the design, and prior to submission, of the request for approval described in  
21.25 paragraph (a), the commissioner must consult with representatives of eligible hospitals, as  
21.26 defined in Minnesota Statutes, section 256.969, subdivision 2g.

21.27 (c) If federal approval is received under paragraph (a), the commissioner shall provide  
21.28 a 30-day public comment period on the federally approved terms and conditions for the  
21.29 surcharge and supplemental payments. If, during the 30-day comment period, the  
21.30 commissioner receives a documented, written statement of opposition from representatives  
21.31 of one or more eligible hospitals, as defined in Minnesota Statutes, section 256.9657,  
21.32 subdivision 2a, the commissioner shall publish the written statement and indefinitely suspend  
21.33 implementation of both the teaching hospital surcharge under Minnesota Statutes, section

22.1 256.9657, subdivision 2a, and the supplemental payments under Minnesota Statutes, section  
22.2 256.969, subdivisions 2b and 2g.

22.3 (d) By December 15, 2024, the commissioner of health may make recommendations to  
22.4 the legislature for program modifications and conforming amendments to Minnesota Statutes,  
22.5 section 62J.692, that are necessary as a result of the amendments to Minnesota Statutes,  
22.6 section 256.969, subdivisions 2b and 2g. In developing the recommendations under this  
22.7 paragraph, the commissioner of health must consult with eligible hospitals, as defined in  
22.8 Minnesota Statutes, section 256.969, subdivision 2g.

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

22.10 Sec. 10. **COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE MODEL.**

22.11 Subdivision 1. **Model development.** (a) The commissioner of human services, in  
22.12 collaboration with the Association of Minnesota Counties and county-based purchasing  
22.13 plans, shall develop a county-administered rural medical assistance (CARMA) model and  
22.14 a detailed plan for implementing the CARMA model.

22.15 (b) The CARMA model must be designed to achieve the following objectives:

22.16 (1) provide a distinct county owned and administered alternative to the prepaid medical  
22.17 assistance program;

22.18 (2) facilitate greater integration of health care and social services to address social  
22.19 determinants of health in rural communities, with the degree of integration of social services  
22.20 varying with each county's needs and resources;

22.21 (3) account for the smaller number of medical assistance enrollees and locally available  
22.22 providers of behavioral health, oral health, specialty and tertiary care, nonemergency medical  
22.23 transportation, and other health care services in rural communities; and

22.24 (4) promote greater accountability for health outcomes, health equity, customer service,  
22.25 community outreach, and cost of care.

22.26 Subd. 2. **County participation.** The CARMA model must give each rural county the  
22.27 option of applying to participate in the CARMA model as an alternative to participation in  
22.28 the prepaid medical assistance program. The CARMA model must include a process for  
22.29 the commissioner to determine whether and how a rural county can participate.

22.30 Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations  
22.31 and an implementation plan for the CARMA model to the chairs and ranking minority  
22.32 members of the legislative committees with jurisdiction over health care policy and finance

23.1 by January 15, 2025. The CARMA model and implementation plan must address the issues  
23.2 and consider the recommendations identified in the document titled "Recommendations  
23.3 Not Contingent on Outcome(s) of Current Litigation," attached to the September 13, 2022,  
23.4 e-filing to the Second Judicial District Court (Correspondence for Judicial Approval Index  
23.5 #102), that relates to the final contract decisions of the commissioner of human services  
23.6 regarding *South Country Health Alliance v. Minnesota Department of Human Services*, No.  
23.7 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

23.8 (b) The report must also identify the clarifications, approvals, and waivers that are needed  
23.9 from the Centers for Medicare and Medicaid Services and include any draft legislation  
23.10 necessary to implement the CARMA model.

## 23.11 **ARTICLE 2**

### 23.12 **DEPARTMENT OF HUMAN SERVICES HEALTH CARE POLICY**

23.13 Section 1. Minnesota Statutes 2022, section 62M.01, subdivision 3, is amended to read:

23.14 Subd. 3. **Scope.** (a) Nothing in this chapter applies to review of claims after submission  
23.15 to determine eligibility for benefits under a health benefit plan. The appeal procedure  
23.16 described in section 62M.06 applies to any complaint as defined under section 62Q.68,  
23.17 subdivision 2, that requires a medical determination in its resolution.

23.18 (b) Effective January 1, 2026, this chapter ~~does not apply~~ applies to managed care plans  
23.19 or county-based purchasing plans when the plan is providing coverage to state public health  
23.20 care program enrollees under chapter 256B or 256L.

23.21 (c) Effective January 1, 2026, the following sections of this chapter apply to services  
23.22 delivered under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to  
23.23 18, and 21; 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07;  
23.24 62M.072; 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

23.25 Sec. 2. Minnesota Statutes 2023 Supplement, section 256.0471, subdivision 1, as amended  
23.26 by Laws 2024, chapter 80, article 1, section 76, is amended to read:

23.27 Subdivision 1. **Qualifying overpayment.** Any overpayment for state-funded medical  
23.28 assistance under chapter 256B and state-funded MinnesotaCare under chapter 256L granted  
23.29 pursuant to section 256.045, subdivision 10; ~~chapter 256B for state-funded medical~~  
23.30 assistance; and for assistance granted under chapters 256D, 256I, and 256K, and 256L for  
23.31 state-funded MinnesotaCare except agency error claims, become a judgment by operation  
23.32 of law 90 days after the notice of overpayment is personally served upon the recipient in a

24.1 manner that is sufficient under rule 4.03(a) of the Rules of Civil Procedure for district courts,  
24.2 or by certified mail, return receipt requested. This judgment shall be entitled to full faith  
24.3 and credit in this and any other state.

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

24.5 Sec. 3. Minnesota Statutes 2022, section 256.9657, subdivision 8, is amended to read:

24.6 Subd. 8. **Commissioner's duties.** ~~(a) Beginning October 1, 2023, the commissioner of~~  
24.7 ~~human services shall annually report to the chairs and ranking minority members of the~~  
24.8 ~~legislative committees with jurisdiction over health care policy and finance regarding the~~  
24.9 ~~provider surcharge program. The report shall include information on total billings, total~~  
24.10 ~~collections, and administrative expenditures for the previous fiscal year. This paragraph~~  
24.11 ~~expires January 1, 2032.~~

24.12 ~~(b)~~ (a) The surcharge shall be adjusted by inflationary and caseload changes in future  
24.13 bienniums to maintain reimbursement of health care providers in accordance with the  
24.14 requirements of the state and federal laws governing the medical assistance program,  
24.15 including the requirements of the Medicaid moratorium amendments of 1991 found in  
24.16 Public Law No. 102-234.

24.17 ~~(e)~~ (b) The commissioner shall request the Minnesota congressional delegation to support  
24.18 a change in federal law that would prohibit federal disallowances for any state that makes  
24.19 a good faith effort to comply with Public Law 102-234 by enacting conforming legislation  
24.20 prior to the issuance of federal implementing regulations.

24.21 Sec. 4. Minnesota Statutes 2022, section 256.969, is amended by adding a subdivision to  
24.22 read:

24.23 Subd. 2h. **Alternate inpatient payment rate for a discharge.** (a) Effective retroactively  
24.24 from January 1, 2024, in any rate year in which a children's hospital discharge is included  
24.25 in the federally required disproportionate share hospital payment audit, where the patient  
24.26 discharged had resided in a children's hospital for over 20 years, the commissioner shall  
24.27 compute an alternate inpatient rate for the children's hospital. The alternate payment rate  
24.28 must be the rate computed under this section excluding the disproportionate share hospital  
24.29 payment under subdivision 9, paragraph (d), clause (1), increased by an amount equal to  
24.30 99 percent of what the disproportionate share hospital payment would have been under  
24.31 subdivision 9, paragraph (d), clause (1), had the discharge been excluded.

25.1 (b) In any rate year in which payment to a children's hospital is made using this alternate  
25.2 payment rate, payments must not be made to the hospital under subdivisions 2e, 2f, and 9.

25.3 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
25.4 of human services shall notify the revisor of statutes when federal approval is obtained.

25.5 Sec. 5. Minnesota Statutes 2022, section 256B.056, subdivision 1a, is amended to read:

25.6 Subd. 1a. **Income and assets generally.** (a)(1) Unless specifically required by state law  
25.7 or rule or federal law or regulation, the methodologies used in counting income and assets  
25.8 to determine eligibility for medical assistance for persons whose eligibility category is based  
25.9 on blindness, disability, or age of 65 or more years, the methodologies for the Supplemental  
25.10 Security Income program shall be used, except as provided ~~under~~ in clause (2) and  
25.11 subdivision 3, paragraph (a), clause (6).

25.12 (2) State tax credits, rebates, and refunds must not be counted as income. State tax credits,  
25.13 rebates, and refunds must not be counted as assets for a period of 12 months after the month  
25.14 of receipt.

25.15 ~~(2)~~ (3) Increases in benefits under title II of the Social Security Act shall not be counted  
25.16 as income for purposes of this subdivision until July 1 of each year. Effective upon federal  
25.17 approval, for children eligible under section 256B.055, subdivision 12, or for home and  
25.18 community-based waiver services whose eligibility for medical assistance is determined  
25.19 without regard to parental income, child support payments, including any payments made  
25.20 by an obligor in satisfaction of or in addition to a temporary or permanent order for child  
25.21 support, and Social Security payments are not counted as income.

25.22 (b)(1) The modified adjusted gross income methodology as defined in United States  
25.23 Code, title 42, section 1396a(e)(14), shall be used for eligibility categories based on:

25.24 (i) children under age 19 and their parents and relative caretakers as defined in section  
25.25 256B.055, subdivision 3a;

25.26 (ii) children ages 19 to 20 as defined in section 256B.055, subdivision 16;

25.27 (iii) pregnant women as defined in section 256B.055, subdivision 6;

25.28 (iv) infants as defined in sections 256B.055, subdivision 10, and 256B.057, subdivision  
25.29 1; and

25.30 (v) adults without children as defined in section 256B.055, subdivision 15.

25.31 For these purposes, a "methodology" does not include an asset or income standard, or  
25.32 accounting method, or method of determining effective dates.

26.1 (2) For individuals whose income eligibility is determined using the modified adjusted  
26.2 gross income methodology in clause (1):

26.3 (i) the commissioner shall subtract from the individual's modified adjusted gross income  
26.4 an amount equivalent to five percent of the federal poverty guidelines; and

26.5 (ii) the individual's current monthly income and household size is used to determine  
26.6 eligibility for the 12-month eligibility period. If an individual's income is expected to vary  
26.7 month to month, eligibility is determined based on the income predicted for the 12-month  
26.8 eligibility period.

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

26.10 Sec. 6. Minnesota Statutes 2022, section 256B.056, subdivision 10, is amended to read:

26.11 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are  
26.12 applying for the continuation of medical assistance coverage following the end of the  
26.13 12-month postpartum period to update their income and asset information and to submit  
26.14 any required income or asset verification.

26.15 (b) The commissioner shall determine the eligibility of private-sector health care coverage  
26.16 for infants less than one year of age eligible under section 256B.055, subdivision 10, or  
26.17 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is  
26.18 determined to be cost-effective.

26.19 (c) The commissioner shall verify assets and income for all applicants, and for all  
26.20 recipients upon renewal.

26.21 (d) The commissioner shall utilize information obtained through the electronic service  
26.22 established by the secretary of the United States Department of Health and Human Services  
26.23 and other available electronic data sources in Code of Federal Regulations, title 42, sections  
26.24 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish  
26.25 standards to define when information obtained electronically is reasonably compatible with  
26.26 information provided by applicants and enrollees, including use of self-attestation, to  
26.27 accomplish real-time eligibility determinations and maintain program integrity.

26.28 (e) Each person applying for or receiving medical assistance under section 256B.055,  
26.29 subdivision 7, and any other person whose resources are required by law to be disclosed to  
26.30 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain  
26.31 information from financial institutions to ~~identify unreported accounts~~ verify assets as  
26.32 required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization,  
26.33 the commissioner may determine that the applicant or recipient is ineligible for medical

27.1 assistance. For purposes of this paragraph, an authorization to ~~identify unreported accounts~~  
27.2 verify assets meets the requirements of the Right to Financial Privacy Act, United States  
27.3 Code, title 12, chapter 35, and need not be furnished to the financial institution.

27.4 (f) County and tribal agencies shall comply with the standards established by the  
27.5 commissioner for appropriate use of the asset verification system specified in section 256.01,  
27.6 subdivision 18f.

27.7 Sec. 7. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 8, is amended  
27.8 to read:

27.9 Subd. 8. **Medical assistance payment for assertive community treatment and**  
27.10 **intensive residential treatment services.** (a) Payment for intensive residential treatment  
27.11 services and assertive community treatment in this section shall be based on one daily rate  
27.12 per provider inclusive of the following services received by an eligible client in a given  
27.13 calendar day: all rehabilitative services under this section, staff travel time to provide  
27.14 rehabilitative services under this section, and nonresidential crisis stabilization services  
27.15 under section 256B.0624.

27.16 (b) Except as indicated in paragraph (c), payment will not be made to more than one  
27.17 entity for each client for services provided under this section on a given day. If services  
27.18 under this section are provided by a team that includes staff from more than one entity, the  
27.19 team must determine how to distribute the payment among the members.

27.20 (c) The commissioner shall determine one rate for each provider that will bill medical  
27.21 assistance for residential services under this section and one rate for each assertive community  
27.22 treatment provider. If a single entity provides both services, one rate is established for the  
27.23 entity's residential services and another rate for the entity's nonresidential services under  
27.24 this section. A provider is not eligible for payment under this section without authorization  
27.25 from the commissioner. The commissioner shall develop rates using the following criteria:

27.26 (1) the provider's cost for services shall include direct services costs, other program  
27.27 costs, and other costs determined as follows:

27.28 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
27.29 payroll taxes, and training of direct service staff and service-related transportation;

27.30 (ii) other program costs not included in item (i) must be determined as a specified  
27.31 percentage of the direct services costs as determined by item (i). The percentage used shall  
27.32 be determined by the commissioner based upon the average of percentages that represent

28.1 the relationship of other program costs to direct services costs among the entities that provide  
28.2 similar services;

28.3 (iii) physical plant costs calculated based on the percentage of space within the program  
28.4 that is entirely devoted to treatment and programming. This does not include administrative  
28.5 or residential space;

28.6 (iv) assertive community treatment physical plant costs must be reimbursed as part of  
28.7 the costs described in item (ii); and

28.8 (v) subject to federal approval, up to an additional five percent of the total rate may be  
28.9 added to the program rate as a quality incentive based upon the entity meeting performance  
28.10 criteria specified by the commissioner;

28.11 (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and  
28.12 consistent with federal reimbursement requirements under Code of Federal Regulations,  
28.13 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and  
28.14 Budget Circular Number A-122, relating to nonprofit entities;

28.15 (3) the number of service units;

28.16 (4) the degree to which clients will receive services other than services under this section;  
28.17 and

28.18 (5) the costs of other services that will be separately reimbursed.

28.19 (d) The rate for intensive residential treatment services and assertive community treatment  
28.20 must exclude the medical assistance room and board rate, as defined in section 256B.056,  
28.21 subdivision 5d, and services not covered under this section, such as partial hospitalization,  
28.22 home care, and inpatient services.

28.23 (e) Physician services that are not separately billed may be included in the rate to the  
28.24 extent that a psychiatrist, or other health care professional providing physician services  
28.25 within their scope of practice, is a member of the intensive residential treatment services  
28.26 treatment team. Physician services, whether billed separately or included in the rate, may  
28.27 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning  
28.28 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth  
28.29 is used to provide intensive residential treatment services.

28.30 (f) When services under this section are provided by an assertive community treatment  
28.31 provider, case management functions must be an integral part of the team.

29.1 (g) The rate for a provider must not exceed the rate charged by that provider for the  
29.2 same service to other payors.

29.3 (h) The rates for existing programs must be established prospectively based upon the  
29.4 expenditures and utilization over a prior 12-month period using the criteria established in  
29.5 paragraph (c). The rates for new programs must be established based upon estimated  
29.6 expenditures and estimated utilization using the criteria established in paragraph (c).

29.7 (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive  
29.8 community treatment, adult residential crisis stabilization services, and intensive residential  
29.9 treatment services must be annually adjusted for inflation using the Centers for Medicare  
29.10 and Medicaid Services Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter  
29.11 of the calendar year before the rate year. The inflation adjustment must be based on the  
29.12 12-month period from the midpoint of the previous rate year to the midpoint of the rate year  
29.13 for which the rate is being determined.

29.14 (j) Entities who discontinue providing services must be subject to a settle-up process  
29.15 whereby actual costs and reimbursement for the previous 12 months are compared. In the  
29.16 event that the entity was paid more than the entity's actual costs plus any applicable  
29.17 performance-related funding due the provider, the excess payment must be reimbursed to  
29.18 the department. If a provider's revenue is less than actual allowed costs due to lower  
29.19 utilization than projected, the commissioner may reimburse the provider to recover its actual  
29.20 allowable costs. The resulting adjustments by the commissioner must be proportional to the  
29.21 percent of total units of service reimbursed by the commissioner and must reflect a difference  
29.22 of greater than five percent.

29.23 (k) A provider may request of the commissioner a review of any rate-setting decision  
29.24 made under this subdivision.

29.25 Sec. 8. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 9, is amended  
29.26 to read:

29.27 Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental  
29.28 services.

29.29 (b) The following guidelines apply to dental services:

29.30 (1) posterior fillings are paid at the amalgam rate;

29.31 (2) application of sealants are covered once every five years per permanent molar; and

29.32 (3) application of fluoride varnish is covered once every six months.

30.1 (c) In addition to the services specified in paragraph ~~(b)~~ (a), medical assistance covers  
30.2 the following services:

30.3 (1) house calls or extended care facility calls for on-site delivery of covered services;

30.4 (2) behavioral management when additional staff time is required to accommodate  
30.5 behavioral challenges and sedation is not used;

30.6 (3) oral or IV sedation, if the covered dental service cannot be performed safely without  
30.7 it or would otherwise require the service to be performed under general anesthesia in a  
30.8 hospital or surgical center; and

30.9 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but  
30.10 no more than four times per year.

30.11 (d) The commissioner shall not require prior authorization for the services included in  
30.12 paragraph (c), clauses (1) to (3), and shall prohibit managed care and county-based purchasing  
30.13 plans from requiring prior authorization for the services included in paragraph (c), clauses  
30.14 (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.

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

30.16 Sec. 9. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13e, as  
30.17 amended by Laws 2024, chapter 85, section 66, is amended to read:

30.18 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall  
30.19 be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the  
30.20 usual and customary price charged to the public. The usual and customary price means the  
30.21 lowest price charged by the provider to a patient who pays for the prescription by cash,  
30.22 check, or charge account and includes prices the pharmacy charges to a patient enrolled in  
30.23 a prescription savings club or prescription discount club administered by the pharmacy or  
30.24 pharmacy chain, unless the prescription savings club or prescription discount club is one  
30.25 in which an individual pays a recurring monthly access fee for unlimited access to a defined  
30.26 list of drugs for which the pharmacy does not bill the member or a payer on a  
30.27 per-standard-transaction basis. The amount of payment basis must be reduced to reflect all  
30.28 discount amounts applied to the charge by any third-party provider/insurer agreement or  
30.29 contract for submitted charges to medical assistance programs. The net submitted charge  
30.30 may not be greater than the patient liability for the service. The professional dispensing fee  
30.31 shall be \$10.77 for prescriptions filled with legend drugs meeting the definition of "covered  
30.32 outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The  
30.33 dispensing fee for intravenous solutions that must be compounded by the pharmacist shall

31.1 be \$10.77 per claim. The professional dispensing fee for prescriptions filled with  
31.2 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$10.77  
31.3 for dispensed quantities equal to or greater than the number of units contained in the  
31.4 manufacturer's original package. The professional dispensing fee shall be prorated based  
31.5 on the percentage of the package dispensed when the pharmacy dispenses a quantity less  
31.6 than the number of units contained in the manufacturer's original package. The pharmacy  
31.7 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered  
31.8 outpatient drugs shall be \$3.65 for quantities equal to or greater than the number of units  
31.9 contained in the manufacturer's original package and shall be prorated based on the  
31.10 percentage of the package dispensed when the pharmacy dispenses a quantity less than the  
31.11 number of units contained in the manufacturer's original package. The National Average  
31.12 Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug.  
31.13 For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient  
31.14 cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for  
31.15 a provider participating in the federal 340B Drug Pricing Program shall be either the 340B  
31.16 Drug Pricing Program ceiling price established by the Health Resources and Services  
31.17 Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as  
31.18 the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in  
31.19 the United States, not including prompt pay or other discounts, rebates, or reductions in  
31.20 price, for the most recent month for which information is available, as reported in wholesale  
31.21 price guides or other publications of drug or biological pricing data. The maximum allowable  
31.22 cost of a multisource drug may be set by the commissioner and it shall be comparable to  
31.23 the actual acquisition cost of the drug product and no higher than the NADAC of the generic  
31.24 product. Establishment of the amount of payment for drugs shall not be subject to the  
31.25 requirements of the Administrative Procedure Act.

31.26 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using  
31.27 an automated drug distribution system meeting the requirements of section 151.58, or a  
31.28 packaging system meeting the packaging standards set forth in Minnesota Rules, part  
31.29 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ  
31.30 retrospective billing for prescription drugs dispensed to long-term care facility residents. A  
31.31 retrospectively billing pharmacy must submit a claim only for the quantity of medication  
31.32 used by the enrolled recipient during the defined billing period. A retrospectively billing  
31.33 pharmacy must use a billing period not less than one calendar month or 30 days.

31.34 (c) A pharmacy provider using packaging that meets the standards set forth in Minnesota  
31.35 Rules, part 6800.2700, is required to credit the department for the actual acquisition cost

32.1 of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective  
32.2 billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that  
32.3 is less than a 30-day supply.

32.4 (d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the NADAC  
32.5 of the generic product or the maximum allowable cost established by the commissioner  
32.6 unless prior authorization for the brand name product has been granted according to the  
32.7 criteria established by the Drug Formulary Committee as required by subdivision 13f,  
32.8 paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in  
32.9 a manner consistent with section 151.21, subdivision 2.

32.10 (e) The basis for determining the amount of payment for drugs administered in an  
32.11 outpatient setting shall be the lower of the usual and customary cost submitted by the  
32.12 provider, 106 percent of the average sales price as determined by the United States  
32.13 Department of Health and Human Services pursuant to title XVIII, section 1847a of the  
32.14 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost  
32.15 set by the commissioner. If average sales price is unavailable, the amount of payment must  
32.16 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition  
32.17 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.  
32.18 The commissioner shall discount the payment rate for drugs obtained through the federal  
32.19 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an  
32.20 outpatient setting shall be made to the administering facility or practitioner. A retail or  
32.21 specialty pharmacy dispensing a drug for administration in an outpatient setting is not  
32.22 eligible for direct reimbursement.

32.23 (f) The commissioner may establish maximum allowable cost rates for specialty pharmacy  
32.24 products that are lower than the ingredient cost formulas specified in paragraph (a). The  
32.25 commissioner may require individuals enrolled in the health care programs administered  
32.26 by the department to obtain specialty pharmacy products from providers with whom the  
32.27 commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are  
32.28 defined as those used by a small number of recipients or recipients with complex and chronic  
32.29 diseases that require expensive and challenging drug regimens. Examples of these conditions  
32.30 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C,  
32.31 growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of  
32.32 cancer. Specialty pharmaceutical products include injectable and infusion therapies,  
32.33 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that  
32.34 require complex care. The commissioner shall consult with the Formulary Committee to  
32.35 develop a list of specialty pharmacy products subject to maximum allowable cost

33.1 reimbursement. In consulting with the Formulary Committee in developing this list, the  
33.2 commissioner shall take into consideration the population served by specialty pharmacy  
33.3 products, the current delivery system and standard of care in the state, and access to care  
33.4 issues. The commissioner shall have the discretion to adjust the maximum allowable cost  
33.5 to prevent access to care issues.

33.6 (g) Home infusion therapy services provided by home infusion therapy pharmacies must  
33.7 be paid at rates according to subdivision 8d.

33.8 (h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey  
33.9 for all pharmacies that are physically located in the state of Minnesota that dispense outpatient  
33.10 drugs under medical assistance. The commissioner shall ensure that the vendor has prior  
33.11 experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the  
33.12 department to dispense outpatient prescription drugs to fee-for-service members must  
33.13 respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under  
33.14 section 256B.064 for failure to respond. The commissioner shall require the vendor to  
33.15 measure a single statewide cost of dispensing for specialty prescription drugs and a single  
33.16 statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies  
33.17 to measure the mean, mean weighted by total prescription volume, mean weighted by  
33.18 medical assistance prescription volume, median, median weighted by total prescription  
33.19 volume, and median weighted by total medical assistance prescription volume. The  
33.20 commissioner shall post a copy of the final cost of dispensing survey report on the  
33.21 department's website. The initial survey must be completed no later than January 1, 2021,  
33.22 and repeated every three years. The commissioner shall provide a summary of the results  
33.23 of each cost of dispensing survey and provide recommendations for any changes to the  
33.24 dispensing fee to the chairs and ranking minority members of the legislative committees  
33.25 with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section  
33.26 256.01, subdivision 42, this paragraph does not expire.

33.27 (i) The commissioner shall increase the ingredient cost reimbursement calculated in  
33.28 paragraphs (a) and (f) by 1.8 percent for prescription and nonprescription drugs subject to  
33.29 the wholesale drug distributor tax under section 295.52.

33.30 Sec. 10. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
33.31 to read:

33.32 Subd. 25c. **Applicability of utilization review provisions.** Effective January 1, 2026,  
33.33 the following provisions of chapter 62M apply to the commissioner when delivering services  
33.34 under chapters 256B and 256L: 62M.02, subdivisions 1 to 5, 7 to 12, 13, 14 to 18, and 21;

34.1 62M.04; 62M.05, subdivisions 1 to 4; 62M.06, subdivisions 1 to 3; 62M.07; 62M.072;  
34.2 62M.09; 62M.10; 62M.12; 62M.17, subdivision 2; and 62M.18.

34.3 Sec. 11. Minnesota Statutes 2023 Supplement, section 256B.0701, subdivision 6, is  
34.4 amended to read:

34.5 Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for  
34.6 facility costs and must be paid from state money in an amount equal to the ~~medical assistance~~  
34.7 ~~room and board~~ MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the  
34.8 time the recuperative care services were provided. The eligibility standards in chapter 256I  
34.9 do not apply to the recuperative care facility rate. The recuperative care facility rate is only  
34.10 paid when the recuperative care services rate is paid to a provider. Providers may opt to  
34.11 only receive the recuperative care services rate.

34.12 (b) Before a recipient is discharged from a recuperative care setting, the provider must  
34.13 ensure that the recipient's medical condition is stabilized or that the recipient is being  
34.14 discharged to a setting that is able to meet that recipient's needs.

34.15 Sec. 12. Minnesota Statutes 2023 Supplement, section 256B.0947, subdivision 7, is  
34.16 amended to read:

34.17 Subd. 7. **Medical assistance payment and rate setting.** (a) Payment for services in this  
34.18 section must be based on one daily encounter rate per provider inclusive of the following  
34.19 services received by an eligible client in a given calendar day: all rehabilitative services,  
34.20 supports, and ancillary activities under this section, staff travel time to provide rehabilitative  
34.21 services under this section, and crisis response services under section 256B.0624.

34.22 (b) Payment must not be made to more than one entity for each client for services  
34.23 provided under this section on a given day. If services under this section are provided by a  
34.24 team that includes staff from more than one entity, the team shall determine how to distribute  
34.25 the payment among the members.

34.26 (c) The commissioner shall establish regional cost-based rates for entities that will bill  
34.27 medical assistance for nonresidential intensive rehabilitative mental health services. In  
34.28 developing these rates, the commissioner shall consider:

34.29 (1) the cost for similar services in the health care trade area;

34.30 (2) actual costs incurred by entities providing the services;

34.31 (3) the intensity and frequency of services to be provided to each client;

35.1 (4) the degree to which clients will receive services other than services under this section;  
35.2 and

35.3 (5) the costs of other services that will be separately reimbursed.

35.4 (d) The rate for a provider must not exceed the rate charged by that provider for the  
35.5 same service to other payers.

35.6 (e) Effective for the rate years beginning on and after January 1, 2024, rates must be  
35.7 annually adjusted for inflation using the Centers for Medicare and Medicaid Services  
35.8 Medicare Economic Index, as forecasted in the ~~fourth~~ third quarter of the calendar year  
35.9 before the rate year. The inflation adjustment must be based on the 12-month period from  
35.10 the midpoint of the previous rate year to the midpoint of the rate year for which the rate is  
35.11 being determined.

35.12 Sec. 13. Minnesota Statutes 2023 Supplement, section 256B.764, is amended to read:

35.13 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

35.14 (a) Effective for services rendered on or after July 1, 2007, payment rates for family  
35.15 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,  
35.16 when these services are provided by a community clinic as defined in section 145.9268,  
35.17 subdivision 1.

35.18 (b) Effective for services rendered on or after July 1, 2013, payment rates for family  
35.19 planning services shall be increased by 20 percent over the rates in effect June 30, 2013,  
35.20 when these services are provided by a community clinic as defined in section 145.9268,  
35.21 subdivision 1. The commissioner shall adjust capitation rates to managed care and  
35.22 county-based purchasing plans to reflect this increase, and shall require plans to pass on the  
35.23 full amount of the rate increase to eligible community clinics, in the form of higher payment  
35.24 rates for family planning services.

35.25 (c) Effective for services provided on or after January 1, 2024, payment rates for family  
35.26 planning, when such services are provided by an eligible community clinic as defined in  
35.27 section 145.9268, subdivision 1, and abortion services shall be increased by 20 percent.  
35.28 This increase does not apply to federally qualified health centers, rural health centers, or  
35.29 Indian health services.

36.1 Sec. 14. Minnesota Statutes 2023 Supplement, section 256L.03, subdivision 1, is amended  
36.2 to read:

36.3 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health  
36.4 services reimbursed under chapter 256B, with the exception of special education services,  
36.5 home care nursing services, ~~adult dental care services other than services covered under~~  
36.6 ~~section 256B.0625, subdivision 9, orthodontic services,~~ nonemergency medical transportation  
36.7 services, personal care assistance and case management services, community first services  
36.8 and supports under section 256B.85, behavioral health home services under section  
36.9 256B.0757, housing stabilization services under section 256B.051, and nursing home or  
36.10 intermediate care facilities services.

36.11 (b) Covered health services shall be expanded as provided in this section.

36.12 (c) For the purposes of covered health services under this section, "child" means an  
36.13 individual younger than 19 years of age.

36.14 Sec. 15. Minnesota Statutes 2022, section 524.3-801, as amended by Laws 2024, chapter  
36.15 79, article 9, section 20, is amended to read:

36.16 **524.3-801 NOTICE TO CREDITORS.**

36.17 (a) Unless notice has already been given under this section, upon appointment of a  
36.18 general personal representative in informal proceedings or upon the filing of a petition for  
36.19 formal appointment of a general personal representative, notice thereof, in the form prescribed  
36.20 by court rule, shall be given under the direction of the court administrator by publication  
36.21 once a week for two successive weeks in a legal newspaper in the county wherein the  
36.22 proceedings are pending giving the name and address of the general personal representative  
36.23 and notifying creditors of the estate to present their claims within four months after the date  
36.24 of the court administrator's notice which is subsequently published or be forever barred,  
36.25 unless they are entitled to further service of notice under paragraph (b) or (c).

36.26 (b) The personal representative shall, within three months after the date of the first  
36.27 publication of the notice, serve a copy of the notice upon each then known and identified  
36.28 creditor in the manner provided in paragraph (c). If the decedent or a predeceased spouse  
36.29 of the decedent received assistance for which a claim could be filed under section 246.53,  
36.30 256B.15, 256D.16, or 261.04, notice to the commissioner of human services or direct care  
36.31 and treatment executive board, as applicable, must be given under paragraph (d) instead of  
36.32 under this paragraph or paragraph (c). A creditor is "known" if: (i) the personal representative  
36.33 knows that the creditor has asserted a claim that arose during the decedent's life against

37.1 either the decedent or the decedent's estate; (ii) the creditor has asserted a claim that arose  
37.2 during the decedent's life and the fact is clearly disclosed in accessible financial records  
37.3 known and available to the personal representative; or (iii) the claim of the creditor would  
37.4 be revealed by a reasonably diligent search for creditors of the decedent in accessible  
37.5 financial records known and available to the personal representative. Under this section, a  
37.6 creditor is "identified" if the personal representative's knowledge of the name and address  
37.7 of the creditor will permit service of notice to be made under paragraph (c).

37.8 (c) Unless the claim has already been presented to the personal representative or paid,  
37.9 the personal representative shall serve a copy of the notice required by paragraph (b) upon  
37.10 each creditor of the decedent who is then known to the personal representative and identified  
37.11 either by delivery of a copy of the required notice to the creditor, or by mailing a copy of  
37.12 the notice to the creditor by certified, registered, or ordinary first class mail addressed to  
37.13 the creditor at the creditor's office or place of residence.

37.14 (d)(1) Effective for decedents dying on or after July 1, 1997, if the decedent or a  
37.15 predeceased spouse of the decedent received assistance for which a claim could be filed  
37.16 under section 246.53, 256B.15, 256D.16, or 261.04, the personal representative or the  
37.17 attorney for the personal representative shall serve the commissioner or executive board,  
37.18 as applicable, with notice in the manner prescribed in paragraph (c), or electronically in a  
37.19 manner prescribed by the commissioner or executive board, as soon as practicable after the  
37.20 appointment of the personal representative. The notice must state the decedent's full name,  
37.21 date of birth, and Social Security number and, to the extent then known after making a  
37.22 reasonably diligent inquiry, the full name, date of birth, and Social Security number for  
37.23 each of the decedent's predeceased spouses. The notice may also contain a statement that,  
37.24 after making a reasonably diligent inquiry, the personal representative has determined that  
37.25 the decedent did not have any predeceased spouses or that the personal representative has  
37.26 been unable to determine one or more of the previous items of information for a predeceased  
37.27 spouse of the decedent. A copy of the notice to creditors must be attached to and be a part  
37.28 of the notice to the commissioner or executive board.

37.29 (2) Notwithstanding a will or other instrument or law to the contrary, except as allowed  
37.30 in this paragraph, no property subject to administration by the estate may be distributed by  
37.31 the estate or the personal representative until 70 days after the date the notice is served on  
37.32 the commissioner or executive board as provided in paragraph (c), unless the local agency  
37.33 consents as provided for in clause (6). This restriction on distribution does not apply to the  
37.34 personal representative's sale of real or personal property, but does apply to the net proceeds  
37.35 the estate receives from these sales. The personal representative, or any person with personal

38.1 knowledge of the facts, may provide an affidavit containing the description of any real or  
38.2 personal property affected by this paragraph and stating facts showing compliance with this  
38.3 paragraph. If the affidavit describes real property, it may be filed or recorded in the office  
38.4 of the county recorder or registrar of titles for the county where the real property is located.  
38.5 This paragraph does not apply to proceedings under sections 524.3-1203 and 525.31, or  
38.6 when a duly authorized agent of a county is acting as the personal representative of the  
38.7 estate.

38.8 (3) At any time before an order or decree is entered under section 524.3-1001 or  
38.9 524.3-1002, or a closing statement is filed under section 524.3-1003, the personal  
38.10 representative or the attorney for the personal representative may serve an amended notice  
38.11 on the commissioner or executive board to add variations or other names of the decedent  
38.12 or a predeceased spouse named in the notice, the name of a predeceased spouse omitted  
38.13 from the notice, to add or correct the date of birth or Social Security number of a decedent  
38.14 or predeceased spouse named in the notice, or to correct any other deficiency in a prior  
38.15 notice. The amended notice must state the decedent's name, date of birth, and Social Security  
38.16 number, the case name, case number, and district court in which the estate is pending, and  
38.17 the date the notice being amended was served on the commissioner or executive board. If  
38.18 the amendment adds the name of a predeceased spouse omitted from the notice, it must also  
38.19 state that spouse's full name, date of birth, and Social Security number. The amended notice  
38.20 must be served on the commissioner or executive board in the same manner as the original  
38.21 notice. Upon service, the amended notice relates back to and is effective from the date the  
38.22 notice it amends was served, and the time for filing claims arising under section 246.53,  
38.23 256B.15, 256D.16 or 261.04 is extended by 60 days from the date of service of the amended  
38.24 notice. Claims filed during the 60-day period are undischarged and unbarred claims, may  
38.25 be prosecuted by the entities entitled to file those claims in accordance with section  
38.26 524.3-1004, and the limitations in section 524.3-1006 do not apply. The personal  
38.27 representative or any person with personal knowledge of the facts may provide and file or  
38.28 record an affidavit in the same manner as provided for in clause (1).

38.29 (4) Within one year after the date an order or decree is entered under section 524.3-1001  
38.30 or 524.3-1002 or a closing statement is filed under section 524.3-1003, any person who has  
38.31 an interest in property that was subject to administration by the estate may serve an amended  
38.32 notice on the commissioner or executive board to add variations or other names of the  
38.33 decedent or a predeceased spouse named in the notice, the name of a predeceased spouse  
38.34 omitted from the notice, to add or correct the date of birth or Social Security number of a  
38.35 decedent or predeceased spouse named in the notice, or to correct any other deficiency in

39.1 a prior notice. The amended notice must be served on the commissioner or executive board  
39.2 in the same manner as the original notice and must contain the information required for  
39.3 amendments under clause (3). If the amendment adds the name of a predeceased spouse  
39.4 omitted from the notice, it must also state that spouse's full name, date of birth, and Social  
39.5 Security number. Upon service, the amended notice relates back to and is effective from  
39.6 the date the notice it amends was served. If the amended notice adds the name of an omitted  
39.7 predeceased spouse or adds or corrects the Social Security number or date of birth of the  
39.8 decedent or a predeceased spouse already named in the notice, then, notwithstanding any  
39.9 other laws to the contrary, claims against the decedent's estate on account of those persons  
39.10 resulting from the amendment and arising under section 246.53, 256B.15, 256D.16, or  
39.11 261.04 are undischarged and unbarred claims, may be prosecuted by the entities entitled to  
39.12 file those claims in accordance with section 524.3-1004, and the limitations in section  
39.13 524.3-1006 do not apply. The person filing the amendment or any other person with personal  
39.14 knowledge of the facts may provide and file or record an affidavit describing affected real  
39.15 or personal property in the same manner as clause (1).

39.16 (5) After one year from the date an order or decree is entered under section 524.3-1001  
39.17 or 524.3-1002, or a closing statement is filed under section 524.3-1003, no error, omission,  
39.18 or defect of any kind in the notice to the commissioner or executive board required under  
39.19 this paragraph or in the process of service of the notice on the commissioner or executive  
39.20 board, or the failure to serve the commissioner or executive board with notice as required  
39.21 by this paragraph, makes any distribution of property by a personal representative void or  
39.22 voidable. The distributee's title to the distributed property shall be free of any claims based  
39.23 upon a failure to comply with this paragraph.

39.24 (6) The local agency may consent to a personal representative's request to distribute  
39.25 property subject to administration by the estate to distributees during the 70-day period after  
39.26 service of notice on the commissioner or executive board. The local agency may grant or  
39.27 deny the request in whole or in part and may attach conditions to its consent as it deems  
39.28 appropriate. When the local agency consents to a distribution, it shall give the estate a written  
39.29 certificate evidencing its consent to the early distribution of assets at no cost. The certificate  
39.30 must include the name, case number, and district court in which the estate is pending, the  
39.31 name of the local agency, describe the specific real or personal property to which the consent  
39.32 applies, state that the local agency consents to the distribution of the specific property  
39.33 described in the consent during the 70-day period following service of the notice on the  
39.34 commissioner or executive board, state that the consent is unconditional or list all of the  
39.35 terms and conditions of the consent, be dated, and may include other contents as may be

40.1 appropriate. The certificate must be signed by the director of the local agency or the director's  
40.2 designees and is effective as of the date it is dated unless it provides otherwise. The signature  
40.3 of the director or the director's designee does not require any acknowledgment. The certificate  
40.4 shall be prima facie evidence of the facts it states, may be attached to or combined with a  
40.5 deed or any other instrument of conveyance and, when so attached or combined, shall  
40.6 constitute a single instrument. If the certificate describes real property, it shall be accepted  
40.7 for recording or filing by the county recorder or registrar of titles in the county in which the  
40.8 property is located. If the certificate describes real property and is not attached to or combined  
40.9 with a deed or other instrument of conveyance, it shall be accepted for recording or filing  
40.10 by the county recorder or registrar of titles in the county in which the property is located.  
40.11 The certificate constitutes a waiver of the 70-day period provided for in clause (2) with  
40.12 respect to the property it describes and is prima facie evidence of service of notice on the  
40.13 commissioner or executive board. The certificate is not a waiver or relinquishment of any  
40.14 claims arising under section 246.53, 256B.15, 256D.16, or 261.04, and does not otherwise  
40.15 constitute a waiver of any of the personal representative's duties under this paragraph.  
40.16 Distributees who receive property pursuant to a consent to an early distribution shall remain  
40.17 liable to creditors of the estate as provided for by law.

40.18 (7) All affidavits provided for under this paragraph:

40.19 (i) shall be provided by persons who have personal knowledge of the facts stated in the  
40.20 affidavit;

40.21 (ii) may be filed or recorded in the office of the county recorder or registrar of titles in  
40.22 the county in which the real property they describe is located for the purpose of establishing  
40.23 compliance with the requirements of this paragraph; and

40.24 (iii) are prima facie evidence of the facts stated in the affidavit.

40.25 (8) This paragraph applies to the estates of decedents dying on or after July 1, 1997.  
40.26 Clause (5) also applies with respect to all notices served on the commissioner of human  
40.27 services before July 1, 1997, under Laws 1996, chapter 451, article 2, section 55. All notices  
40.28 served on the commissioner before July 1, 1997, pursuant to Laws 1996, chapter 451, article  
40.29 2, section 55, shall be deemed to be legally sufficient for the purposes for which they were  
40.30 intended, notwithstanding any errors, omissions or other defects.



42.1 Sec. 2. Minnesota Statutes 2022, section 62V.08, is amended to read:

42.2 **62V.08 REPORTS.**

42.3 (a) MNsure shall submit a report to the legislature by ~~January 15, 2015~~ March 31, 2025,  
42.4 and each ~~January 15~~ March 31 thereafter, on: (1) the performance of MNsure operations;  
42.5 (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4)  
42.6 practices and procedures that have been implemented to ensure compliance with data  
42.7 practices laws, and a description of any violations of data practices laws or procedures; and  
42.8 (5) the effectiveness of the outreach and implementation activities of MNsure in reducing  
42.9 the rate of uninsurance.

42.10 (b) MNsure must publish its administrative and operational costs on a website to educate  
42.11 consumers on those costs. The information published must include: (1) the amount of  
42.12 premiums and federal premium subsidies collected; (2) the amount and source of revenue  
42.13 received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and  
42.14 source of any other fees collected for purposes of supporting operations; and (4) any misuse  
42.15 of funds as identified in accordance with section 3.975. The website must be updated at  
42.16 least annually.

42.17 Sec. 3. Minnesota Statutes 2022, section 62V.11, subdivision 4, is amended to read:

42.18 Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure  
42.19 for the next fiscal year by ~~March 15~~ 31 of each year, beginning ~~March 15, 2014~~ 31, 2025.

42.20 Sec. 4. Minnesota Statutes 2023 Supplement, section 151.74, subdivision 3, is amended  
42.21 to read:

42.22 Subd. 3. **Access to urgent-need insulin.** (a) MNsure shall develop an application form  
42.23 to be used by an individual who is in urgent need of insulin. The application must ask the  
42.24 individual to attest to the eligibility requirements described in subdivision 2. The form shall  
42.25 be accessible through MNsure's website. MNsure shall also make the form available to  
42.26 pharmacies and health care providers who prescribe or dispense insulin, hospital emergency  
42.27 departments, urgent care clinics, and community health clinics. By submitting a completed,  
42.28 signed, and dated application to a pharmacy, the individual attests that the information  
42.29 contained in the application is correct.

42.30 (b) If the individual is in urgent need of insulin, the individual may present a completed,  
42.31 signed, and dated application form to a pharmacy. The individual must also:

42.32 (1) have a valid insulin prescription; and

43.1 (2) present the pharmacist with identification indicating Minnesota residency in the form  
43.2 of a valid Minnesota identification card, driver's license or permit, individual taxpayer  
43.3 identification number, or Tribal identification card as defined in section 171.072, paragraph  
43.4 (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent  
43.5 or legal guardian must provide the pharmacist with proof of residency.

43.6 (c) Upon receipt of a completed and signed application, the pharmacist shall dispense  
43.7 the prescribed insulin in an amount that will provide the individual with a 30-day supply.  
43.8 The pharmacy must notify the health care practitioner who issued the prescription order no  
43.9 later than 72 hours after the insulin is dispensed.

43.10 (d) The pharmacy may submit to the manufacturer of the dispensed insulin product or  
43.11 to the manufacturer's vendor a claim for payment that is in accordance with the National  
43.12 Council for Prescription Drug Program standards for electronic claims processing, unless  
43.13 the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin  
43.14 as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the  
43.15 manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the  
43.16 pharmacy in an amount that covers the pharmacy's acquisition cost.

43.17 (e) The pharmacy may collect an insulin co-payment from the individual to cover the  
43.18 pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day  
43.19 supply of insulin dispensed.

43.20 (f) The pharmacy shall also provide each eligible individual with the information sheet  
43.21 described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy  
43.22 for the individual to contact if the individual ~~is in need of~~ accessing needs to access ongoing  
43.23 insulin coverage options, including assistance in:

43.24 (1) applying for medical assistance or MinnesotaCare;

43.25 (2) applying for a qualified health plan offered through MNsure, subject to open and  
43.26 special enrollment periods;

43.27 (3) accessing information on providers who participate in prescription drug discount  
43.28 programs, including providers who are authorized to participate in the 340B program under  
43.29 section 340b of the federal Public Health Services Act, United States Code, title 42, section  
43.30 256b; and

43.31 (4) accessing insulin manufacturers' patient assistance programs, co-payment assistance  
43.32 programs, and other foundation-based programs.

44.1 (g) The pharmacist shall retain a copy of the application form submitted by the individual  
44.2 to the pharmacy for reporting and auditing purposes.

44.3 (h) A manufacturer may submit to the commissioner of administration a request for  
44.4 reimbursement in an amount not to exceed \$35 for each 30-day supply of insulin the  
44.5 manufacturer provides under paragraph (d). The commissioner of administration shall  
44.6 determine the manner and format for submitting and processing requests for reimbursement.  
44.7 After receiving a reimbursement request, the commissioner of administration shall reimburse  
44.8 the manufacturer in an amount not to exceed \$35 for each 30-day supply of insulin the  
44.9 manufacturer provided under paragraph (d).

44.10 **EFFECTIVE DATE.** This section is effective December 1, 2024.

44.11 Sec. 5. Minnesota Statutes 2022, section 151.74, subdivision 6, is amended to read:

44.12 Subd. 6. **Continuing safety net program; process.** (a) The individual shall submit to  
44.13 a pharmacy the statement of eligibility provided by the manufacturer under subdivision 5,  
44.14 paragraph (b). Upon receipt of an individual's eligibility status, the pharmacy shall submit  
44.15 an order containing the name of the insulin product and the daily dosage amount as contained  
44.16 in a valid prescription to the product's manufacturer.

44.17 (b) The pharmacy must include with the order to the manufacturer the following  
44.18 information:

44.19 (1) the pharmacy's name and shipping address;

44.20 (2) the pharmacy's office telephone number, fax number, email address, and contact  
44.21 name; and

44.22 (3) any specific days or times when deliveries are not accepted by the pharmacy.

44.23 (c) Upon receipt of an order from a pharmacy and the information described in paragraph  
44.24 (b), the manufacturer shall send to the pharmacy a 90-day supply of insulin as ordered,  
44.25 unless a lesser amount is requested in the order, at no charge to the individual or pharmacy.

44.26 (d) Except as authorized under paragraph (e), the pharmacy shall provide the insulin to  
44.27 the individual at no charge to the individual. The pharmacy shall not provide insulin received  
44.28 from the manufacturer to any individual other than the individual associated with the specific  
44.29 order. The pharmacy shall not seek reimbursement for the insulin received from the  
44.30 manufacturer or from any third-party payer.

45.1 (e) The pharmacy may collect a co-payment from the individual to cover the pharmacy's  
45.2 costs for processing and dispensing in an amount not to exceed \$50 for each 90-day supply  
45.3 if the insulin is sent to the pharmacy.

45.4 (f) The pharmacy may submit to a manufacturer a reorder for an individual if the  
45.5 individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy,  
45.6 the manufacturer must send to the pharmacy an additional 90-day supply of the product,  
45.7 unless a lesser amount is requested, at no charge to the individual or pharmacy if the  
45.8 individual's eligibility statement has not expired.

45.9 (g) Notwithstanding paragraph (c), a manufacturer may send the insulin as ordered  
45.10 directly to the individual if the manufacturer provides a mail order service option.

45.11 (h) A manufacturer may submit to the commissioner of administration a request for  
45.12 reimbursement in an amount not to exceed \$105 for each 90-day supply of insulin the  
45.13 manufacturer provides under paragraphs (c) and (f). The commissioner of administration  
45.14 shall determine the manner and format for submitting and processing requests for  
45.15 reimbursement. After receiving a reimbursement request, the commissioner of administration  
45.16 shall reimburse the manufacturer in an amount not to exceed \$105 for each 90-day supply  
45.17 of insulin the manufacturer provided under paragraphs (c) and (f). If the manufacturer  
45.18 provides less than a 90-day supply of insulin under paragraphs (c) and (f), the manufacturer  
45.19 may submit a request for reimbursement not to exceed \$35 for each 30-day supply of insulin  
45.20 provided.

45.21 **EFFECTIVE DATE.** This section is effective December 1, 2024.

45.22 **Sec. 6. [151.741] INSULIN MANUFACTURER REGISTRATION FEE.**

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

45.25 (b) "Board" means the Minnesota Board of Pharmacy under section 151.02.

45.26 (c) "Manufacturer" means a manufacturer licensed under section 151.252 and engaged  
45.27 in the manufacturing of prescription insulin.

45.28 Subd. 2. Assessment of registration fee. (a) The board shall assess each manufacturer  
45.29 an annual registration fee of \$100,000, except as provided in paragraph (b). The board shall  
45.30 notify each manufacturer of this requirement beginning November 1, 2024, and each  
45.31 November 1 thereafter.

46.1 (b) A manufacturer may request an exemption from the annual registration fee. The  
46.2 board shall exempt a manufacturer from the annual registration fee if the manufacturer can  
46.3 demonstrate to the board, in the form and manner specified by the board, that gross revenue  
46.4 from sales of prescription insulin produced by that manufacturer and sold or delivered within  
46.5 or into Minnesota was less than five percent of the total gross revenue from sales of  
46.6 prescription insulin produced by all manufacturers and sold or delivered within or into  
46.7 Minnesota in the previous calendar year.

46.8 Subd. 3. **Payment of the registration fee; deposit of fee.** (a) Each manufacturer must  
46.9 pay the registration fee by March 1, 2025, and by each March 1 thereafter. In the event of  
46.10 a change in ownership of the manufacturer, the new owner must pay the registration fee  
46.11 that the original owner would have been assessed had the original owner retained ownership.  
46.12 The board may assess a late fee of ten percent per month or any portion of a month that the  
46.13 registration fee is paid after the due date.

46.14 (b) The registration fee, including any late fees, must be deposited in the insulin safety  
46.15 net program account.

46.16 Subd. 4. **Insulin safety net program account.** The insulin safety net program account  
46.17 is established in the special revenue fund in the state treasury. Money in the account is  
46.18 appropriated each fiscal year to:

46.19 (1) the MNsure board in an amount sufficient to carry out assigned duties under section  
46.20 151.74, subdivision 7; and

46.21 (2) the Board of Pharmacy in an amount sufficient to cover costs incurred by the board  
46.22 in assessing and collecting the registration fee under this section and in administering the  
46.23 insulin safety net program under section 151.74.

46.24 Subd. 5. **Insulin repayment account; annual transfer from health care access fund.** (a)  
46.25 The insulin repayment account is established in the special revenue fund in the state treasury.  
46.26 Money in the account is appropriated each fiscal year to the commissioner of administration  
46.27 to reimburse manufacturers for insulin dispensed under the insulin safety net program in  
46.28 section 151.74, in accordance with section 151.74, subdivisions 3, paragraph (h), and 6,  
46.29 paragraph (h), and to cover costs incurred by the commissioner in providing these  
46.30 reimbursement payments.

46.31 (b) By June 30, 2025, and each June 30 thereafter, the commissioner of administration  
46.32 shall certify to the commissioner of management and budget the total amount expended in  
46.33 the prior fiscal year for:

47.1 (1) reimbursement to manufacturers for insulin dispensed under the insulin safety net  
47.2 program in section 151.74, in accordance with section 151.74, subdivisions 3, paragraph  
47.3 (h), and 6, paragraph (h); and

47.4 (2) costs incurred by the commissioner of administration in providing the reimbursement  
47.5 payments described in clause (1).

47.6 (c) The commissioner of management and budget shall transfer from the health care  
47.7 access fund to the special revenue fund, beginning July 1, 2025, and each July 1 thereafter,  
47.8 an amount equal to the amount to which the commissioner of administration certified  
47.9 pursuant to paragraph (b).

47.10 Subd. 6. Contingent transfer by commissioner. If subdivisions 2 and 3, or the  
47.11 application of subdivisions 2 and 3 to any person or circumstance, are held invalid for any  
47.12 reason in a court of competent jurisdiction, the invalidity of subdivisions 2 and 3 does not  
47.13 affect other provisions of this act, and the commissioner of management and budget shall  
47.14 annually transfer from the health care access fund to the insulin safety net program account  
47.15 an amount sufficient to implement subdivision 4.

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

47.17 Sec. 7. Laws 2020, chapter 73, section 8, is amended to read:

47.18 Sec. 8. **APPROPRIATIONS.**

47.19 (a) \$297,000 is appropriated in fiscal year 2020 from the health care access fund to the  
47.20 Board of Directors of MNsure ~~to train navigators to assist individuals and provide~~  
47.21 ~~compensation as required~~ for the insulin safety net program under Minnesota Statutes,  
47.22 section 151.74, ~~subdivision 7. Of this appropriation, \$108,000 is for implementing the~~  
47.23 ~~training requirements for navigators and \$189,000 is for application assistance bonus~~  
47.24 ~~payments.~~ This is a onetime appropriation and is available until ~~December 31, 2024~~ June  
47.25 30, 2027.

47.26 (b) \$250,000 is appropriated in fiscal year 2020 from the health care access fund to the  
47.27 Board of Directors of MNsure for a public awareness campaign for the insulin safety net  
47.28 program established under Minnesota Statutes, section 151.74. This is a onetime appropriation  
47.29 and is available until December 31, 2024.

47.30 (c) \$76,000 is appropriated in fiscal year 2021 from the health care access fund to the  
47.31 Board of Pharmacy to implement Minnesota Statutes, section 151.74. The base for this

48.1 appropriation is \$76,000 in fiscal year 2022; \$76,000 in fiscal year 2023; \$76,000 in fiscal  
48.2 year 2024; \$38,000 in fiscal year 2025; and \$0 in fiscal year 2026.

48.3 (d) \$136,000 in fiscal year 2021 is appropriated from the health care access fund to the  
48.4 commissioner of health to implement the survey to assess program satisfaction in Minnesota  
48.5 Statutes, section 151.74, subdivision 12. The base for this appropriation is \$80,000 in fiscal  
48.6 year 2022 and \$0 in fiscal year 2023. This is a onetime appropriation.

48.7 **Sec. 8. REPEALER; SUNSET FOR THE LONG-TERM SAFETY NET INSULIN**  
48.8 **PROGRAM.**

48.9 Minnesota Statutes 2022, section 151.74, subdivision 16, is repealed.

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

48.11 **ARTICLE 4**  
48.12 **HEALTH INSURANCE**

48.13 Section 1. Minnesota Statutes 2022, section 43A.24, is amended by adding a subdivision  
48.14 to read:

48.15 Subd. 4. **For-profit health maintenance organizations prohibited.** The commissioner  
48.16 must ensure that state paid hospital, medical, and dental benefits are not provided to eligible  
48.17 employees by a health maintenance organization which is not a nonprofit corporation  
48.18 organized under chapter 317A or a local governmental unit, as defined in section 62D.02.

48.19 **EFFECTIVE DATE.** This section is effective January 1, 2025.

48.20 Sec. 2. Minnesota Statutes 2022, section 62A.0411, is amended to read:

48.21 **62A.0411 MATERNITY CARE.**

48.22 Subdivision 1. **Minimum inpatient care.** Every health plan as defined in section 62Q.01,  
48.23 subdivision 3, that provides maternity benefits must, consistent with other coinsurance,  
48.24 co-payment, deductible, and related contract terms, provide coverage of a minimum of 48  
48.25 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient  
48.26 care following a caesarean section for a mother and her newborn. The health plan shall not  
48.27 provide any compensation or other nonmedical remuneration to encourage a mother and  
48.28 newborn to leave inpatient care before the duration minimums specified in this section.

48.29 Subd. 1a. **Medical facility transfer.** (a) If a health care provider acting within the  
48.30 provider's scope of practice recommends that either the mother or newborn be transferred  
48.31 to a different medical facility, every health plan must provide the coverage required under

49.1 subdivision 1 for the mother, newborn, and newborn siblings at both medical facilities. The  
49.2 coverage required under this subdivision includes but is not limited to expenses related to  
49.3 transferring all individuals from one medical facility to a different medical facility.

49.4 (b) The coverage required under this subdivision must be provided without cost sharing,  
49.5 including but not limited to deductible, co-pay, or coinsurance. The coverage required under  
49.6 this paragraph must be provided without any limitation that is not generally applicable to  
49.7 other coverages under the plan.

49.8 (c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in  
49.9 conjunction with a health savings account must include cost-sharing for the coverage required  
49.10 under this subdivision at the minimum level necessary to preserve the enrollee's ability to  
49.11 make tax-exempt contributions and withdrawals from the health savings account as provided  
49.12 in section 223 of the Internal Revenue Code of 1986.

49.13 Subd. 2. **Minimum postdelivery outpatient care.** (a) The health plan must also provide  
49.14 coverage for postdelivery outpatient care to a mother and her newborn if the duration of  
49.15 inpatient care is less than the minimums provided in this section.

49.16 (b) Postdelivery care consists of a minimum of one home visit by a registered nurse.  
49.17 Services provided by the registered nurse include, but are not limited to, parent education,  
49.18 assistance and training in breast and bottle feeding, and conducting any necessary and  
49.19 appropriate clinical tests. The home visit must be conducted within four days following the  
49.20 discharge of the mother and her child.

49.21 Subd. 3. **Health plan defined.** For purposes of this section, "health plan" has the meaning  
49.22 given in section 62Q.01, subdivision 3, and county-based purchasing plans.

49.23 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all policies,  
49.24 plans, certificates, and contracts offered, issued, or renewed on or after that date.

49.25 Sec. 3. Minnesota Statutes 2022, section 62A.15, is amended by adding a subdivision to  
49.26 read:

49.27 Subd. 3d. **Pharmacist.** All benefits provided by a policy or contract referred to in  
49.28 subdivision 1 relating to expenses incurred for medical treatment or services provided by  
49.29 a licensed physician must include services provided by a licensed pharmacist, according to  
49.30 the requirements of section 151.01, to the extent a licensed pharmacist's services are within  
49.31 the pharmacist's scope of practice.

49.32 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to policies  
49.33 or contracts offered, issued, or renewed on or after that date.

50.1 Sec. 4. Minnesota Statutes 2022, section 62A.15, subdivision 4, is amended to read:

50.2 Subd. 4. **Denial of benefits.** (a) No carrier referred to in subdivision 1 may, in the  
50.3 payment of claims to employees in this state, deny benefits payable for services covered by  
50.4 the policy or contract if the services are lawfully performed by a licensed chiropractor, a  
50.5 licensed optometrist, a registered nurse meeting the requirements of subdivision 3a, a licensed  
50.6 physician assistant, ~~or a licensed acupuncture practitioner,~~ or a licensed pharmacist.

50.7 (b) When carriers referred to in subdivision 1 make claim determinations concerning  
50.8 the appropriateness, quality, or utilization of chiropractic health care for Minnesotans, any  
50.9 of these determinations that are made by health care professionals must be made by, or  
50.10 under the direction of, or subject to the review of licensed doctors of chiropractic.

50.11 (c) When a carrier referred to in subdivision 1 makes a denial of payment claim  
50.12 determination concerning the appropriateness, quality, or utilization of acupuncture services  
50.13 for individuals in this state performed by a licensed acupuncture practitioner, a denial of  
50.14 payment claim determination that is made by a health professional must be made by, under  
50.15 the direction of, or subject to the review of a licensed acupuncture practitioner.

50.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to policies  
50.17 or contracts offered, issued, or renewed on or after that date.

50.18 Sec. 5. Minnesota Statutes 2022, section 62A.28, subdivision 2, is amended to read:

50.19 Subd. 2. **Required coverage.** (a) Every policy, plan, certificate, or contract referred to  
50.20 in subdivision 1 ~~issued or renewed after August 1, 1987,~~ must provide coverage for scalp  
50.21 hair prostheses, including all equipment and accessories necessary for regular use of scalp  
50.22 hair prostheses, worn for hair loss suffered as a result of a health condition, including but  
50.23 not limited to alopecia areata or the treatment for cancer, unless there is a clinical basis for  
50.24 limitation.

50.25 (b) The coverage required by this section is subject to the co-payment, coinsurance,  
50.26 deductible, and other enrollee cost-sharing requirements that apply to similar types of items  
50.27 under the policy, plan, certificate, or contract and may be limited to one prosthesis per  
50.28 benefit year.

50.29 (c) The coverage required by this section for scalp hair prostheses is limited to \$1,000  
50.30 per benefit year.

50.31 (d) A scalp hair prosthesis must be prescribed by a doctor to be covered under this  
50.32 section.

51.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all policies,  
51.2 plans, certificates, and contracts offered, issued, or renewed on or after that date.

51.3 Sec. 6. **[62A.3098] RAPID WHOLE GENOME SEQUENCING; COVERAGE.**

51.4 Subdivision 1. **Definition.** For purposes of this section, "rapid whole genome sequencing"  
51.5 or "rWGS" means an investigation of the entire human genome, including coding and  
51.6 noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing  
51.7 genetic changes that returns the final results in 14 days. Rapid whole genome sequencing  
51.8 includes patient-only whole genome sequencing and duo and trio whole genome sequencing  
51.9 of the patient and the patient's biological parent or parents.

51.10 Subd. 2. **Required coverage.** A health plan that provides coverage to Minnesota residents  
51.11 must cover rWGS testing if the enrollee:

51.12 (1) is 21 years of age or younger;

51.13 (2) has a complex or acute illness of unknown etiology that is not confirmed to have  
51.14 been caused by an environmental exposure, toxic ingestion, an infection with a normal  
51.15 response to therapy, or trauma; and

51.16 (3) is receiving inpatient hospital services in an intensive care unit or a neonatal or high  
51.17 acuity pediatric care unit.

51.18 Subd. 3. **Coverage criteria.** Coverage may be based on the following medical necessity  
51.19 criteria:

51.20 (1) the enrollee has symptoms that suggest a broad differential diagnosis that would  
51.21 require an evaluation by multiple genetic tests if rWGS testing is not performed;

51.22 (2) timely identification of a molecular diagnosis is necessary in order to guide clinical  
51.23 decision making, and the rWGS testing may aid in guiding the treatment or management  
51.24 of the enrollee's condition; and

51.25 (3) the enrollee's complex or acute illness of unknown etiology includes at least one of  
51.26 the following conditions:

51.27 (i) congenital anomalies involving at least two organ systems, or complex or multiple  
51.28 congenital anomalies in one organ system;

51.29 (ii) specific organ malformations that are highly suggestive of a genetic etiology;

51.30 (iii) abnormal laboratory tests or abnormal chemistry profiles suggesting the presence  
51.31 of a genetic disease, complex metabolic disorder, or inborn error of metabolism;

- 52.1 (iv) refractory or severe hypoglycemia or hyperglycemia;
- 52.2 (v) abnormal response to therapy related to an underlying medical condition affecting  
52.3 vital organs or bodily systems;
- 52.4 (vi) severe muscle weakness, rigidity, or spasticity;
- 52.5 (vii) refractory seizures;
- 52.6 (viii) a high-risk stratification on evaluation for a brief resolved unexplained event with  
52.7 any of the following features:
- 52.8 (A) a recurrent event without respiratory infection;
- 52.9 (B) a recurrent seizure-like event; or
- 52.10 (C) a recurrent cardiopulmonary resuscitation;
- 52.11 (ix) abnormal cardiac diagnostic testing results that are suggestive of possible  
52.12 channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease;
- 52.13 (x) abnormal diagnostic imaging studies that are suggestive of underlying genetic  
52.14 condition;
- 52.15 (xi) abnormal physiologic function studies that are suggestive of an underlying genetic  
52.16 etiology; or
- 52.17 (xii) family genetic history related to the patient's condition.
- 52.18 Subd. 4. **Cost sharing.** Coverage provided in this section is subject to the enrollee's  
52.19 health plan cost-sharing requirements, including any deductibles, co-payments, or coinsurance  
52.20 requirements that apply to diagnostic testing services.
- 52.21 Subd. 5. **Payment for services provided.** If the enrollee's health plan uses a capitated  
52.22 or bundled payment arrangement to reimburse a provider for services provided in an inpatient  
52.23 setting, reimbursement for services covered under this section must be paid separately and  
52.24 in addition to any reimbursement otherwise payable to the provider under the capitated or  
52.25 bundled payment arrangement, unless the health carrier and the provider have negotiated  
52.26 an increased capitated or bundled payment rate that includes the services covered under this  
52.27 section.
- 52.28 Subd. 6. **Genetic data.** Genetic data generated as a result of performing rWGS and  
52.29 covered under this section: (1) must be used for the primary purpose of assisting the ordering  
52.30 provider and treating care team to diagnose and treat the patient; (2) is protected health  
52.31 information as set forth under the Health Insurance Portability and Accountability Act

53.1 (HIPAA), the Health Information Technology for Economic and Clinical Health Act, and  
53.2 any promulgated regulations, including but not limited to Code of Federal Regulations, title  
53.3 45, parts 160 and 164, subparts A and E; and (3) is a protected health record under sections  
53.4 144.291 to 144.298.

53.5 Subd. 7. **Reimbursement.** (a) The commissioner of commerce must reimburse health  
53.6 carriers for coverage under this section. Reimbursement is available only for coverage that  
53.7 would not have been provided by the health plan without the requirements of this section.  
53.8 Treatments and services covered by the health plan as of January 1, 2024, are ineligible for  
53.9 payments under this subdivision by the commissioner of commerce.

53.10 (b) Health carriers must report to the commissioner of commerce quantified costs  
53.11 attributable to the additional benefit under this section in a format developed by the  
53.12 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health  
53.13 carrier as the basis for determining whether coverage would not have been provided by the  
53.14 health plan for purposes of this subdivision.

53.15 (c) The commissioner of commerce must evaluate submissions and make payments to  
53.16 health carriers as provided in Code of Federal Regulations, title 45, section 155.170.

53.17 Subd. 8. **Appropriation.** Each fiscal year, an amount necessary to make payments to  
53.18 health carriers to defray the cost of providing coverage under this section is appropriated  
53.19 to the commissioner of commerce.

53.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to a health  
53.21 plan offered, issued, or sold on or after that date.

53.22 Sec. 7. **[62A.59] COVERAGE OF SERVICE; PRIOR AUTHORIZATION.**

53.23 Subdivision 1. **Service for which prior authorization not required.** A health carrier  
53.24 must not retrospectively deny or limit coverage of a health care service for which prior  
53.25 authorization was not required by the health carrier, unless there is evidence that the health  
53.26 care service was provided based on fraud or misinformation.

53.27 Subd. 2. **Service for which prior authorization required but not obtained.** A health  
53.28 carrier must not deny or limit coverage of a health care service which the enrollee has already  
53.29 received solely on the basis of lack of prior authorization if the service would otherwise  
53.30 have been covered had the prior authorization been obtained.

53.31 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health  
53.32 plans offered, sold, issued, or renewed on or after that date.

54.1 Sec. 8. [62C.045] APPLICATION OF OTHER LAW.

54.2 Sections 145D.30 to 145D.37 apply to service plan corporations operating under this  
54.3 chapter.

54.4 **EFFECTIVE DATE.** This section is effective July 1, 2025.

54.5 Sec. 9. Minnesota Statutes 2022, section 62D.02, subdivision 7, is amended to read:

54.6 Subd. 7. **Comprehensive health maintenance services.** "Comprehensive health  
54.7 maintenance services" means a set of comprehensive health services which the enrollees  
54.8 might reasonably require to be maintained in good health including as a minimum, but not  
54.9 limited to, emergency care, emergency ground ambulance transportation services, inpatient  
54.10 hospital and physician care, outpatient health services and preventive health services.  
54.11 ~~Elective, induced abortion, except as medically necessary to prevent the death of the mother,~~  
54.12 ~~whether performed in a hospital, other abortion facility or the office of a physician, shall~~  
54.13 ~~not be mandatory for any health maintenance organization.~~

54.14 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
54.15 plans offered, sold, issued, or renewed on or after that date.

54.16 Sec. 10. Minnesota Statutes 2022, section 62D.04, subdivision 5, is amended to read:

54.17 Subd. 5. **Participation; government programs.** Health maintenance organizations that  
54.18 are a nonprofit corporation organized under chapter 317A or a local governmental unit shall,  
54.19 as a condition of receiving and retaining a certificate of authority, participate in the medical  
54.20 assistance and MinnesotaCare programs. A health maintenance organization governed by  
54.21 this subdivision is required to submit proposals in good faith that meet the requirements of  
54.22 the request for proposal provided that the requirements can be reasonably met by a health  
54.23 maintenance organization to serve individuals eligible for the above programs in a geographic  
54.24 region of the state if, at the time of publication of a request for proposal, the percentage of  
54.25 recipients in the public programs in the region who are enrolled in the health maintenance  
54.26 organization is less than the health maintenance organization's percentage of the total number  
54.27 of individuals enrolled in health maintenance organizations in the same region. Geographic  
54.28 regions shall be defined by the commissioner of human services in the request for proposals.

54.29 **EFFECTIVE DATE.** This section is effective January 1, 2025.

55.1 Sec. 11. **[62D.1071] COVERAGE OF LICENSED PHARMACIST SERVICES.**

55.2 Subdivision 1. **Pharmacist.** All benefits provided by a health maintenance contract  
55.3 relating to expenses incurred for medical treatment or services provided by a licensed  
55.4 physician must include services provided by a licensed pharmacist to the extent a licensed  
55.5 pharmacist's services are within the pharmacist's scope of practice.

55.6 Subd. 2. **Denial of benefits.** When paying claims for enrollees in Minnesota, a health  
55.7 maintenance organization must not deny payment for medical services covered by an  
55.8 enrollee's health maintenance contract if the services are lawfully performed by a licensed  
55.9 pharmacist.

55.10 Subd. 3. **Exemptions.** (a) This section does not apply to or affect the coverage or  
55.11 reimbursement for medication therapy management services under section 62Q.676 or  
55.12 256B.0625, subdivisions 5, 13h, and 28a.

55.13 (b) This section does not apply to managed care organizations or county-based purchasing  
55.14 plans when the plan provides coverage to public health care program enrollees under chapter  
55.15 256B or 256L.

55.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
55.17 plans offered, issued, or renewed on or after that date.

55.18 Sec. 12. Minnesota Statutes 2022, section 62D.12, subdivision 19, is amended to read:

55.19 Subd. 19. **Coverage of service.** A health maintenance organization may not deny or  
55.20 limit coverage of a service which the enrollee has already received solely on the basis of  
55.21 lack of prior authorization or second opinion, to the extent that the service would otherwise  
55.22 have been covered under the member's contract by the health maintenance organization had  
55.23 prior authorization or second opinion been obtained. This subdivision expires December  
55.24 31, 2025, for health plans offered, sold, issued, or renewed on or after that date.

55.25 Sec. 13. Minnesota Statutes 2022, section 62D.20, subdivision 1, is amended to read:

55.26 Subdivision 1. **Rulemaking.** The commissioner of health may, pursuant to chapter 14,  
55.27 promulgate such reasonable rules as are necessary or proper to carry out the provisions of  
55.28 sections 62D.01 to 62D.30. Included among such rules shall be those which provide minimum  
55.29 requirements for the provision of comprehensive health maintenance services, as defined  
55.30 in section 62D.02, subdivision 7, and reasonable exclusions therefrom. ~~Nothing in such~~  
55.31 ~~rules shall force or require a health maintenance organization to provide elective, induced~~  
55.32 ~~abortions, except as medically necessary to prevent the death of the mother, whether~~

56.1 ~~performed in a hospital, other abortion facility, or the office of a physician; the rules shall~~  
56.2 ~~provide every health maintenance organization the option of excluding or including elective,~~  
56.3 ~~induced abortions, except as medically necessary to prevent the death of the mother, as part~~  
56.4 ~~of its comprehensive health maintenance services.~~

56.5 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
56.6 plans offered, sold, issued, or renewed on or after that date.

56.7 Sec. 14. Minnesota Statutes 2022, section 62D.22, subdivision 5, is amended to read:

56.8 Subd. 5. **Other state law.** Except as otherwise provided in sections 62A.01 to 62A.42  
56.9 and 62D.01 to 62D.30, ~~and except as they eliminate elective, induced abortions, wherever~~  
56.10 ~~performed, from health or maternity benefits,~~ provisions of the insurance laws and provisions  
56.11 of nonprofit health service plan corporation laws shall not be applicable to any health  
56.12 maintenance organization granted a certificate of authority under sections 62D.01 to 62D.30.

56.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
56.14 plans offered, sold, issued, or renewed on or after that date.

56.15 Sec. 15. Minnesota Statutes 2022, section 62D.22, is amended by adding a subdivision to  
56.16 read:

56.17 Subd. 5a. **Application of other law.** Effective July 1, 2025, sections 145D.30 to 145D.37  
56.18 apply to nonprofit health maintenance organizations operating under this chapter.

56.19 Sec. 16. **[62D.221] OVERSIGHT OF TRANSACTIONS.**

56.20 Subdivision 1. **Insurance provisions applicable to health maintenance**  
56.21 **organizations.** Health maintenance organizations are subject to sections 60A.135, 60A.136,  
56.22 60A.137, 60A.16, 60A.161, 60D.17, 60D.18, and 60D.20 and must comply with the  
56.23 provisions of these sections applicable to insurers. In applying these sections to health  
56.24 maintenance organizations, "commissioner" means the commissioner of health. Health  
56.25 maintenance organizations are subject to Minnesota Rules, chapter 2720, as applicable to  
56.26 sections 60D.17, 60D.18, and 60D.20, and must comply with the provisions of chapter 2720  
56.27 applicable to insurers, unless the commissioner of health adopts rules to implement this  
56.28 subdivision.

56.29 Subd. 2. **Statement.** In addition to the conditions in section 60D.17, subdivision 1,  
56.30 subjecting a health maintenance organization to filing requirements, no person other than  
56.31 the issuer shall acquire all or substantially all of the assets of a domestic nonprofit health  
56.32 maintenance organization through any means unless at the time the offer, request, or

57.1 invitation is made or the agreement is entered into the person has filed with the commissioner  
57.2 and has sent to the health maintenance organization a statement containing the information  
57.3 required in section 60D.17 and the offer, request, invitation, agreement, or acquisition has  
57.4 been approved by the commissioner of health in the manner prescribed in section 60D.17.

57.5 Sec. 17. Minnesota Statutes 2022, section 62M.02, subdivision 1a, is amended to read:

57.6 Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a  
57.7 utilization review organization relating to an admission, extension of stay, or health care  
57.8 service that is partially or wholly adverse to the enrollee, including:

57.9 (1) a decision to deny an admission, extension of stay, or health care service on the basis  
57.10 that it is not medically necessary; or

57.11 (2) an authorization for a health care service that is less intensive than the health care  
57.12 service specified in the original request for authorization.

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

57.14 Sec. 18. Minnesota Statutes 2022, section 62M.02, subdivision 5, is amended to read:

57.15 Subd. 5. **Authorization.** "Authorization" means a determination by a utilization review  
57.16 organization that an admission, extension of stay, or other health care service has been  
57.17 reviewed and that, based on the information provided, it satisfies the utilization review  
57.18 requirements of the applicable health benefit plan and the health plan company or  
57.19 commissioner will then pay for the covered benefit, provided the preexisting limitation  
57.20 provisions, the general exclusion provisions, and any deductible, co-payment, coinsurance,  
57.21 or other policy requirements have been met.

57.22 Sec. 19. Minnesota Statutes 2022, section 62M.02, is amended by adding a subdivision  
57.23 to read:

57.24 Subd. 8a. **Commissioner.** "Commissioner" means, effective January 1, 2026, for the  
57.25 sections specified in section 62M.01, subdivision 3, paragraph (c), the commissioner of  
57.26 human services, unless otherwise specified.

57.27 Sec. 20. Minnesota Statutes 2022, section 62M.02, subdivision 11, is amended to read:

57.28 Subd. 11. **Enrollee.** "Enrollee" means:

57.29 (1) an individual covered by a health benefit plan and includes an insured policyholder,  
57.30 subscriber, contract holder, member, covered person, or certificate holder; or

58.1 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision  
58.2 3, paragraph (c), a recipient receiving coverage through fee-for-service under chapters 256B  
58.3 and 256L.

58.4 Sec. 21. Minnesota Statutes 2022, section 62M.02, subdivision 12, is amended to read:

58.5 Subd. 12. **Health benefit plan.** (a) "Health benefit plan" means:

58.6 (1) a policy, contract, or certificate issued by a health plan company for the coverage of  
58.7 medical, dental, or hospital benefits; or

58.8 (2) effective January 1, 2026, for the sections specified in section 62M.01, subdivision  
58.9 3, paragraph (c), coverage of medical, dental, or hospital benefits through fee-for-service  
58.10 under chapters 256B and 256L, as specified by the commissioner on the agency's public  
58.11 website or through other forms of recipient and provider guidance.

58.12 (b) A health benefit plan does not include coverage that is:

58.13 (1) limited to disability or income protection coverage;

58.14 (2) automobile medical payment coverage;

58.15 (3) supplemental to liability insurance;

58.16 (4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense  
58.17 incurred basis;

58.18 (5) credit accident and health insurance issued under chapter 62B;

58.19 (6) blanket accident and sickness insurance as defined in section 62A.11;

58.20 (7) accident only coverage issued by a licensed and tested insurance agent; or

58.21 (8) workers' compensation.

58.22 Sec. 22. Minnesota Statutes 2022, section 62M.02, subdivision 21, is amended to read:

58.23 Subd. 21. **Utilization review organization.** "Utilization review organization" means an  
58.24 entity including but not limited to an insurance company licensed under chapter 60A to  
58.25 offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;  
58.26 a prepaid limited health service organization issued a certificate of authority and operating  
58.27 under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a  
58.28 health maintenance organization licensed under chapter 62D; a community integrated service  
58.29 network licensed under chapter 62N; an accountable provider network operating under  
58.30 chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance

59.1 employee health plan operating under chapter 62H; a multiple employer welfare arrangement,  
 59.2 as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA),  
 59.3 United States Code, title 29, section 1103, as amended; a third-party administrator licensed  
 59.4 under section 60A.23, subdivision 8, which conducts utilization review and authorizes or  
 59.5 makes adverse determinations regarding an admission, extension of stay, or other health  
 59.6 care services for a Minnesota resident; effective January 1, 2026, for the sections specified  
 59.7 in section 62M.01, subdivision 3, paragraph (c), the commissioner of human services for  
 59.8 purposes of delivering services through fee-for-service under chapters 256B and 256L; any  
 59.9 other entity that provides, offers, or administers hospital, outpatient, medical, prescription  
 59.10 drug, or other health benefits to individuals treated by a health professional under a policy,  
 59.11 plan, or contract; or any entity performing utilization review that is affiliated with, under  
 59.12 contract with, or conducting utilization review on behalf of, a business entity in this state.  
 59.13 Utilization review organization does not include a clinic or health care system acting pursuant  
 59.14 to a written delegation agreement with an otherwise regulated utilization review organization  
 59.15 that contracts with the clinic or health care system. The regulated utilization review  
 59.16 organization is accountable for the delegated utilization review activities of the clinic or  
 59.17 health care system.

59.18 Sec. 23. Minnesota Statutes 2022, section 62M.04, subdivision 1, is amended to read:

59.19 Subdivision 1. **Responsibility for obtaining authorization.** A health benefit plan that  
 59.20 includes utilization review requirements must specify the process for notifying the utilization  
 59.21 review organization in a timely manner and obtaining authorization for health care services.  
 59.22 Each health plan company must provide a clear and concise description of this process to  
 59.23 an enrollee as part of the policy, subscriber contract, or certificate of coverage. Effective  
 59.24 January 1, 2026, the commissioner must provide a clear and concise description of this  
 59.25 process to fee-for-service recipients receiving services under chapters 256B and 256L,  
 59.26 through the agency's public website or through other forms of recipient guidance. In addition  
 59.27 to the enrollee, the utilization review organization must allow any provider or provider's  
 59.28 designee, or responsible patient representative, including a family member, to fulfill the  
 59.29 obligations under the health benefit plan.

59.30 A claims administrator that contracts directly with providers for the provision of health  
 59.31 care services to enrollees may, through contract, require the provider to notify the review  
 59.32 organization in a timely manner and obtain authorization for health care services.

60.1 Sec. 24. Minnesota Statutes 2022, section 62M.05, subdivision 3a, is amended to read:

60.2 Subd. 3a. **Standard review determination.** (a) ~~Notwithstanding subdivision 3b, a~~  
60.3 ~~standard review determination on all requests for utilization review must be communicated~~  
60.4 ~~to the provider and enrollee in accordance with this subdivision within five business days~~  
60.5 ~~after receiving the request if the request is received electronically, or within six business~~  
60.6 ~~days if received through nonelectronic means, provided that all information reasonably~~  
60.7 ~~necessary to make a determination on the request has been made available to the utilization~~  
60.8 ~~review organization. Effective January 1, 2022, A standard review determination on all~~  
60.9 requests for utilization review must be communicated to the provider and enrollee in  
60.10 accordance with this subdivision within five business days after receiving the request,  
60.11 regardless of how the request was received, provided that all information reasonably  
60.12 necessary to make a determination on the request has been made available to the utilization  
60.13 review organization.

60.14 (b) When a determination is made to authorize, notification must be provided promptly  
60.15 by telephone to the provider. The utilization review organization shall send written  
60.16 notification to the provider or shall maintain an audit trail of the determination and telephone  
60.17 notification. For purposes of this subdivision, "audit trail" includes documentation of the  
60.18 telephone notification, including the date; the name of the person spoken to; the enrollee;  
60.19 the service, procedure, or admission authorized; and the date of the service, procedure, or  
60.20 admission. If the utilization review organization indicates authorization by use of a number,  
60.21 the number must be called the "authorization number." For purposes of this subdivision,  
60.22 notification may also be made by facsimile to a verified number or by electronic mail to a  
60.23 secure electronic mailbox. These electronic forms of notification satisfy the "audit trail"  
60.24 requirement of this paragraph.

60.25 (c) When an adverse determination is made, notification must be provided within the  
60.26 time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or  
60.27 by electronic mail to a secure electronic mailbox to the attending health care professional  
60.28 and hospital or physician office as applicable. Written notification must also be sent to the  
60.29 hospital or physician office as applicable and attending health care professional if notification  
60.30 occurred by telephone. For purposes of this subdivision, notification may be made by  
60.31 facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written  
60.32 notification must be sent to the enrollee and may be sent by United States mail, facsimile  
60.33 to a verified number, or by electronic mail to a secure mailbox. The written notification  
60.34 must include all reasons relied on by the utilization review organization for the determination  
60.35 and the process for initiating an appeal of the determination. Upon request, the utilization

61.1 review organization shall provide the provider or enrollee with the criteria used to determine  
61.2 the necessity, appropriateness, and efficacy of the health care service and identify the  
61.3 database, professional treatment parameter, or other basis for the criteria. Reasons for an  
61.4 adverse determination may include, among other things, the lack of adequate information  
61.5 to authorize after a reasonable attempt has been made to contact the provider or enrollee.

61.6 (d) When an adverse determination is made, the written notification must inform the  
61.7 enrollee and the attending health care professional of the right to submit an appeal to the  
61.8 internal appeal process described in section 62M.06 and the procedure for initiating the  
61.9 internal appeal. The written notice shall be provided in a culturally and linguistically  
61.10 appropriate manner consistent with the provisions of the Affordable Care Act as defined  
61.11 under section 62A.011, subdivision 1a.

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

61.13 Sec. 25. Minnesota Statutes 2022, section 62M.07, subdivision 2, is amended to read:

61.14 Subd. 2. **Prior authorization of emergency certain services prohibited.** No utilization  
61.15 review organization, health plan company, or claims administrator may conduct or require  
61.16 prior authorization of:

61.17 (1) emergency confinement or an emergency service. The enrollee or the enrollee's  
61.18 authorized representative may be required to notify the health plan company, claims  
61.19 administrator, or utilization review organization as soon as reasonably possible after the  
61.20 beginning of the emergency confinement or emergency service;

61.21 (2) outpatient mental health treatment or outpatient substance use disorder treatment,  
61.22 except for treatment which is a medication. Prior authorizations required for medications  
61.23 used for outpatient mental health treatment or outpatient substance use disorder treatment  
61.24 must be processed according to section 62M.05, subdivision 3b, for initial determinations,  
61.25 and according to section 62M.06, subdivision 2, for appeals;

61.26 (3) antineoplastic cancer treatment that is consistent with guidelines of the National  
61.27 Comprehensive Cancer Network, except for treatment which is a medication. Prior  
61.28 authorizations required for medications used for antineoplastic cancer treatment must be  
61.29 processed according to section 62M.05, subdivision 3b, for initial determinations, and  
61.30 according to section 62M.06, subdivision 2, for appeals;

61.31 (4) services that currently have a rating of A or B from the United States Preventive  
61.32 Services Task Force, immunizations recommended by the Advisory Committee on  
61.33 Immunization Practices of the Centers for Disease Control and Prevention, or preventive

62.1 services and screenings provided to women as described in Code of Federal Regulations,  
62.2 title 45, section 147.130;

62.3 (5) pediatric hospice services provided by a hospice provider licensed under sections  
62.4 144A.75 to 144A.755; and

62.5 (6) treatment delivered through a neonatal abstinence program operated by pediatric  
62.6 pain or palliative care subspecialists.

62.7 Clauses (2) to (6) are effective January 1, 2026, and apply to health benefit plans offered,  
62.8 sold, issued, or renewed on or after that date.

62.9 Sec. 26. Minnesota Statutes 2022, section 62M.07, subdivision 4, is amended to read:

62.10 Subd. 4. **Submission of prior authorization requests.** (a) If prior authorization for a  
62.11 health care service is required, the utilization review organization, health plan company, or  
62.12 claim administrator must allow providers to submit requests for prior authorization of the  
62.13 health care services without unreasonable delay by telephone, facsimile, or voice mail or  
62.14 through an electronic mechanism 24 hours a day, seven days a week. This subdivision does  
62.15 not apply to dental service covered under MinnesotaCare or medical assistance.

62.16 (b) Effective January 1, 2027, for health benefit plans offered, sold, issued, or renewed  
62.17 on or after that date, utilization review organizations, health plan companies, and claims  
62.18 administrators must have and maintain a prior authorization application programming  
62.19 interface (API) that automates the prior authorization process for health care services,  
62.20 excluding prescription drugs and medications. The API must allow providers to determine  
62.21 whether a prior authorization is required for health care services, identify prior authorization  
62.22 information and documentation requirements, and facilitate the exchange of prior  
62.23 authorization requests and determinations from provider electronic health records or practice  
62.24 management systems. The API must use the Health Level Seven (HL7) Fast Healthcare  
62.25 Interoperability Resources (FHIR) standard in accordance with Code of Federal Regulations,  
62.26 title 45, section 170.215(a)(1), and the most recent standards and guidance adopted by the  
62.27 United States Department of Health and Human Services to implement that section. Prior  
62.28 authorization submission requests for prescription drugs and medications must comply with  
62.29 the requirements of section 62J.497.

63.1 Sec. 27. Minnesota Statutes 2022, section 62M.07, is amended by adding a subdivision  
63.2 to read:

63.3 Subd. 5. **Treatment of a chronic condition.** This subdivision is effective January 1,  
63.4 2026, and applies to health benefit plans offered, sold, issued, or renewed on or after that  
63.5 date. An authorization for treatment of a chronic health condition does not expire unless  
63.6 the standard of treatment for that health condition changes. A chronic health condition is a  
63.7 condition that is expected to last one year or more and:

63.8 (1) requires ongoing medical attention to effectively manage the condition or prevent  
63.9 an adverse health event; or

63.10 (2) limits one or more activities of daily living.

63.11 Sec. 28. Minnesota Statutes 2022, section 62M.10, subdivision 7, is amended to read:

63.12 **Subd. 7. Availability of criteria.** (a) For utilization review determinations other than  
63.13 prior authorization, a utilization review organization shall, upon request, provide to an  
63.14 enrollee, a provider, and the commissioner of commerce the criteria used to determine the  
63.15 medical necessity, appropriateness, and efficacy of a procedure or service and identify the  
63.16 database, professional treatment guideline, or other basis for the criteria.

63.17 (b) For prior authorization determinations, a utilization review organization must submit  
63.18 the organization's current prior authorization requirements and restrictions, including written,  
63.19 evidence-based, clinical criteria used to make an authorization or adverse determination, to  
63.20 all health plan companies for which the organization performs utilization review. A health  
63.21 plan company must post on its public website the prior authorization requirements and  
63.22 restrictions of any utilization review organization that performs utilization review for the  
63.23 health plan company. These prior authorization requirements and restrictions must be detailed  
63.24 and written in language that is easily understandable to providers. This paragraph does not  
63.25 apply to the commissioner of human services when delivering services through fee-for-service  
63.26 under chapters 256B and 256L.

63.27 (c) Effective January 1, 2026, the commissioner of human services must post on the  
63.28 department's public website the prior authorization requirements and restrictions, including  
63.29 written, evidence-based, clinical criteria used to make an authorization or adverse  
63.30 determination, that apply to prior authorization determinations for fee-for-service under  
63.31 chapters 256B and 256L. These prior authorization requirements and restrictions must be  
63.32 detailed and written in language that is easily understandable to providers.

64.1 Sec. 29. Minnesota Statutes 2022, section 62M.10, subdivision 8, is amended to read:

64.2 Subd. 8. **Notice; new prior authorization requirements or restrictions; change to**  
64.3 **existing requirement or restriction.** (a) Before a utilization review organization may  
64.4 implement a new prior authorization requirement or restriction or amend an existing prior  
64.5 authorization requirement or restriction, the utilization review organization must submit the  
64.6 new or amended requirement or restriction to all health plan companies for which the  
64.7 organization performs utilization review. A health plan company must post on its website  
64.8 the new or amended requirement or restriction. This paragraph does not apply to the  
64.9 commissioner of human services when delivering services through fee-for-service under  
64.10 chapters 256B and 256L.

64.11 (b) At least 45 days before a new prior authorization requirement or restriction or an  
64.12 amended existing prior authorization requirement or restriction is implemented, the utilization  
64.13 review organization, health plan company, or claims administrator must provide written or  
64.14 electronic notice of the new or amended requirement or restriction to all Minnesota-based,  
64.15 in-network attending health care professionals who are subject to the prior authorization  
64.16 requirements and restrictions. This paragraph does not apply to the commissioner of human  
64.17 services when delivering services through fee-for-service under chapters 256B and 256L.

64.18 (c) Effective January 1, 2026, before the commissioner of human services may implement  
64.19 a new prior authorization requirement or restriction or amend an existing prior authorization  
64.20 requirement or restriction, the commissioner, at least 45 days before the new or amended  
64.21 requirement or restriction takes effect, must provide written or electronic notice of the new  
64.22 or amended requirement or restriction, to all health care professionals participating as  
64.23 fee-for-service providers under chapters 256B and 256L who are subject to the prior  
64.24 authorization requirements and restrictions.

64.25 Sec. 30. Minnesota Statutes 2022, section 62M.17, subdivision 2, is amended to read:

64.26 Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan  
64.27 year, a utilization review organization changes coverage terms for a health care service or  
64.28 the clinical criteria used to conduct prior authorizations for a health care service, the change  
64.29 in coverage terms or change in clinical criteria shall not apply until the next plan year for  
64.30 any enrollee who received prior authorization for a health care service using the coverage  
64.31 terms or clinical criteria in effect before the effective date of the change.

64.32 (b) Paragraph (a) does not apply if a utilization review organization changes coverage  
64.33 terms for a drug or device that has been deemed unsafe by the United States Food and Drug  
64.34 Administration (FDA); that has been withdrawn by either the FDA or the product

65.1 manufacturer; or when an independent source of research, clinical guidelines, or  
65.2 evidence-based standards has issued drug- or device-specific warnings or recommended  
65.3 changes in drug or device usage.

65.4 (c) Paragraph (a) does not apply if a utilization review organization changes coverage  
65.5 terms for a service or the clinical criteria used to conduct prior authorizations for a service  
65.6 when an independent source of research, clinical guidelines, or evidence-based standards  
65.7 has recommended changes in usage of the service for reasons related to patient harm. This  
65.8 paragraph expires December 31, 2025, for health benefit plans offered, sold, issued, or  
65.9 renewed on or after that date.

65.10 (d) Effective January 1, 2026, and applicable to health benefit plans offered, sold, issued,  
65.11 or renewed on or after that date, paragraph (a) does not apply if a utilization review  
65.12 organization changes coverage terms for a service or the clinical criteria used to conduct  
65.13 prior authorizations for a service when an independent source of research, clinical guidelines,  
65.14 or evidence-based standards has recommended changes in usage of the service for reasons  
65.15 related to previously unknown and imminent patient harm.

65.16 ~~(d)~~ (e) Paragraph (a) does not apply if a utilization review organization removes a brand  
65.17 name drug from its formulary or places a brand name drug in a benefit category that increases  
65.18 the enrollee's cost, provided the utilization review organization (1) adds to its formulary a  
65.19 generic or multisource brand name drug rated as therapeutically equivalent according to  
65.20 the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA  
65.21 Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to  
65.22 prescribers, pharmacists, and affected enrollees.

65.23 Sec. 31. **[62M.19] ANNUAL REPORT TO COMMISSIONER OF HEALTH; PRIOR**  
65.24 **AUTHORIZATIONS.**

65.25 On or before September 1 each year, each utilization review organization must report  
65.26 to the commissioner of health, in a form and manner specified by the commissioner,  
65.27 information on prior authorization requests for the previous calendar year. The report  
65.28 submitted under this subdivision must include the following data:

65.29 (1) the total number of prior authorization requests received;

65.30 (2) the number of prior authorization requests for which an authorization was issued;

65.31 (3) the number of prior authorization requests for which an adverse determination was  
65.32 issued;

65.33 (4) the number of adverse determinations reversed on appeal;

66.1 (5) the 25 codes with the highest number of prior authorization requests and the  
66.2 percentage of authorizations for each of these codes;

66.3 (6) the 25 codes with the highest percentage of prior authorization requests for which  
66.4 an authorization was issued and the total number of the requests;

66.5 (7) the 25 codes with the highest percentage of prior authorization requests for which  
66.6 an adverse determination was issued but which was reversed on appeal and the total number  
66.7 of the requests;

66.8 (8) the 25 codes with the highest percentage of prior authorization requests for which  
66.9 an adverse determination was issued and the total number of the requests; and

66.10 (9) the reasons an adverse determination to a prior authorization request was issued,  
66.11 expressed as a percentage of all adverse determinations. The reasons listed may include but  
66.12 are not limited to:

66.13 (i) the patient did not meet prior authorization criteria;

66.14 (ii) incomplete information was submitted by the provider to the utilization review  
66.15 organization;

66.16 (iii) the treatment program changed; and

66.17 (iv) the patient is no longer covered by the health benefit plan.

66.18 Sec. 32. Minnesota Statutes 2022, section 62Q.097, is amended by adding a subdivision  
66.19 to read:

66.20 Subd. 3. **Prohibited application questions.** An application for provider credentialing  
66.21 must not:

66.22 (1) require the provider to disclose past health conditions;

66.23 (2) require the provider to disclose current health conditions, if the provider is being  
66.24 treated so that the condition does not affect the provider's ability to practice medicine; or

66.25 (3) require the disclosure of any health conditions that would not affect the provider's  
66.26 ability to practice medicine in a competent, safe, and ethical manner.

66.27 **EFFECTIVE DATE.** This section applies to applications for provider credentialing  
66.28 submitted to a health plan company on or after January 1, 2025.

67.1 Sec. 33. Minnesota Statutes 2022, section 62Q.14, is amended to read:

67.2 **62Q.14 RESTRICTIONS ON ENROLLEE SERVICES.**

67.3 No health plan company may restrict the choice of an enrollee as to where the enrollee  
67.4 receives services related to:

67.5 (1) the voluntary planning of the conception and bearing of children, ~~provided that this~~  
67.6 ~~clause does not refer to abortion services;~~

67.7 (2) the diagnosis of infertility;

67.8 (3) the testing and treatment of a sexually transmitted disease; and

67.9 (4) the testing for AIDS or other HIV-related conditions.

67.10 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
67.11 plans offered, sold, issued, or renewed on or after that date.

67.12 Sec. 34. Minnesota Statutes 2022, section 62Q.19, subdivision 3, is amended to read:

67.13 Subd. 3. **Health plan company affiliation.** A health plan company must offer a provider  
67.14 contract to ~~any~~ all designated essential community ~~provider~~ providers located within the  
67.15 area served by the health plan company. A health plan company must include all essential  
67.16 community providers that have accepted a contract in each of the company's provider  
67.17 networks. A health plan company shall not restrict enrollee access to services designated  
67.18 to be provided by the essential community provider for the population that the essential  
67.19 community provider is certified to serve. A health plan company may also make other  
67.20 providers available for these services. A health plan company may require an essential  
67.21 community provider to meet all data requirements, utilization review, and quality assurance  
67.22 requirements on the same basis as other health plan providers.

67.23 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
67.24 plans offered, issued, or renewed on or after that date.

67.25 Sec. 35. Minnesota Statutes 2022, section 62Q.19, is amended by adding a subdivision to  
67.26 read:

67.27 Subd. 4a. **Contract payment rates; private.** An essential community provider and a  
67.28 health plan company may negotiate the payment rate for covered services provided by the  
67.29 essential community provider. This rate must be at least the same rate per unit of service  
67.30 as is paid by the health plan company to the essential community provider under the provider  
67.31 contract between the two with the highest number of enrollees receiving health care services

68.1 from the provider or, if there is no provider contract between the health plan company and  
68.2 the essential community provider, the rate must be at least the same rate per unit of service  
68.3 as is paid to other plan providers for the same or similar services. The provider contract  
68.4 used to set the rate under this subdivision must be in relation to an individual, small group,  
68.5 or large group health plan. This subdivision applies only to provider contracts in relation  
68.6 to individual, small employer, and large group health plans.

68.7 Sec. 36. Minnesota Statutes 2022, section 62Q.19, subdivision 5, is amended to read:

68.8 Subd. 5. **Contract payment rates; public.** An essential community provider and a  
68.9 health plan company may negotiate the payment rate for covered services provided by the  
68.10 essential community provider. This rate must be at least the same rate per unit of service  
68.11 as is paid to other health plan providers for the same or similar services. This subdivision  
68.12 applies only to provider contracts in relation to health plans offered through the State  
68.13 Employee Group Insurance Program, medical assistance, and MinnesotaCare.

68.14 Sec. 37. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a  
68.15 subdivision to read:

68.16 Subd. 3. **Reimbursement.** (a) The commissioner of commerce must reimburse health  
68.17 plan companies for coverage under this section. Reimbursement is available only for coverage  
68.18 that would not have been provided by the health plan without the requirements of this  
68.19 section. Treatments and services covered by the health plan as of January 1, 2023, are  
68.20 ineligible for payment under this subdivision by the commissioner of commerce.

68.21 (b) Health plan companies must report to the commissioner of commerce quantified  
68.22 costs attributable to the additional benefit under this section in a format developed by the  
68.23 commissioner. A health plan's coverage as of January 1, 2023, must be used by the health  
68.24 plan company as the basis for determining whether coverage would not have been provided  
68.25 by the health plan for purposes of this subdivision.

68.26 (c) The commissioner of commerce must evaluate submissions and make payments to  
68.27 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

68.28 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
68.29 plans offered, issued, or renewed on or after that date.

69.1 Sec. 38. Minnesota Statutes 2023 Supplement, section 62Q.473, is amended by adding a  
69.2 subdivision to read:

69.3 Subd. 4. **Appropriation.** Each fiscal year, an amount necessary to make payments to  
69.4 health plan companies to defray the cost of providing coverage under this section is  
69.5 appropriated to the commissioner of commerce.

69.6 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
69.7 plans offered, issued, or renewed on or after that date.

69.8 Sec. 39. **[62Q.524] COVERAGE OF ABORTIONS AND ABORTION-RELATED**  
69.9 **SERVICES.**

69.10 Subdivision 1. **Definition.** For purposes of this section, "abortion" means any medical  
69.11 treatment intended to induce the termination of a pregnancy with a purpose other than  
69.12 producing a live birth.

69.13 Subd. 2. **Required coverage.** (a) A health plan must provide coverage for abortions and  
69.14 abortion-related services, including preabortion services and follow-up services.

69.15 (b) A health plan must not impose on the coverage under this section any co-payment,  
69.16 coinsurance, deductible, or other enrollee cost-sharing that is greater than the cost-sharing  
69.17 that applies to similar services covered under the health plan.

69.18 (c) A health plan must not impose any limitation on the coverage under this section,  
69.19 including but not limited to any utilization review, prior authorization, referral requirements,  
69.20 restrictions, or delays, that is not generally applicable to other coverages under the plan.

69.21 Subd. 3. **Exclusion.** This section does not apply to managed care organizations or  
69.22 county-based purchasing plans when the plan provides coverage to public health care  
69.23 program enrollees under chapter 256B or 256L.

69.24 Subd. 4. **Reimbursement.** (a) The commissioner of commerce must reimburse health  
69.25 plan companies for coverage under this section. Reimbursement is available only for coverage  
69.26 that would not have been provided by the health plan without the requirements of this  
69.27 section. Treatments and services covered by the health plan as of January 1, 2024, are  
69.28 ineligible for payment under this subdivision by the commissioner of commerce.

69.29 (b) Health plan companies must report to the commissioner of commerce quantified  
69.30 costs attributable to the additional benefit under this section in a format developed by the  
69.31 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health

70.1 plan company as the basis for determining whether coverage would not have been provided  
70.2 by the health plan for purposes of this subdivision.

70.3 (c) The commissioner of commerce must evaluate submissions and make payments to  
70.4 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

70.5 Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to  
70.6 health plan companies to defray the cost of providing coverage under this section is  
70.7 appropriated to the commissioner of commerce.

70.8 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
70.9 plans offered, sold, issued, or renewed on or after that date.

70.10 Sec. 40. **[62Q.531] AMINO ACID-BASED FORMULA COVERAGE.**

70.11 Subdivision 1. **Definition.** (a) For purposes of this section, the following term has the  
70.12 meaning given.

70.13 (b) "Formula" means an amino acid-based elemental formula.

70.14 Subd. 2. **Required coverage.** A health plan company must provide coverage for formula  
70.15 when formula is medically necessary.

70.16 Subd. 3. **Covered conditions.** Conditions for which formula is medically necessary  
70.17 include but are not limited to:

70.18 (1) cystic fibrosis;

70.19 (2) amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;

70.20 (3) IgE mediated allergies to food proteins;

70.21 (4) food protein-induced enterocolitis syndrome;

70.22 (5) eosinophilic esophagitis;

70.23 (6) eosinophilic gastroenteritis;

70.24 (7) eosinophilic colitis; and

70.25 (8) mast cell activation syndrome.

70.26 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
70.27 plans offered, issued, or sold on or after that date.

71.1 Sec. 41. **[62Q.665] COVERAGE FOR ORTHOTIC AND PROSTHETIC DEVICES.**

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

71.4 (b) "Accredited facility" means any entity that is accredited to provide comprehensive  
71.5 orthotic or prosthetic devices or services by a Centers for Medicare and Medicaid Services  
71.6 approved accrediting agency.

71.7 (c) "Orthosis" means:

71.8 (1) an external medical device that is:

71.9 (i) custom-fabricated or custom-fitted to a specific patient based on the patient's unique  
71.10 physical condition;

71.11 (ii) applied to a part of the body to correct a deformity, provide support and protection,  
71.12 restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or  
71.13 postoperative condition; and

71.14 (iii) deemed medically necessary by a prescribing physician or licensed health care  
71.15 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,  
71.16 and services; and

71.17 (2) any provision, repair, or replacement of a device that is furnished or performed by:

71.18 (i) an accredited facility in comprehensive orthotic services; or

71.19 (ii) a health care provider licensed in Minnesota and operating within the provider's  
71.20 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,  
71.21 or services.

71.22 (d) "Orthotics" means:

71.23 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,  
71.24 fitting, adjusting, or servicing and providing the initial training necessary to accomplish the  
71.25 fitting of an orthotic device for the support, correction, or alleviation of a neuromuscular  
71.26 or musculoskeletal dysfunction, disease, injury, or deformity;

71.27 (2) evaluation, treatment, and consultation related to an orthotic device;

71.28 (3) basic observation of gait and postural analysis;

71.29 (4) assessing and designing orthosis to maximize function and provide support and  
71.30 alignment necessary to prevent or correct a deformity or to improve the safety and efficiency  
71.31 of mobility and locomotion;

72.1 (5) continuing patient care to assess the effect of an orthotic device on the patient's  
72.2 tissues; and

72.3 (6) proper fit and function of the orthotic device by periodic evaluation.

72.4 (e) "Prosthesis" means:

72.5 (1) an external medical device that is:

72.6 (i) used to replace or restore a missing limb, appendage, or other external human body  
72.7 part; and

72.8 (ii) deemed medically necessary by a prescribing physician or licensed health care  
72.9 provider who has authority in Minnesota to prescribe orthotic and prosthetic devices, supplies,  
72.10 and services; and

72.11 (2) any provision, repair, or replacement of a device that is furnished or performed by:

72.12 (i) an accredited facility in comprehensive prosthetic services; or

72.13 (ii) a health care provider licensed in Minnesota and operating within the provider's  
72.14 scope of practice which allows the provider to provide orthotic or prosthetic devices, supplies,  
72.15 or services.

72.16 (f) "Prosthetics" means:

72.17 (1) the science and practice of evaluating, measuring, designing, fabricating, assembling,  
72.18 fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary  
72.19 to accomplish the fitting of, a prosthesis through the replacement of external parts of a  
72.20 human body lost due to amputation or congenital deformities or absences;

72.21 (2) the generation of an image, form, or mold that replicates the patient's body segment  
72.22 and that requires rectification of dimensions, contours, and volumes for use in the design  
72.23 and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial  
72.24 appendage that is designed either to support body weight or to improve or restore function  
72.25 or anatomical appearance, or both;

72.26 (3) observational gait analysis and clinical assessment of the requirements necessary to  
72.27 refine and mechanically fix the relative position of various parts of the prosthesis to maximize  
72.28 function, stability, and safety of the patient;

72.29 (4) providing and continuing patient care in order to assess the prosthetic device's effect  
72.30 on the patient's tissues; and

72.31 (5) assuring proper fit and function of the prosthetic device by periodic evaluation.

73.1 Subd. 2. Coverage. (a) A health plan must provide coverage for orthotic and prosthetic  
73.2 devices, supplies, and services, including repair and replacement, at least equal to the  
73.3 coverage provided under federal law for health insurance for the aged and disabled under  
73.4 sections 1832, 1833, and 1834 of the Social Security Act, United States Code, title 42,  
73.5 sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

73.6 (b) A health plan must not subject orthotic and prosthetic benefits to separate financial  
73.7 requirements that apply only with respect to those benefits. A health plan may impose  
73.8 co-payment and coinsurance amounts on those benefits, except that any financial  
73.9 requirements that apply to such benefits must not be more restrictive than the financial  
73.10 requirements that apply to the health plan's medical and surgical benefits, including those  
73.11 for internal restorative devices.

73.12 (c) A health plan may limit the benefits for, or alter the financial requirements for,  
73.13 out-of-network coverage of prosthetic and orthotic devices, except that the restrictions and  
73.14 requirements that apply to those benefits must not be more restrictive than the financial  
73.15 requirements that apply to the out-of-network coverage for the health plan's medical and  
73.16 surgical benefits.

73.17 (d) A health plan must cover orthoses and prostheses when furnished under an order by  
73.18 a prescribing physician or licensed health care prescriber who has authority in Minnesota  
73.19 to prescribe orthoses and prostheses, and that coverage for orthotic and prosthetic devices,  
73.20 supplies, accessories, and services must include those devices or device systems, supplies,  
73.21 accessories, and services that are customized to the covered individual's needs.

73.22 (e) A health plan must cover orthoses and prostheses determined by the enrollee's provider  
73.23 to be the most appropriate model that meets the medical needs of the enrollee for purposes  
73.24 of performing physical activities, as applicable, including but not limited to running, biking,  
73.25 and swimming, and maximizing the enrollee's limb function.

73.26 (f) A health plan must cover orthoses and prostheses for showering or bathing.

73.27 Subd. 3. Prior authorization. A health plan may require prior authorization for orthotic  
73.28 and prosthetic devices, supplies, and services in the same manner and to the same extent as  
73.29 prior authorization is required for any other covered benefit.

73.30 Subd. 4. Reimbursement. (a) The commissioner of commerce must reimburse health  
73.31 plan companies for coverage under this section. Reimbursement is available only for coverage  
73.32 that would not have been provided by the health plan without the requirements of this  
73.33 section. Treatments and services covered by the health plan as of January 1, 2024, are  
73.34 ineligible for payment under this subdivision by the commissioner of commerce.

74.1 (b) Health plan companies must report to the commissioner of commerce quantified  
74.2 costs attributable to the additional benefit under this section in a format developed by the  
74.3 commissioner. A health plan's coverage as of January 1, 2024, must be used by the health  
74.4 plan company as the basis for determining whether coverage would not have been provided  
74.5 by the health plan for purposes of this subdivision.

74.6 (c) The commissioner of commerce must evaluate submissions and make payments to  
74.7 health plan companies as provided in Code of Federal Regulations, title 45, section 155.170.

74.8 Subd. 5. **Appropriation.** Each fiscal year, an amount necessary to make payments to  
74.9 health plan companies to defray the cost of providing coverage under this section is  
74.10 appropriated to the commissioner of commerce.

74.11 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health  
74.12 plans offered, issued, or renewed on or after that date.

74.13 Sec. 42. **[62Q.6651] MEDICAL NECESSITY AND NONDISCRIMINATION**  
74.14 **STANDARDS FOR COVERAGE OF PROSTHETICS OR ORTHOTICS.**

74.15 (a) When performing a utilization review for a request for coverage of prosthetic or  
74.16 orthotic benefits, a health plan company shall apply the most recent version of evidence-based  
74.17 treatment and fit criteria as recognized by relevant clinical specialists.

74.18 (b) A health plan company shall render utilization review determinations in a  
74.19 nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative  
74.20 benefits, including prosthetics or orthotics, solely on the basis of an enrollee's actual or  
74.21 perceived disability.

74.22 (c) A health plan company shall not deny a prosthetic or orthotic benefit for an individual  
74.23 with limb loss or absence that would otherwise be covered for a nondisabled person seeking  
74.24 medical or surgical intervention to restore or maintain the ability to perform the same  
74.25 physical activity.

74.26 (d) A health plan offered, issued, or renewed in Minnesota that offers coverage for  
74.27 prosthetics and custom orthotic devices shall include language describing an enrollee's rights  
74.28 pursuant to paragraphs (b) and (c) in its evidence of coverage and any benefit denial letters.

74.29 (e) A health plan that provides coverage for prosthetic or orthotic services shall ensure  
74.30 access to medically necessary clinical care and to prosthetic and custom orthotic devices  
74.31 and technology from not less than two distinct prosthetic and custom orthotic providers in  
74.32 the plan's provider network located in Minnesota. In the event that medically necessary  
74.33 covered orthotics and prosthetics are not available from an in-network provider, the health

75.1 plan company shall provide processes to refer a member to an out-of-network provider and  
75.2 shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member  
75.3 cost sharing determined on an in-network basis.

75.4 (f) If coverage for prosthetic or custom orthotic devices is provided, payment shall be  
75.5 made for the replacement of a prosthetic or custom orthotic device or for the replacement  
75.6 of any part of the devices, without regard to continuous use or useful lifetime restrictions,  
75.7 if an ordering health care provider determines that the provision of a replacement device,  
75.8 or a replacement part of a device, is necessary because:

75.9 (1) of a change in the physiological condition of the patient;

75.10 (2) of an irreparable change in the condition of the device or in a part of the device; or

75.11 (3) the condition of the device, or the part of the device, requires repairs and the cost of  
75.12 the repairs would be more than 60 percent of the cost of a replacement device or of the part  
75.13 being replaced.

75.14 (g) Confirmation from a prescribing health care provider may be required if the prosthetic  
75.15 or custom orthotic device or part being replaced is less than three years old.

75.16 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to all health  
75.17 plans offered, issued, or renewed on or after that date.

75.18 Sec. 43. **[62Q.666] INTERMITTENT CATHETERS.**

75.19 Subdivision 1. **Required coverage.** A health plan must provide coverage for intermittent  
75.20 urinary catheters and insertion supplies if intermittent catheterization is recommended by  
75.21 the enrollee's health care provider. At least 180 intermittent catheters per month with insertion  
75.22 supplies must be covered unless a lesser amount is prescribed by the enrollee's health care  
75.23 provider. A health plan providing coverage under the medical assistance program may be  
75.24 required to provide coverage for more than 180 intermittent catheters per month with  
75.25 insertion supplies.

75.26 Subd. 2. **Cost-sharing requirements.** A health plan is prohibited from imposing a  
75.27 deductible, co-payment, coinsurance, or other restriction on intermittent catheters and  
75.28 insertion supplies that the health plan does not apply to durable medical equipment in general.

75.29 **EFFECTIVE DATE.** This section is effective for any health plan issued or renewed  
75.30 on or after January 1, 2025.

76.1 Sec. 44. [62Q.679] RELIGIOUS OBJECTIONS.

76.2 Subdivision 1. Definitions. (a) The definitions in this subdivision apply to this section.

76.3 (b) "Closely held for-profit entity" means an entity that is not a nonprofit entity, has  
76.4 more than 50 percent of the value of its ownership interest owned directly or indirectly by  
76.5 five or fewer owners, and has no publicly traded ownership interest. For purposes of this  
76.6 paragraph:

76.7 (1) ownership interests owned by a corporation, partnership, limited liability company,  
76.8 estate, trust, or similar entity are considered owned by that entity's shareholders, partners,  
76.9 members, or beneficiaries in proportion to their interest held in the corporation, partnership,  
76.10 limited liability company, estate, trust, or similar entity;

76.11 (2) ownership interests owned by a nonprofit entity are considered owned by a single  
76.12 owner;

76.13 (3) ownership interests owned by all individuals in a family are considered held by a  
76.14 single owner. For purposes of this clause, "family" means brothers and sisters, including  
76.15 half-brothers and half-sisters, a spouse, ancestors, and lineal descendants; and

76.16 (4) if an individual or entity holds an option, warrant, or similar right to purchase an  
76.17 ownership interest, the individual or entity is considered to be the owner of those ownership  
76.18 interests.

76.19 (c) "Eligible organization" means an organization that opposes covering some or all  
76.20 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on account of religious  
76.21 objections and that is:

76.22 (1) organized as a nonprofit entity and holds itself out to be religious; or

76.23 (2) organized and operates as a closely held for-profit entity, and the organization's  
76.24 owners or highest governing body has adopted, under the organization's applicable rules of  
76.25 governance and consistent with state law, a resolution or similar action establishing that the  
76.26 organization objects to covering some or all health benefits under section 62Q.522, 62Q.524,  
76.27 or 62Q.585 on account of the owners' sincerely held religious beliefs.

76.28 (d) "Exempt organization" means an organization that is organized and operates as a  
76.29 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal  
76.30 Revenue Code of 1986, as amended.

76.31 Subd. 2. Exemption. (a) An exempt organization is not required to provide coverage  
76.32 under section 62Q.522, 62Q.524, or 62Q.585 if the exempt organization has religious

77.1 objections to the coverage. An exempt organization that chooses to not provide coverage  
77.2 pursuant to this paragraph must notify employees as part of the hiring process and must  
77.3 notify all employees at least 30 days before:

77.4 (1) an employee enrolls in the health plan; or

77.5 (2) the effective date of the health plan, whichever occurs first.

77.6 (b) If the exempt organization provides partial coverage under section 62Q.522, 62Q.524,  
77.7 or 62Q.585, the notice required under paragraph (a) must provide a list of the portions of  
77.8 such coverage which the organization refuses to cover.

77.9 Subd. 3. **Accommodation for eligible organizations.** (a) A health plan established or  
77.10 maintained by an eligible organization complies with the coverage requirements of section  
77.11 62Q.522, 62Q.524, or 62Q.585, with respect to the health benefits identified in the notice  
77.12 under this paragraph, if the eligible organization provides notice to any health plan company  
77.13 with which the eligible organization contracts that it is an eligible organization and that the  
77.14 eligible organization has a religious objection to coverage for all or a subset of the health  
77.15 benefits under section 62Q.522, 62Q.524, or 62Q.585.

77.16 (b) The notice from an eligible organization to a health plan company under paragraph  
77.17 (a) must include: (1) the name of the eligible organization; (2) a statement that it objects to  
77.18 coverage for some or all of the health benefits under section 62Q.522, 62Q.524, or 62Q.585,  
77.19 including a list of the health benefits to which the eligible organization objects, if applicable;  
77.20 and (3) the health plan name. The notice must be executed by a person authorized to provide  
77.21 notice on behalf of the eligible organization.

77.22 (c) An eligible organization must provide a copy of the notice under paragraph (a) to  
77.23 prospective employees as part of the hiring process and to all employees at least 30 days  
77.24 before:

77.25 (1) an employee enrolls in the health plan; or

77.26 (2) the effective date of the health plan, whichever occurs first.

77.27 (d) A health plan company that receives a copy of the notice under paragraph (a) with  
77.28 respect to a health plan established or maintained by an eligible organization must, for all  
77.29 future enrollments in the health plan:

77.30 (1) expressly exclude coverage for those health benefits identified in the notice under  
77.31 paragraph (a) from the health plan; and

78.1 (2) provide separate payments for any health benefits required to be covered under  
78.2 section 62Q.522, 62Q.524, or 62Q.585 for enrollees as long as the enrollee remains enrolled  
78.3 in the health plan.

78.4 (e) The health plan company must not impose any cost-sharing requirements, including  
78.5 co-pays, deductibles, or coinsurance, or directly or indirectly impose any premium, fee, or  
78.6 other charge for the health benefits under section 62Q.522 on the enrollee. The health plan  
78.7 company must not directly or indirectly impose any premium, fee, or other charge for the  
78.8 health benefits under section 62Q.522, 62Q.524, or 62Q.585 on the eligible organization  
78.9 or health plan.

78.10 (f) On January 1, 2025, and every year thereafter a health plan company must notify the  
78.11 commissioner, in a manner determined by the commissioner, of the number of eligible  
78.12 organizations granted an accommodation under this subdivision.

78.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to health  
78.14 plans offered, sold, issued, or renewed on or after that date.

78.15 Sec. 45. Minnesota Statutes 2022, section 62Q.73, subdivision 2, is amended to read:

78.16 Subd. 2. **Exception.** (a) This section does not apply to governmental programs except  
78.17 as permitted under paragraph (b). For purposes of this subdivision, "governmental programs"  
78.18 means the prepaid medical assistance program; effective January 1, 2026, the medical  
78.19 assistance fee-for-service program; the MinnesotaCare program; the demonstration project  
78.20 for people with disabilities; and the federal Medicare program.

78.21 (b) In the course of a recipient's appeal of a medical determination to the commissioner  
78.22 of human services under section 256.045, the recipient may request an expert medical  
78.23 opinion be arranged by the external review entity under contract to provide independent  
78.24 external reviews under this section. If such a request is made, the cost of the review shall  
78.25 be paid by the commissioner of human services. Any medical opinion obtained under this  
78.26 paragraph shall only be used by a state human services judge as evidence in the recipient's  
78.27 appeal to the commissioner of human services under section 256.045.

78.28 (c) Nothing in this subdivision shall be construed to limit or restrict the appeal rights  
78.29 provided in section 256.045 for governmental program recipients.

79.1 Sec. 46. Minnesota Statutes 2023 Supplement, section 145D.01, subdivision 1, is amended  
79.2 to read:

79.3 Subdivision 1. **Definitions.** (a) For purposes of this ~~chapter~~ section and section 145D.02,  
79.4 the following terms have the meanings given.

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

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

79.10 (d) "Control," including the terms "controlling," "controlled by," and "under common  
79.11 control with," means the possession, direct or indirect, of the power to direct or cause the  
79.12 direction of the management and policies of a health care entity, whether through the  
79.13 ownership of voting securities, membership in an entity formed under chapter 317A, by  
79.14 contract other than a commercial contract for goods or nonmanagement services, or otherwise,  
79.15 unless the power is the result of an official position with, corporate office held by, or court  
79.16 appointment of, the person. Control is presumed to exist if any person, directly or indirectly,  
79.17 owns, controls, holds with the power to vote, or holds proxies representing 40 percent or  
79.18 more of the voting securities of any other person, or if any person, directly or indirectly,  
79.19 constitutes 40 percent or more of the membership of an entity formed under chapter 317A.  
79.20 The attorney general may determine that control exists in fact, notwithstanding the absence  
79.21 of a presumption to that effect.

79.22 (e) "Health care entity" means:

79.23 (1) a hospital;

79.24 (2) a hospital system;

79.25 (3) a captive professional entity;

79.26 (4) a medical foundation;

79.27 (5) a health care provider group practice;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

81.7 (7) an agreement or series of agreements that results in the sharing of 40 percent or more  
81.8 of the health care entity's revenues with another entity, including affiliates of such other  
81.9 entity;

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

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

81.15 (k) A transaction as defined in paragraph (j) does not include:

81.16 (1) an action or series of actions that meets one or more of the criteria set forth in  
81.17 paragraph (j), clauses (1) to (9), if, immediately prior to all such actions, the health care  
81.18 entity directly, or indirectly through one or more intermediaries, controls, is controlled by,  
81.19 or is under common control with, all other parties to the action or series of actions;

81.20 (2) a mortgage or other secured loan for business improvement purposes entered into  
81.21 by a health care entity that does not directly affect delivery of health care or governance of  
81.22 the health care entity;

81.23 (3) a clinical affiliation of health care entities formed solely for the purpose of  
81.24 collaborating on clinical trials or providing graduate medical education;

81.25 (4) the mere offer of employment to, or hiring of, a health care provider by a health care  
81.26 entity;

81.27 (5) contracts between a health care entity and a health care provider primarily for clinical  
81.28 services; or

81.29 (6) a single action or series of actions within a five-year period involving only entities  
81.30 that operate solely as a nursing home licensed under chapter 144A; a boarding care home  
81.31 licensed under sections 144.50 to 144.56; a supervised living facility licensed under sections  
81.32 144.50 to 144.56; an assisted living facility licensed under chapter 144G; a foster care setting

82.1 licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, for a physical location that  
82.2 is not the primary residence of the license holder; a community residential setting as defined  
82.3 in section 245D.02, subdivision 4a; or a home care provider licensed under sections 144A.471  
82.4 to 144A.483.

82.5 **EFFECTIVE DATE.** This section is effective July 1, 2025.

82.6 Sec. 47. **[145D.30] DEFINITIONS.**

82.7 Subdivision 1. **Application.** For purposes of sections 145D.30 to 145D.37, the following  
82.8 terms have the meanings given unless the context clearly indicates otherwise.

82.9 Subd. 2. **Commissioner** "Commissioner" means the commissioner of commerce for a  
82.10 nonprofit health coverage entity that is a nonprofit health service plan corporation operating  
82.11 under chapter 62C or the commissioner of health for a nonprofit health coverage entity that  
82.12 is a nonprofit health maintenance organization operating under chapter 62D.

82.13 Subd. 3. **Control.** "Control," including the terms "controlling," "controlled by," and  
82.14 "under common control with," means the possession, direct or indirect, of the power to  
82.15 direct or cause the direction of the management and policies of a nonprofit health coverage  
82.16 entity, whether through the ownership of voting securities, through membership in an entity  
82.17 formed under chapter 317A, by contract other than a commercial contract for goods or  
82.18 nonmanagement services, or otherwise, unless the power is the result of an official position  
82.19 with, corporate office held by, or court appointment of the person. Control is presumed to  
82.20 exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or  
82.21 holds proxies representing 40 percent or more of the voting securities of any other person  
82.22 or if any person, directly or indirectly, constitutes 40 percent or more of the membership  
82.23 of an entity formed under chapter 317A. The attorney general may determine that control  
82.24 exists in fact, notwithstanding the absence of a presumption to that effect.

82.25 Subd. 4. **Conversion transaction.** "Conversion transaction" means a transaction otherwise  
82.26 permitted under applicable law in which a nonprofit health coverage entity:

82.27 (1) merges, consolidates, converts, or transfers all or substantially all of its assets to any  
82.28 entity except a corporation that is exempt under United States Code, title 26, section  
82.29 501(c)(3);

82.30 (2) makes a series of separate transfers within a 60-month period that in the aggregate  
82.31 constitute a transfer of all or substantially all of the nonprofit health coverage entity's assets  
82.32 to any entity except a corporation that is exempt under United States Code, title 26, section  
82.33 501(c)(3); or

83.1 (3) adds or substitutes one or more directors or officers that effectively transfer the  
83.2 control of, responsibility for, or governance of the nonprofit health coverage entity to any  
83.3 entity except a corporation that is exempt under United States Code, title 26, section  
83.4 501(c)(3).

83.5 Subd. 5. **Corporation.** "Corporation" has the meaning given in section 317A.011,  
83.6 subdivision 6, and also includes a nonprofit limited liability company organized under  
83.7 section 322C.1101.

83.8 Subd. 6. **Director.** "Director" has the meaning given in section 317A.011, subdivision  
83.9 7.

83.10 Subd. 7. **Family member.** "Family member" means a spouse, parent, child, spouse of  
83.11 a child, brother, sister, or spouse of a brother or sister.

83.12 Subd. 8. **Full and fair value.** "Full and fair value" means at least the amount that the  
83.13 public benefit assets of the nonprofit health coverage entity would be worth if the assets  
83.14 were equal to stock in the nonprofit health coverage entity, if the nonprofit health coverage  
83.15 entity was a for-profit corporation and if the nonprofit health coverage entity had 100 percent  
83.16 of its stock authorized by the corporation and available for purchase without transfer  
83.17 restrictions. The valuation shall consider market value, investment or earning value, net  
83.18 asset value, goodwill, amount of donations received, and control premium, if any.

83.19 Subd. 9. **Nonprofit health coverage entity.** "Nonprofit health coverage entity" means  
83.20 a domestic nonprofit health service plan corporation operating under chapter 62C or a  
83.21 domestic nonprofit health maintenance organization operating under chapter 62D.

83.22 Subd. 10. **Officer.** "Officer" has the meaning given in section 317A.011, subdivision  
83.23 15.

83.24 Subd. 11. **Public benefit assets.** "Public benefit assets" means the entirety of a nonprofit  
83.25 health coverage entity's assets, whether tangible or intangible, including but not limited to  
83.26 its goodwill and anticipated future revenue.

83.27 Subd. 12. **Related organization.** "Related organization" has the meaning given in section  
83.28 317A.011, subdivision 18.

83.29 **EFFECTIVE DATE.** This section is effective July 1, 2025.

83.30 Sec. 48. **[145D.31] CERTAIN CONVERSION TRANSACTIONS PROHIBITED.**

83.31 A nonprofit health coverage entity must not enter into a conversion transaction if:

84.1 (1) doing so would result in less than the full and fair value of all public benefit assets  
84.2 remaining dedicated to the public benefit; or

84.3 (2) an individual who has been an officer, director, or other executive of the nonprofit  
84.4 health coverage entity or of a related organization, or a family member of such an individual:

84.5 (i) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,  
84.6 securities, investment, or other financial interest in an entity to which the nonprofit health  
84.7 coverage entity transfers public benefit assets in connection with the conversion transaction;

84.8 (ii) has received or will receive any type of compensation or other financial benefit,  
84.9 except for salary or wages paid for employment, from an entity to which the nonprofit health  
84.10 coverage entity transfers public benefit assets in connection with the conversion transaction;

84.11 (iii) has held or will hold, whether guaranteed or contingent, an ownership stake, stock,  
84.12 securities, investment, or other financial interest in an entity that has or will have a business  
84.13 relationship with an entity to which the nonprofit health coverage entity transfers public  
84.14 benefit assets in connection with the conversion transaction; or

84.15 (iv) has received or will receive any type of compensation or other financial benefit,  
84.16 except for salary or wages paid for employment, from an entity that has or will have a  
84.17 business relationship with an entity to which the nonprofit health coverage entity transfers  
84.18 public benefit assets in connection with the conversion transaction.

84.19 **EFFECTIVE DATE.** This section is effective July 1, 2025.

84.20 **Sec. 49. [145D.32] REQUIREMENTS FOR NONPROFIT HEALTH COVERAGE**  
84.21 **ENTITY CONVERSION TRANSACTIONS.**

84.22 Subdivision 1. **Notice.** (a) Before entering into a conversion transaction, a nonprofit  
84.23 health coverage entity must notify the attorney general according to section 317A.811. In  
84.24 addition to the elements listed in section 317A.811, subdivision 1, the notice required by  
84.25 this subdivision must also include: (1) an itemization of the nonprofit health coverage entity's  
84.26 public benefit assets and an independent third-party valuation of the nonprofit health coverage  
84.27 entity's public benefit assets; and (2) other information contained in forms provided by the  
84.28 attorney general.

84.29 (b) When the nonprofit health coverage entity provides the attorney general with the  
84.30 notice and other information required under paragraph (a), the nonprofit health coverage  
84.31 entity must also provide a copy of this notice and other information to the applicable  
84.32 commissioner.

85.1 Subd. 2. **Nonprofit health coverage entity requirements.** Before entering into a  
85.2 conversion transaction, a nonprofit health coverage entity must ensure that:

85.3 (1) the proposed conversion transaction complies with chapters 317A and 501B and  
85.4 other applicable laws;

85.5 (2) the proposed conversion transaction does not involve or constitute a breach of  
85.6 charitable trust;

85.7 (3) the nonprofit health coverage entity shall receive full and fair value for its public  
85.8 benefit assets;

85.9 (4) the value of the public benefit assets to be transferred has not been manipulated in  
85.10 a manner that causes or caused the value of the assets to decrease;

85.11 (5) the proceeds of the proposed conversion transaction shall be used in a manner  
85.12 consistent with the public benefit for which the assets are held by the nonprofit health  
85.13 coverage entity; and

85.14 (6) the proposed conversion transaction shall not result in a breach of fiduciary duty.

85.15 Subd. 3. **Listening sessions and public comment.** The attorney general or the  
85.16 commissioner may hold public listening sessions or forums and may solicit public comments  
85.17 regarding the proposed conversion transaction.

85.18 Subd. 4. **Waiting period.** (a) Subject to paragraphs (b) and (c), a nonprofit health  
85.19 coverage entity must not enter into a conversion transaction until 60 days after the nonprofit  
85.20 health coverage entity has given written notice as required in subdivision 1.

85.21 (b) The attorney general may waive all or part of the waiting period or may extend the  
85.22 waiting period for an additional 60 days by notifying the nonprofit health coverage entity  
85.23 of the extension in writing.

85.24 (c) The time periods specified in this subdivision shall be suspended while an  
85.25 investigation into the conversion transaction is pending or while a request from the attorney  
85.26 general for additional information is outstanding.

85.27 Subd. 5. **Funds restricted for a particular purpose.** Nothing in this section relieves a  
85.28 nonprofit health coverage entity from complying with requirements for funds that are  
85.29 restricted for a particular purpose. Funds restricted for a particular purpose must continue  
85.30 to be used in accordance with the purpose for which they were restricted under sections  
85.31 317A.671 and 501B.31. A nonprofit health coverage entity may not convert, transfer, or

86.1 sell assets if the transaction would result in the use of the assets conflicting with their  
86.2 restricted purpose.

86.3 **EFFECTIVE DATE.** This section is effective July 1, 2025.

86.4 Sec. 50. **[145D.34] ENFORCEMENT AND REMEDIES.**

86.5 Subdivision 1. **Investigation.** The attorney general has the powers in section 8.31.  
86.6 Nothing in this subdivision limits the powers, remedies, or responsibilities of the attorney  
86.7 general under this chapter; chapter 8, 309, 317A, or 501B; or any other chapter. For purposes  
86.8 of this section, an approval by the commissioner for regulatory purposes does not impair  
86.9 or inform the attorney general's authority.

86.10 Subd. 2. **Enforcement and penalties.** (a) The attorney general may bring an action in  
86.11 district court to enjoin or unwind a conversion transaction or seek other equitable relief  
86.12 necessary to protect the public interest if:

86.13 (1) a nonprofit health coverage entity or conversion transaction violates sections 145D.30  
86.14 to 145D.32; or

86.15 (2) the conversion transaction is contrary to the public interest.

86.16 In seeking injunctive relief, the attorney general must not be required to establish irreparable  
86.17 harm but must instead establish that a violation of sections 145D.30 to 145D.32 occurred  
86.18 or that the requested order promotes the public interest.

86.19 (b) Factors informing whether a conversion transaction is contrary to the public interest  
86.20 include but are not limited to whether:

86.21 (1) the conversion transaction shall result in increased health care costs for patients; and

86.22 (2) the conversion transaction shall adversely impact provider cost trends and containment  
86.23 of total health care spending.

86.24 (c) The attorney general may enforce sections 145D.30 to 145D.32 under section 8.31.

86.25 (d) Failure of the entities involved in a conversion transaction to provide timely  
86.26 information as required by the attorney general or the commissioner shall be an independent  
86.27 and sufficient ground for a court to enjoin or unwind the transaction or provide other equitable  
86.28 relief, provided the attorney general notifies the entities of the inadequacy of the information  
86.29 provided and provides the entities with a reasonable opportunity to remedy the inadequacy.

86.30 (e) An officer, director, or other executive found to have violated sections 145D.30 to  
86.31 145D.32 shall be subject to a civil penalty of up to \$100,000 for each violation. A corporation

87.1 or other entity which is a party to or materially participated in a conversion transaction  
87.2 found to have violated sections 145D.30 to 145D.32 shall be subject to a civil penalty of  
87.3 up to \$1,000,000. A court may also award reasonable attorney fees and costs of investigation  
87.4 and litigation.

87.5 Subd. 3. **Commissioner of health; data and research.** The commissioner of health  
87.6 must provide the attorney general, upon request, with data and research on broader market  
87.7 trends, impacts on prices and outcomes, public health and population health considerations,  
87.8 and health care access, for the attorney general to use when evaluating whether a conversion  
87.9 transaction is contrary to public interest. The commissioner of health may share with the  
87.10 attorney general, according to section 13.05, subdivision 9, any not public data, as defined  
87.11 in section 13.02, subdivision 8a, held by the commissioner to aid in the investigation and  
87.12 review of the conversion transaction, and the attorney general must maintain this data with  
87.13 the same classification according to section 13.03, subdivision 4, paragraph (c).

87.14 Subd. 4. **Failure to take action.** Failure by the attorney general to take action with  
87.15 respect to a conversion transaction under this section does not constitute approval of the  
87.16 conversion transaction or waiver, nor shall failure prevent the attorney general from taking  
87.17 action in the same, similar, or subsequent circumstances.

87.18 **EFFECTIVE DATE.** This section is effective July 1, 2025.

87.19 Sec. 51. **[145D.35] DATA PRACTICES.**

87.20 Data provided by a nonprofit health coverage entity to the commissioner or the attorney  
87.21 general under sections 145D.30 to 145D.32 are, for data on individuals, confidential data  
87.22 on individuals as defined under section 13.02, subdivision 3, and, for data not on individuals,  
87.23 protected nonpublic data as defined under section 13.02, subdivision 13. The provided data  
87.24 are not subject to subpoena and shall not be subject to discovery or admissible in evidence  
87.25 in any private civil action. The attorney general or the commissioner may provide access  
87.26 to any data classified as confidential or protected nonpublic under this section to any law  
87.27 enforcement agency if the attorney general or commissioner determines that the access aids  
87.28 the law enforcement process. This section shall not be construed to limit the attorney general's  
87.29 authority to use the data in furtherance of any legal action brought according to section  
87.30 145D.34.

87.31 **EFFECTIVE DATE.** This section is effective July 1, 2025.

88.1 **Sec. 52. [145D.36] COMMISSIONER OF HEALTH; REPORTS AND ANALYSIS.**

88.2 Notwithstanding any law to the contrary, the commissioner of health may use data or  
88.3 information submitted under sections 60A.135 to 60A.137, 60A.17, 60D.18, 60D.20,  
88.4 62D.221, and 145D.32 to conduct analyses of the aggregate impact of transactions within  
88.5 nonprofit health coverage entities and organizations which include nonprofit health coverage  
88.6 entities or their affiliates on access to or the cost of health care services, health care market  
88.7 consolidation, and health care quality. The commissioner of health must issue periodic  
88.8 public reports on the number and types of conversion transactions subject to sections 145D.30  
88.9 to 145D.35 and on the aggregate impact of conversion transactions on health care costs,  
88.10 quality, and competition in Minnesota.

88.11 **EFFECTIVE DATE.** This section is effective July 1, 2025.

88.12 **Sec. 53. [145D.37] RELATION TO OTHER LAW.**

88.13 (a) Sections 145D.30 to 145D.36 are in addition to and do not affect or limit any power,  
88.14 remedy, or responsibility of a health maintenance organization, a service plan corporation,  
88.15 the attorney general, the commissioner of health, or the commissioner of commerce under  
88.16 this chapter; chapter 8, 62C, 62D, 309, 317A, or 501B; or other law.

88.17 (b) Nothing in sections 145D.03 to 145D.36 authorizes a nonprofit health coverage entity  
88.18 to enter into a conversion transaction not otherwise permitted under chapter 317A or 501B  
88.19 or other law.

88.20 **EFFECTIVE DATE.** This section is effective July 1, 2025.

88.21 **Sec. 54. [214.41] PHYSICIAN WELLNESS PROGRAM.**

88.22 Subdivision 1. **Definition.** For the purposes of this section, "physician wellness program"  
88.23 means a program of evaluation, counseling, or other modality to address an issue related to  
88.24 career fatigue or wellness related to work stress for physicians licensed under chapter 147  
88.25 that is administered by a statewide association that is exempt from taxation under United  
88.26 States Code, title 26, section 501(c)(6), and that primarily represents physicians and  
88.27 osteopaths of multiple specialties. Physician wellness program does not include the provision  
88.28 of services intended to monitor for impairment under the authority of section 214.31.

88.29 Subd. 2. **Confidentiality.** Any record of a person's participation in a physician wellness  
88.30 program is confidential and not subject to discovery, subpoena, or a reporting requirement  
88.31 to the applicable board, unless the person voluntarily provides for written release of the

89.1 information or the disclosure is required to meet the licensee's obligation to report according  
89.2 to section 147.111.

89.3 Subd. 3. **Civil liability.** Any person, agency, institution, facility, or organization employed  
89.4 by, contracting with, or operating a physician wellness program is immune from civil liability  
89.5 for any action related to their duties in connection with a physician wellness program when  
89.6 acting in good faith.

89.7 Sec. 55. Minnesota Statutes 2022, section 256B.035, is amended to read:

89.8 **256B.035 MANAGED CARE.**

89.9 The commissioner of human services may contract with public or private entities or  
89.10 operate a preferred provider program to deliver health care services to medical assistance  
89.11 and MinnesotaCare program recipients. The commissioner may enter into risk-based and  
89.12 non-risk-based contracts. The commissioner must not enter into a contract with a health  
89.13 maintenance organization, as defined in section 62D.02, which is not a nonprofit corporation  
89.14 organized under chapter 317A or a local governmental unit, as defined in section 62D.02.  
89.15 Contracts may be for the full range of health services, or a portion thereof, for medical  
89.16 assistance populations to determine the effectiveness of various provider reimbursement  
89.17 and care delivery mechanisms. The commissioner may seek necessary federal waivers and  
89.18 implement projects when approval of the waivers is obtained from the Centers for Medicare  
89.19 and Medicaid Services of the United States Department of Health and Human Services.

89.20 **EFFECTIVE DATE.** This section is effective January 1, 2025, and applies to managed  
89.21 care contracts under medical assistance and MinnesotaCare that take effect on or after that  
89.22 date.

89.23 Sec. 56. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 3a, is  
89.24 amended to read:

89.25 Subd. 3a. **Gender-affirming services care.** Medical assistance covers gender-affirming  
89.26 services care, as defined in section 62Q.585.

89.27 **EFFECTIVE DATE.** This section is effective January 1, 2025.

89.28 Sec. 57. Minnesota Statutes 2022, section 256B.0625, subdivision 12, is amended to read:

89.29 Subd. 12. ~~**Eyeglasses, dentures, and prosthetic and orthotic devices.**~~ (a) Medical  
89.30 assistance covers eyeglasses, ~~dentures, and prosthetic and orthotic devices~~ if prescribed by  
89.31 a licensed practitioner.

90.1 ~~(b) For purposes of prescribing prosthetic and orthotic devices, "licensed practitioner"~~  
90.2 ~~includes a physician, an advanced practice registered nurse, a physician assistant, or a~~  
90.3 ~~podiatrist.~~

90.4 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
90.5 whichever is later. The commissioner of human services shall notify the revisor of statutes  
90.6 when federal approval is obtained.

90.7 Sec. 58. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 16, is  
90.8 amended to read:

90.9 Subd. 16. **Abortion services.** Medical assistance covers ~~abortion services determined~~  
90.10 ~~to be medically necessary by the treating provider and delivered in accordance with all~~  
90.11 ~~applicable Minnesota laws~~ abortion and abortion-related services, including preabortion  
90.12 services and follow-up services.

90.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
90.14 whichever is later. The commissioner of human services shall notify the revisor of statutes  
90.15 when federal approval is obtained.

90.16 Sec. 59. Minnesota Statutes 2022, section 256B.0625, subdivision 32, is amended to read:

90.17 Subd. 32. **Nutritional products.** Medical assistance covers nutritional products needed  
90.18 for nutritional supplementation because solid food or nutrients thereof cannot be properly  
90.19 absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple  
90.20 syrup urine disease, a combined allergy to human milk, cow's milk, and soy formula, or  
90.21 any other childhood or adult diseases, conditions, or disorders identified by the commissioner  
90.22 as requiring a similarly necessary nutritional product. Medical assistance covers amino  
90.23 acid-based elemental formulas in the same manner as is required under section 62Q.531.  
90.24 Nutritional products needed for the treatment of a combined allergy to human milk, cow's  
90.25 milk, and soy formula require prior authorization. Separate payment shall not be made for  
90.26 nutritional products for residents of long-term care facilities. Payment for dietary  
90.27 requirements is a component of the per diem rate paid to these facilities.

90.28 **EFFECTIVE DATE.** This section is effective January 1, 2025.

90.29 Sec. 60. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
90.30 to read:

90.31 Subd. 72. **Orthotic and prosthetic devices.** Medical assistance covers orthotic and  
90.32 prosthetic devices, supplies, and services according to section 256B.066.

91.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
91.2 whichever is later. The commissioner of human services shall notify the revisor of statutes  
91.3 when federal approval is obtained.

91.4 Sec. 61. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
91.5 to read:

91.6 Subd. 73. **Rapid whole genome sequencing.** Medical assistance covers rapid whole  
91.7 genome sequencing (rWGS) testing. Coverage and eligibility for rWGS testing, and the use  
91.8 of genetic data, must meet the requirements specified in section 62A.3098, subdivisions 1  
91.9 to 3 and 6.

91.10 **EFFECTIVE DATE.** This section is effective January 1, 2025.

91.11 Sec. 62. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
91.12 to read:

91.13 Subd. 74. **Intermittent catheters.** Medical assistance covers intermittent urinary catheters  
91.14 and insertion supplies if intermittent catheterization is recommended by the enrollee's health  
91.15 care provider. Medical assistance must meet the requirements that would otherwise apply  
91.16 to a health plan under section 62Q.666.

91.17 Sec. 63. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
91.18 to read:

91.19 Subd. 75. **Scalp hair prostheses.** Medical assistance covers scalp hair prostheses and  
91.20 all equipment and accessories necessary for their regular use under the conditions and in  
91.21 compliance with the requirements specified in section 62A.28, except that the limitation on  
91.22 coverage required per benefit year set forth in section 62A.28, subdivision 2, paragraph (c),  
91.23 does not apply.

91.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

91.25 Sec. 64. Minnesota Statutes 2022, section 256B.0625, is amended by adding a subdivision  
91.26 to read:

91.27 Subd. 76. **Transfer of mothers and newborns.** Medical assistance covers the transfer  
91.28 of mothers or newborns between medical facilities. Medical assistance must meet the same  
91.29 requirements that would otherwise apply to a health plan under section 62A.0411.

91.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

92.1 Sec. 65. **[256B.066] ORTHOTIC AND PROSTHETIC DEVICES, SUPPLIES, AND**  
92.2 **SERVICES.**

92.3 Subdivision 1. Definitions. All terms used in this section have the meanings given them  
92.4 in section 62Q.665, subdivision 1.

92.5 Subd. 2. Coverage requirements. (a) Medical assistance covers orthotic and prosthetic  
92.6 devices, supplies, and services:

92.7 (1) furnished under an order by a prescribing physician or licensed health care prescriber  
92.8 who has authority in Minnesota to prescribe orthoses and prostheses. Coverage for orthotic  
92.9 and prosthetic devices, supplies, accessories, and services under this clause includes those  
92.10 devices or device systems, supplies, accessories, and services that are customized to the  
92.11 enrollee's needs;

92.12 (2) determined by the enrollee's provider to be the most appropriate model that meets  
92.13 the medical needs of the enrollee for purposes of performing physical activities, as applicable,  
92.14 including but not limited to running, biking, and swimming, and maximizing the enrollee's  
92.15 limb function; or

92.16 (3) for showering or bathing.

92.17 (b) The coverage set forth in paragraph (a) includes the repair and replacement of those  
92.18 orthotic and prosthetic devices, supplies, and services described therein.

92.19 (c) Coverage of a prosthetic or orthotic benefit must not be denied for an individual with  
92.20 limb loss or absence that would otherwise be covered for a nondisabled person seeking  
92.21 medical or surgical intervention to restore or maintain the ability to perform the same  
92.22 physical activity.

92.23 (d) If coverage for prosthetic or custom orthotic devices is provided, payment must be  
92.24 made for the replacement of a prosthetic or custom orthotic device or for the replacement  
92.25 of any part of the devices, without regard to useful lifetime restrictions, if an ordering health  
92.26 care provider determines that the provision of a replacement device, or a replacement part  
92.27 of a device, is necessary because:

92.28 (1) of a change in the physiological condition of the enrollee;

92.29 (2) of an irreparable change in the condition of the device or in a part of the device; or

92.30 (3) the condition of the device, or the part of the device, requires repairs and the cost of  
92.31 the repairs would be more than 60 percent of the cost of a replacement device or of the part  
92.32 being replaced.

93.1 Subd. 3. **Restrictions on coverage.** (a) Prior authorization may be required for orthotic  
93.2 and prosthetic devices, supplies, and services.

93.3 (b) A utilization review for a request for coverage of prosthetic or orthotic benefits must  
93.4 apply the most recent version of evidence-based treatment and fit criteria as recognized by  
93.5 relevant clinical specialists.

93.6 (c) Utilization review determinations must be rendered in a nondiscriminatory manner  
93.7 and must not deny coverage for habilitative or rehabilitative benefits, including prosthetics  
93.8 or orthotics, solely on the basis of an enrollee's actual or perceived disability.

93.9 (d) Evidence of coverage and any benefit denial letters must include language describing  
93.10 an enrollee's rights pursuant to paragraphs (b) and (c).

93.11 (e) Confirmation from a prescribing health care provider may be required if the prosthetic  
93.12 or custom orthotic device or part being replaced is less than three years old.

93.13 Subd. 4. **Managed care plan access to care.** (a) Managed care plans and county-based  
93.14 purchasing plans subject to this section must ensure access to medically necessary clinical  
93.15 care and to prosthetic and custom orthotic devices and technology from at least two distinct  
93.16 prosthetic and custom orthotic providers in the plan's provider network located in Minnesota.

93.17 (b) In the event that medically necessary covered orthotics and prosthetics are not  
93.18 available from an in-network provider, the plan must provide processes to refer an enrollee  
93.19 to an out-of-network provider and must fully reimburse the out-of-network provider at a  
93.20 mutually agreed upon rate less enrollee cost sharing determined on an in-network basis.

93.21 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
93.22 whichever is later. The commissioner of human services shall notify the revisor of statutes  
93.23 when federal approval is obtained.

93.24 Sec. 66. Minnesota Statutes 2022, section 256B.69, subdivision 2, is amended to read:

93.25 Subd. 2. **Definitions.** For the purposes of this section, the following terms have the  
93.26 meanings given.

93.27 (a) "Commissioner" means the commissioner of human services. For the remainder of  
93.28 this section, the commissioner's responsibilities for methods and policies for implementing  
93.29 the project will be proposed by the project advisory committees and approved by the  
93.30 commissioner.

93.31 (b) "Demonstration provider" means a nonprofit health maintenance organization,  
93.32 community integrated service network, or accountable provider network authorized and

94.1 operating under chapter 62D, 62N, or 62T that participates in the demonstration project  
94.2 according to criteria, standards, methods, and other requirements established for the project  
94.3 and approved by the commissioner. For purposes of this section, a county board, or group  
94.4 of county boards operating under a joint powers agreement, is considered a demonstration  
94.5 provider if the county or group of county boards meets the requirements of section 256B.692.

94.6 (c) "Eligible individuals" means those persons eligible for medical assistance benefits  
94.7 as defined in sections 256B.055, 256B.056, and 256B.06.

94.8 (d) "Limitation of choice" means suspending freedom of choice while allowing eligible  
94.9 individuals to choose among the demonstration providers.

94.10 **EFFECTIVE DATE.** This section is effective January 1, 2025.

94.11 Sec. 67. Minnesota Statutes 2022, section 256L.12, subdivision 7, is amended to read:

94.12 Subd. 7. **Managed care plan vendor requirements.** (a) The following requirements  
94.13 apply to all counties or vendors who contract with the Department of Human Services to  
94.14 serve MinnesotaCare recipients. Managed care plan contractors:

94.15 (1) shall authorize and arrange for the provision of the full range of services listed in  
94.16 section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

94.17 (2) shall accept the prospective, per capita payment or other contractually defined payment  
94.18 from the commissioner in return for the provision and coordination of covered health care  
94.19 services for eligible individuals enrolled in the program;

94.20 (3) may contract with other health care and social service practitioners to provide services  
94.21 to enrollees;

94.22 (4) shall provide for an enrollee grievance process as required by the commissioner and  
94.23 set forth in the contract with the department;

94.24 (5) shall retain all revenue from enrollee co-payments;

94.25 (6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or  
94.26 previous utilization of health services;

94.27 (7) shall demonstrate capacity to accept financial risk according to requirements specified  
94.28 in the contract with the department. A health maintenance organization licensed under  
94.29 chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to  
94.30 demonstrate financial risk capacity, beyond that which is required to comply with chapters  
94.31 62C and 62D; and

95.1 (8) shall submit information as required by the commissioner, including data required  
95.2 for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

95.3 (b) A health maintenance organization must be a nonprofit corporation organized under  
95.4 chapter 317A to serve as a managed care contractor under this section and section 256L.121.

95.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

95.6 Sec. 68. Minnesota Statutes 2022, section 317A.811, subdivision 1, is amended to read:

95.7 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following  
95.8 corporations shall notify the attorney general of their intent to dissolve, merge, consolidate,  
95.9 or convert, or to transfer all or substantially all of their assets:

95.10 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,  
95.11 subdivision 2; ~~or~~

95.12 (2) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code  
95.13 of 1986, or any successor section; or

95.14 (3) effective July 1, 2025, a nonprofit health coverage entity as defined in section  
95.15 145D.30.

95.16 (b) The notice must include:

95.17 (1) the purpose of the corporation that is giving the notice;

95.18 (2) a list of assets owned or held by the corporation for charitable purposes;

95.19 (3) a description of restricted assets and purposes for which the assets were received;

95.20 (4) a description of debts, obligations, and liabilities of the corporation;

95.21 (5) a description of tangible assets being converted to cash and the manner in which  
95.22 they will be sold;

95.23 (6) anticipated expenses of the transaction, including attorney fees;

95.24 (7) a list of persons to whom assets will be transferred, if known, or the name of the  
95.25 converted organization;

95.26 (8) the purposes of persons receiving the assets or of the converted organization; and

95.27 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred or  
95.28 converted assets.

95.29 The notice must be signed on behalf of the corporation by an authorized person.

96.1 Sec. 69. SUPERSEDING EFFECT.

96.2 Minnesota Statutes, section 62Q.679, in this article shall supersede Minnesota Statutes,  
96.3 section 62Q.679, in 2024 S.F. No. 4097, article 1, section 8, if enacted.

96.4 Sec. 70. INITIAL REPORTS TO COMMISSIONER OF HEALTH; PRIOR  
96.5 AUTHORIZATIONS.

96.6 Utilization review organizations must submit initial reports to the commissioner of health  
96.7 under Minnesota Statutes, section 62M.19, by September 1, 2025.

96.8 Sec. 71. REPEALER.

96.9 (a) Minnesota Statutes 2022, section 62A.041, subdivision 3, is repealed.

96.10 (b) Minnesota Statutes 2023 Supplement, section 62Q.522, subdivisions 3 and 4, are  
96.11 repealed.

96.12 EFFECTIVE DATE. This section is effective January 1, 2025, and applies to health  
96.13 plans offered, sold, issued, or renewed on or after that date.

96.14 **ARTICLE 5**

96.15 **DEPARTMENT OF HEALTH FINANCE**

96.16 Section 1. Minnesota Statutes 2022, section 103I.621, subdivision 1, is amended to read:

96.17 Subdivision 1. **Permit.** (a) Notwithstanding any department or agency rule to the contrary,  
96.18 the commissioner shall issue, on request by the owner of the property and payment of the  
96.19 permit fee, permits for the reinjection of water by a properly constructed well into the same  
96.20 aquifer from which the water was drawn for the operation of a groundwater thermal exchange  
96.21 device.

96.22 (b) As a condition of the permit, an applicant must agree to allow inspection by the  
96.23 commissioner during regular working hours for department inspectors.

96.24 (c) Not more than 200 permits may be issued for small systems having maximum  
96.25 capacities of 20 gallons per minute or less and that are compliant with the natural resource  
96.26 water-use requirements under subdivision 2. ~~The small systems are subject to inspection~~  
96.27 ~~twice a year.~~

96.28 (d) Not more than ~~ten~~ 100 permits may be issued for larger systems having maximum  
96.29 capacities ~~from~~ over 20 to 50 gallons per minute and that are compliant with the natural

97.1 resource water-use requirements under subdivision 2. The larger systems are subject to  
97.2 inspection four times a year.

97.3 (e) A person issued a permit must comply with this section and permit conditions deemed  
97.4 necessary to protect public health and safety of the groundwater for the permit to be valid.

97.5 The permit conditions may include but are not limited to requirements for:

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

97.7 (2) system operation and maintenance;

97.8 (3) system location and construction;

97.9 (4) well location and construction;

97.10 (5) signage;

97.11 (6) reports of system construction, performance, operation, and maintenance;

97.12 (7) removal of the system upon termination of its use or system failure;

97.13 (8) disclosure of the system at the time of property transfer;

97.14 (9) obtaining approval from the commissioner prior to deviation from the approval plan  
97.15 and conditions;

97.16 (10) groundwater level monitoring; and

97.17 (11) groundwater quality monitoring.

97.18 (f) The property owner or the property owner's agent must submit to the commissioner  
97.19 a permit application on a form provided by the commissioner, or in a format approved by  
97.20 the commissioner, that provides any information necessary to protect public health and  
97.21 safety of the groundwater.

97.22 (g) A permit granted under this section is not valid if a water-use permit is required for  
97.23 the project and is not approved by the commissioner of natural resources.

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

97.25 Sec. 2. Minnesota Statutes 2022, section 103I.621, subdivision 2, is amended to read:

97.26 Subd. 2. **Water-use requirements apply.** Water-use permit requirements and penalties  
97.27 under chapter ~~103F~~ 103G and related rules adopted and enforced by the commissioner of  
97.28 natural resources apply to groundwater thermal exchange permit recipients. A person who  
97.29 violates a provision of this section is subject to enforcement or penalties for the noncomplying  
97.30 activity that are available to the commissioner and the Pollution Control Agency.

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

98.2 Sec. 3. Minnesota Statutes 2023 Supplement, section 144.1501, subdivision 2, is amended  
98.3 to read:

98.4 Subd. 2. ~~Creation of account~~ Availability. (a) ~~A health professional education loan~~  
98.5 ~~forgiveness program account is established.~~ The commissioner of health shall use money  
98.6 ~~from the account to establish a~~ appropriated for health professional education loan forgiveness  
98.7 program in this section:

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

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

98.14 (3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate  
98.15 care facility for persons with developmental disability; in a hospital if the hospital owns  
98.16 and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked  
98.17 by the nurse is in the nursing home; in an assisted living facility as defined in section  
98.18 144G.08, subdivision 7; or for a home care provider as defined in section 144A.43,  
98.19 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing  
98.20 field in a postsecondary program at the undergraduate level or the equivalent at the graduate  
98.21 level;

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

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

98.30 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient  
98.31 encounters to state public program enrollees or patients receiving sliding fee schedule  
98.32 discounts through a formal sliding fee schedule meeting the standards established by the

99.1 United States Department of Health and Human Services under Code of Federal Regulations,  
99.2 title 42, section ~~51, chapter 303~~ 51c.303; and

99.3 (7) for nurses employed as a hospital nurse by a nonprofit hospital and providing direct  
99.4 care to patients at the nonprofit hospital.

99.5 (b) Appropriations made ~~to the account~~ for health professional education loan forgiveness  
99.6 in this section do not cancel and are available until expended, except that at the end of each  
99.7 biennium, any remaining balance in the account that is not committed by contract and not  
99.8 needed to fulfill existing commitments shall cancel to the fund.

99.9 Sec. 4. Minnesota Statutes 2022, section 144.1501, subdivision 5, is amended to read:

99.10 Subd. 5. **Penalty for nonfulfillment.** If a participant does not fulfill the required  
99.11 minimum commitment of service according to subdivision 3, the commissioner of health  
99.12 shall collect from the participant the total amount paid to the participant under the loan  
99.13 forgiveness program plus interest at a rate established according to section 270C.40. The  
99.14 commissioner shall deposit the money collected in ~~the health care access fund to be credited~~  
99.15 ~~to a dedicated account in the special revenue fund. The balance of the account is appropriated~~  
99.16 annually to the commissioner for the health professional education loan forgiveness program  
99.17 ~~account~~ established in subdivision 2. The commissioner shall allow waivers of all or part  
99.18 of the money owed the commissioner as a result of a nonfulfillment penalty if emergency  
99.19 circumstances prevented fulfillment of the minimum service commitment.

99.20 Sec. 5. Minnesota Statutes 2022, section 144.555, subdivision 1a, is amended to read:

99.21 Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to**  
99.22 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under  
99.23 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health ~~and,~~  
99.24 the public, and others at least ~~120~~ 182 days before the hospital or hospital campus voluntarily  
99.25 plans to implement one of the following scheduled actions listed in paragraph (b), unless  
99.26 the controlling persons can demonstrate to the commissioner that meeting the advanced  
99.27 notice requirement is not feasible and the commissioner approves a shorter advanced notice.

99.28 (b) The following scheduled actions require advanced notice under paragraph (a):

99.29 (1) ~~cease~~ ceasing operations;

99.30 (2) ~~curtail~~ curtailing operations to the extent that patients must be relocated;

99.31 (3) ~~relocate~~ relocating the provision of health services to another hospital or another  
99.32 hospital campus; or

100.1 (4) ~~cease offering~~ ceasing to offer maternity care and newborn care services, intensive  
100.2 care unit services, inpatient mental health services, or inpatient substance use disorder  
100.3 treatment services.

100.4 (c) A notice required under this subdivision must comply with the requirements in  
100.5 subdivision 1d.

100.6 ~~(b)~~ (d) The commissioner shall cooperate with the controlling persons and advise them  
100.7 about relocating the patients.

100.8 Sec. 6. Minnesota Statutes 2022, section 144.555, subdivision 1b, is amended to read:

100.9 Subd. 1b. **Public hearing.** Within ~~45~~ 30 days after receiving notice under subdivision  
100.10 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations,  
100.11 curtailment of operations, relocation of health services, or cessation in offering health  
100.12 services. The commissioner must provide adequate public notice of the hearing in a time  
100.13 and manner determined by the commissioner. The controlling persons of the hospital or  
100.14 hospital campus must participate in the public hearing. The public hearing must be held at  
100.15 a location that is within ten miles of the hospital or hospital campus or with the  
100.16 commissioner's approval as close as is practicable, and that is provided or arranged by the  
100.17 hospital or hospital campus. Video conferencing technology must be used to allow members  
100.18 of the public to view and participate in the hearing. The public hearing must include:

100.19 (1) an explanation by the controlling persons of the reasons for ceasing or curtailing  
100.20 operations, relocating health services, or ceasing to offer any of the listed health services;

100.21 (2) a description of the actions that controlling persons will take to ensure that residents  
100.22 in the hospital's or campus's service area have continued access to the health services being  
100.23 eliminated, curtailed, or relocated;

100.24 (3) an opportunity for public testimony on the scheduled cessation or curtailment of  
100.25 operations, relocation of health services, or cessation in offering any of the listed health  
100.26 services, and on the hospital's or campus's plan to ensure continued access to those health  
100.27 services being eliminated, curtailed, or relocated; and

100.28 (4) an opportunity for the controlling persons to respond to questions from interested  
100.29 persons.

101.1 Sec. 7. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision to  
101.2 read:

101.3 Subd. 1d. **Methods of providing notice; content of notice.** (a) A notice required under  
101.4 subdivision 1a must be provided to patients, hospital personnel, the public, local units of  
101.5 government, and the commissioner of health using at least the following methods:

101.6 (1) posting a notice of the proposed cessation of operations, curtailment, relocation of  
101.7 health services, or cessation in offering health services at the main public entrance of the  
101.8 hospital or hospital campus;

101.9 (2) providing written notice to the commissioner of health, to the city council in the city  
101.10 where the hospital or hospital campus is located, and to the county board in the county  
101.11 where the hospital or hospital campus is located;

101.12 (3) providing written notice to the local health department as defined in section 145A.02,  
101.13 subdivision 8b, for the community where the hospital or hospital campus is located;

101.14 (4) providing notice to the public through a written public announcement which must  
101.15 be distributed to local media outlets;

101.16 (5) providing written notice to existing patients of the hospital or hospital campus; and

101.17 (6) notifying all personnel currently employed in the unit, hospital, or hospital campus  
101.18 impacted by the proposed cessation, curtailment, or relocation.

101.19 (b) A notice required under subdivision 1a must include:

101.20 (1) a description of the proposed cessation of operations, curtailment, relocation of health  
101.21 services, or cessation in offering health services. The description must include:

101.22 (i) the number of beds, if any, that will be eliminated, repurposed, reassigned, or otherwise  
101.23 reconfigured to serve populations or patients other than those currently served;

101.24 (ii) the current number of beds in the impacted unit, hospital, or hospital campus, and  
101.25 the number of beds in the impacted unit, hospital, or hospital campus after the proposed  
101.26 cessation, curtailment, or relocation takes place;

101.27 (iii) the number of existing patients who will be impacted by the proposed cessation,  
101.28 curtailment, or relocation;

101.29 (iv) any decrease in personnel, or relocation of personnel to a different unit, hospital, or  
101.30 hospital campus, caused by the proposed cessation, curtailment, or relocation;

102.1 (v) a description of the health services provided by the unit, hospital, or hospital campus  
102.2 impacted by the proposed cessation, curtailment, or relocation; and

102.3 (vi) identification of the three nearest available health care facilities where patients may  
102.4 obtain the health services provided by the unit, hospital, or hospital campus impacted by  
102.5 the proposed cessation, curtailment, or relocation, and any potential barriers to seamlessly  
102.6 transition patients to receive services at one of these facilities. If the unit, hospital, or hospital  
102.7 campus impacted by the proposed cessation, curtailment, or relocation serves medical  
102.8 assistance or Medicare enrollees, the information required under this item must specify  
102.9 whether any of the three nearest available facilities serves medical assistance or Medicare  
102.10 enrollees; and

102.11 (2) a telephone number, email address, and address for each of the following, to which  
102.12 interested parties may offer comments on the proposed cessation, curtailment, or relocation:

102.13 (i) the hospital or hospital campus; and

102.14 (ii) the parent entity, if any, or the entity under contract, if any, that acts as the corporate  
102.15 administrator of the hospital or hospital campus.

102.16 Sec. 8. Minnesota Statutes 2022, section 144.555, subdivision 2, is amended to read:

102.17 Subd. 2. **Penalty; facilities other than hospitals.** Failure to notify the commissioner  
102.18 under subdivision 1, ~~1a, or 1c or failure to participate in a public hearing under subdivision~~  
102.19 ~~1b~~ may result in issuance of a correction order under section 144.653, subdivision 5.

102.20 Sec. 9. Minnesota Statutes 2022, section 144.555, is amended by adding a subdivision to  
102.21 read:

102.22 Subd. 3. **Penalties; hospitals.** (a) Failure to participate in a public hearing under  
102.23 subdivision 1b or failure to notify the commissioner under subdivision 1c may result in  
102.24 issuance of a correction order under section 144.653, subdivision 5.

102.25 (b) Notwithstanding any law to the contrary, the commissioner must impose on the  
102.26 controlling persons of a hospital or hospital campus a fine of \$20,000 for each failure to  
102.27 provide notice to an individual or entity or at a location required under subdivision 1d,  
102.28 paragraph (a). The cumulative fines imposed under this paragraph must not exceed \$60,000  
102.29 for any scheduled action requiring notice under subdivision 1a. The commissioner is not  
102.30 required to issue a correction order before imposing a fine under this paragraph. Section  
102.31 144.653, subdivision 8, applies to fines imposed under this paragraph.

103.1 Sec. 10. [144.556] RIGHT OF FIRST REFUSAL; SALE OF HOSPITAL OR  
103.2 HOSPITAL CAMPUS.

103.3 (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a  
103.4 hospital campus must not sell or convey the hospital or hospital campus, offer to sell or  
103.5 convey the hospital or hospital campus to a person other than a local unit of government  
103.6 listed in this paragraph, or voluntarily cease operations of the hospital or hospital campus  
103.7 unless the controlling persons have first made a good faith offer to sell or convey the hospital  
103.8 or hospital campus to the home rule charter or statutory city, county, town, or hospital  
103.9 district in which the hospital or hospital campus is located.

103.10 (b) The offer to sell or convey the hospital or hospital campus to a local unit of  
103.11 government under paragraph (a) must be at a price that does not exceed the current fair  
103.12 market value of the hospital or hospital campus. A party to whom an offer is made under  
103.13 paragraph (a) must accept or decline the offer within 60 days of receipt. If the party to whom  
103.14 the offer is made fails to respond within 60 days of receipt, the offer is deemed declined.

103.15 Sec. 11. Minnesota Statutes 2022, section 144A.61, subdivision 3a, is amended to read:

103.16 Subd. 3a. **Competency evaluation program.** (a) The commissioner of health shall  
103.17 approve the competency evaluation program.

103.18 (b) A competency evaluation must be administered to persons who desire to be listed  
103.19 in the nursing assistant registry. The tests may only be administered by technical colleges,  
103.20 community colleges, or other organizations approved by the ~~Department of Health~~  
103.21 commissioner of health. The commissioner must ensure any written portions of the  
103.22 competency evaluation are available in languages other than English that are commonly  
103.23 spoken by persons who desire to be listed in the nursing assistant registry. The commissioner  
103.24 may consult with the state demographer or the commissioner of employment and economic  
103.25 development when identifying languages that are commonly spoken by persons who desire  
103.26 to be listed in the nursing assistant registry.

103.27 (c) The commissioner of health shall approve a nursing assistant for the registry without  
103.28 requiring a competency evaluation if the nursing assistant is in good standing on a nursing  
103.29 assistant registry in another state.

103.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

104.1 Sec. 12. Minnesota Statutes 2022, section 144A.70, subdivision 3, is amended to read:

104.2 Subd. 3. **Controlling person.** "Controlling person" means a business entity or entities,  
104.3 officer, program administrator, or director, whose responsibilities include ~~the direction of~~  
104.4 ~~the management or policies of a supplemental nursing services agency~~ the management and  
104.5 decision-making authority to establish or control business policy and all other policies of a  
104.6 supplemental nursing services agency. Controlling person also means an individual who,  
104.7 directly or indirectly, beneficially owns an interest in a corporation, partnership, or other  
104.8 business association that is a controlling person.

104.9 Sec. 13. Minnesota Statutes 2022, section 144A.70, subdivision 5, is amended to read:

104.10 Subd. 5. **Person.** "Person" includes an individual, ~~firm,~~ corporation, partnership, limited  
104.11 liability company, or association.

104.12 Sec. 14. Minnesota Statutes 2022, section 144A.70, subdivision 6, is amended to read:

104.13 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services  
104.14 agency" means a person, ~~firm,~~ corporation, partnership, limited liability company, or  
104.15 association engaged for hire in the business of providing or procuring temporary employment  
104.16 in health care facilities for nurses, nursing assistants, nurse aides, and orderlies. Supplemental  
104.17 nursing services agency does not include an individual who only engages in providing the  
104.18 individual's services on a temporary basis to health care facilities. Supplemental nursing  
104.19 services agency does not include a professional home care agency licensed under section  
104.20 144A.471 that only provides staff to other home care providers.

104.21 Sec. 15. Minnesota Statutes 2022, section 144A.70, subdivision 7, is amended to read:

104.22 Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental  
104.23 nursing services agencies through ~~annual~~ semiannual unannounced surveys and follow-up  
104.24 surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions  
104.25 necessary to ensure compliance with sections 144A.70 to 144A.74.

104.26 Sec. 16. Minnesota Statutes 2022, section 144A.71, subdivision 2, is amended to read:

104.27 Subd. 2. **Application information and fee.** The commissioner shall establish forms and  
104.28 procedures for processing each supplemental nursing services agency registration application.  
104.29 An application for a supplemental nursing services agency registration must include at least  
104.30 the following:

105.1 (1) the names and addresses of ~~the owner or owners~~ all owners and controlling persons  
105.2 of the supplemental nursing services agency;

105.3 (2) if the owner is a corporation, copies of its articles of incorporation and current bylaws,  
105.4 together with the names and addresses of its officers and directors;

105.5 (3) ~~satisfactory proof of compliance with section 144A.72, subdivision 1, clauses (5) to~~  
105.6 ~~(7)~~ if the owner is a limited liability company, copies of its articles of organization and  
105.7 operating agreement, together with the names and addresses of its officers and directors;

105.8 (4) documentation that the supplemental nursing services agency has medical malpractice  
105.9 insurance to insure against the loss, damage, or expense of a claim arising out of the death  
105.10 or injury of any person as the result of negligence or malpractice in the provision of health  
105.11 care services by the supplemental nursing services agency or by any employee of the agency;

105.12 (5) documentation that the supplemental nursing services agency has an employee  
105.13 dishonesty bond in the amount of \$10,000;

105.14 (6) documentation that the supplemental nursing services agency has insurance coverage  
105.15 for workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies  
105.16 provided or procured by the agency;

105.17 (7) documentation that the supplemental nursing services agency filed with the  
105.18 commissioner of revenue: (i) the name and address of the bank, savings bank, or savings  
105.19 association in which the supplemental nursing services agency deposits all employee income  
105.20 tax withholdings; and (ii) the name and address of any nurse, nursing assistant, nurse aide,  
105.21 or orderly whose income is derived from placement by the agency, if the agency purports  
105.22 the income is not subject to withholding;

105.23 ~~(4)~~ (8) any other relevant information that the commissioner determines is necessary to  
105.24 properly evaluate an application for registration;

105.25 ~~(5)~~ (9) a policy and procedure that describes how the supplemental nursing services  
105.26 agency's records will be immediately available at all times to the commissioner and facility;  
105.27 and

105.28 ~~(6)~~ (10) a nonrefundable registration fee of \$2,035.

105.29 If a supplemental nursing services agency fails to provide the items in this subdivision  
105.30 to the department, the commissioner shall immediately suspend or refuse to issue the  
105.31 supplemental nursing services agency registration. The supplemental nursing services agency  
105.32 may appeal the commissioner's findings according to section 144A.475, subdivisions 3a

106.1 and 7, except that the hearing must be conducted by an administrative law judge within 60  
106.2 calendar days of the request for hearing assignment.

106.3 Sec. 17. Minnesota Statutes 2022, section 144A.71, is amended by adding a subdivision  
106.4 to read:

106.5 Subd. 2a. **Renewal applications.** An applicant for registration renewal must complete  
106.6 the registration application form supplied by the department. An application must be  
106.7 submitted at least 60 days before the expiration of the current registration.

106.8 Sec. 18. **[144A.715] PENALTIES.**

106.9 Subdivision 1. **Authority.** The fines imposed under this section are in accordance with  
106.10 section 144.653, subdivision 6.

106.11 Subd. 2. **Fines.** Each violation of sections 144A.70 to 144A.74, not corrected at the time  
106.12 of a follow-up survey, is subject to a fine. A fine must be assessed according to the schedules  
106.13 established in the sections violated.

106.14 Subd. 3. **Failure to correct.** If, upon a subsequent follow-up survey after a fine has been  
106.15 imposed under subdivision 2, a violation is still not corrected, another fine shall be assessed.  
106.16 The fine shall be double the amount of the previous fine.

106.17 Subd. 4. **Payment of fines.** Payment of fines is due 15 business days from the registrant's  
106.18 receipt of notice of the fine from the department.

106.19 Sec. 19. Minnesota Statutes 2022, section 144A.72, subdivision 1, is amended to read:

106.20 Subdivision 1. **Minimum criteria.** (a) The commissioner shall require that, as a condition  
106.21 of registration:

106.22 (1) all owners and controlling persons must complete a background study under section  
106.23 144.057 and receive a clearance or set aside of any disqualification;

106.24 ~~(1)~~ (2) the supplemental nursing services agency shall document that each temporary  
106.25 employee provided to health care facilities currently meets the minimum licensing, training,  
106.26 and continuing education standards for the position in which the employee will be working  
106.27 and verifies competency for the position. A supplemental nursing services agency that  
106.28 violates this clause may be subject to a fine of \$3,000;

106.29 ~~(2)~~ (3) the supplemental nursing services agency shall comply with all pertinent  
106.30 requirements relating to the health and other qualifications of personnel employed in health  
106.31 care facilities;

107.1 ~~(3)~~ (4) the supplemental nursing services agency must not restrict in any manner the  
107.2 employment opportunities of its employees; A supplemental nursing services agency that  
107.3 violates this clause may be subject to a fine of \$3,000;

107.4 ~~(4)~~ the supplemental nursing services agency shall carry medical malpractice insurance  
107.5 to insure against the loss, damage, or expense incident to a claim arising out of the death  
107.6 or injury of any person as the result of negligence or malpractice in the provision of health  
107.7 care services by the supplemental nursing services agency or by any employee of the agency;

107.8 ~~(5)~~ the supplemental nursing services agency shall carry an employee dishonesty bond  
107.9 in the amount of \$10,000;

107.10 ~~(6)~~ the supplemental nursing services agency shall maintain insurance coverage for  
107.11 workers' compensation for all nurses, nursing assistants, nurse aides, and orderlies provided  
107.12 or procured by the agency;

107.13 ~~(7)~~ the supplemental nursing services agency shall file with the commissioner of revenue:  
107.14 ~~(i)~~ the name and address of the bank, savings bank, or savings association in which the  
107.15 supplemental nursing services agency deposits all employee income tax withholdings; and  
107.16 ~~(ii)~~ the name and address of any nurse, nursing assistant, nurse aide, or orderly whose income  
107.17 is derived from placement by the agency, if the agency purports the income is not subject  
107.18 to withholding;

107.19 ~~(8)~~ (5) the supplemental nursing services agency must not, in any contract with any  
107.20 employee or health care facility, require the payment of liquidated damages, employment  
107.21 fees, or other compensation should the employee be hired as a permanent employee of a  
107.22 health care facility; A supplemental nursing services agency that violates this clause may  
107.23 be subject to a fine of \$3,000;

107.24 ~~(9)~~ (6) the supplemental nursing services agency shall document that each temporary  
107.25 employee provided to health care facilities is an employee of the agency and is not an  
107.26 independent contractor; and

107.27 ~~(10)~~ (7) the supplemental nursing services agency shall retain all records for five calendar  
107.28 years. All records of the supplemental nursing services agency must be immediately available  
107.29 to the department.

107.30 (b) In order to retain registration, the supplemental nursing services agency must provide  
107.31 services to a health care facility during the year in Minnesota within the past 12 months  
107.32 preceding the supplemental nursing services agency's registration renewal date.

108.1 Sec. 20. Minnesota Statutes 2022, section 144A.73, is amended to read:

108.2 **144A.73 COMPLAINT SYSTEM.**

108.3 The commissioner shall establish a system for reporting complaints against a supplemental  
108.4 nursing services agency or its employees. Complaints may be made by any member of the  
108.5 public. Complaints against a supplemental nursing services agency shall be investigated by  
108.6 the ~~Office of Health Facility Complaints~~ commissioner of health under sections 144A.51  
108.7 to 144A.53.

108.8 Sec. 21. Minnesota Statutes 2022, section 149A.02, subdivision 3, is amended to read:

108.9 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means any  
108.10 action normally taken by a funeral provider in anticipation of or preparation for the  
108.11 entombment, burial in a cemetery, alkaline hydrolysis, ~~or cremation,~~ or, effective July 1,  
108.12 2025, natural organic reduction of a dead human body.

108.13 Sec. 22. Minnesota Statutes 2022, section 149A.02, subdivision 16, is amended to read:

108.14 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the  
108.15 entombment, burial in a cemetery, alkaline hydrolysis, ~~or cremation,~~ or, effective July 1,  
108.16 2025, natural organic reduction of a dead human body.

108.17 Sec. 23. Minnesota Statutes 2022, section 149A.02, subdivision 26a, is amended to read:

108.18 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains in  
108.19 a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.  
108.20 Effective July 1, 2025, inurnment also includes placing naturally reduced remains in a  
108.21 naturally reduced remains container suitable for placement, burial, or shipment.

108.22 Sec. 24. Minnesota Statutes 2022, section 149A.02, subdivision 27, is amended to read:

108.23 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued a license  
108.24 to practice mortuary science, to operate a funeral establishment, to operate an alkaline  
108.25 hydrolysis facility, ~~or to operate a crematory,~~ or, effective July 1, 2025, to operate a natural  
108.26 organic reduction facility by the Minnesota commissioner of health.

109.1 Sec. 25. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
109.2 to read:

109.3 Subd. 30b. **Natural organic reduction or naturally reduce.** "Natural organic reduction"  
109.4 or "naturally reduce" means the contained, accelerated conversion of a dead human body  
109.5 to soil. This subdivision is effective July 1, 2025.

109.6 Sec. 26. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
109.7 to read:

109.8 Subd. 30c. **Natural organic reduction facility.** "Natural organic reduction facility"  
109.9 means a structure, room, or other space in a building or real property where natural organic  
109.10 reduction of a dead human body occurs. This subdivision is effective July 1, 2025.

109.11 Sec. 27. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
109.12 to read:

109.13 Subd. 30d. **Natural organic reduction vessel.** "Natural organic reduction vessel" means  
109.14 the enclosed container in which natural organic reduction takes place. This subdivision is  
109.15 effective July 1, 2025.

109.16 Sec. 28. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
109.17 to read:

109.18 Subd. 30e. **Naturally reduced remains.** "Naturally reduced remains" means the soil  
109.19 remains following the natural organic reduction of a dead human body and the accompanying  
109.20 plant material. This subdivision is effective July 1, 2025.

109.21 Sec. 29. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
109.22 to read:

109.23 Subd. 30f. **Naturally reduced remains container.** "Naturally reduced remains container"  
109.24 means a receptacle in which naturally reduced remains are placed. This subdivision is  
109.25 effective July 1, 2025.

109.26 Sec. 30. Minnesota Statutes 2022, section 149A.02, subdivision 35, is amended to read:

109.27 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or  
109.28 cooling, and the reduction of the hydrolyzed ~~or~~ remains, cremated remains, or, effective  
109.29 July 1, 2025, naturally reduced remains by mechanical means including, but not limited to,

110.1 grinding, crushing, or pulverizing, to a granulated appearance appropriate for final disposition  
110.2 or the final reduction to naturally reduced remains.

110.3 Sec. 31. Minnesota Statutes 2022, section 149A.02, subdivision 37c, is amended to read:

110.4 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed ~~or~~  
110.5 remains, cremated remains, or, effective July 1, 2025, naturally reduced remains in a defined  
110.6 area of a dedicated cemetery or in areas where no local prohibition exists provided that the  
110.7 hydrolyzed ~~or~~, cremated, or naturally reduced remains are not distinguishable to the public,  
110.8 are not in a container, and that the person who has control over disposition of the hydrolyzed  
110.9 ~~or~~, cremated, or naturally reduced remains has obtained written permission of the property  
110.10 owner or governing agency to scatter on the property.

110.11 Sec. 32. Minnesota Statutes 2022, section 149A.03, is amended to read:

110.12 **149A.03 DUTIES OF COMMISSIONER.**

110.13 The commissioner shall:

110.14 (1) enforce all laws and adopt and enforce rules relating to the:

110.15 (i) removal, preparation, transportation, arrangements for disposition, and final disposition  
110.16 of dead human bodies;

110.17 (ii) licensure and professional conduct of funeral directors, morticians, interns, practicum  
110.18 students, and clinical students;

110.19 (iii) licensing and operation of a funeral establishment;

110.20 (iv) licensing and operation of an alkaline hydrolysis facility; ~~and~~

110.21 (v) licensing and operation of a crematory; and

110.22 (vi) effective July 1, 2025, licensing and operation of a natural organic reduction facility;

110.23 (2) provide copies of the requirements for licensure and permits to all applicants;

110.24 (3) administer examinations and issue licenses and permits to qualified persons and other  
110.25 legal entities;

110.26 (4) maintain a record of the name and location of all current licensees and interns;

110.27 (5) perform periodic compliance reviews and premise inspections of licensees;

110.28 (6) accept and investigate complaints relating to conduct governed by this chapter;

110.29 (7) maintain a record of all current preneed arrangement trust accounts;

111.1 (8) maintain a schedule of application, examination, permit, and licensure fees, initial  
111.2 and renewal, sufficient to cover all necessary operating expenses;

111.3 (9) educate the public about the existence and content of the laws and rules for mortuary  
111.4 science licensing and the removal, preparation, transportation, arrangements for disposition,  
111.5 and final disposition of dead human bodies to enable consumers to file complaints against  
111.6 licensees and others who may have violated those laws or rules;

111.7 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary science  
111.8 in order to refine the standards for licensing and to improve the regulatory and enforcement  
111.9 methods used; and

111.10 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in the  
111.11 laws, rules, or procedures governing the practice of mortuary science and the removal,  
111.12 preparation, transportation, arrangements for disposition, and final disposition of dead  
111.13 human bodies.

111.14 Sec. 33. **[149A.56] LICENSE TO OPERATE A NATURAL ORGANIC REDUCTION**  
111.15 **FACILITY.**

111.16 Subdivision 1. License requirement. This section is effective July 1, 2025. Except as  
111.17 provided in section 149A.01, subdivision 3, no person shall maintain, manage, or operate  
111.18 a place or premises devoted to or used in the holding and natural organic reduction of a  
111.19 dead human body without possessing a valid license to operate a natural organic reduction  
111.20 facility issued by the commissioner of health.

111.21 Subd. 2. Requirements for natural organic reduction facility. (a) A natural organic  
111.22 reduction facility licensed under this section must consist of:

111.23 (1) a building or structure that complies with applicable local and state building codes,  
111.24 zoning laws and ordinances, and environmental standards, and that contains one or more  
111.25 natural organic reduction vessels for the natural organic reduction of dead human bodies;

111.26 (2) a motorized mechanical device for processing the remains in natural reduction; and

111.27 (3) an appropriate refrigerated holding facility for dead human bodies awaiting natural  
111.28 organic reduction.

111.29 (b) A natural organic reduction facility licensed under this section may also contain a  
111.30 display room for funeral goods.

112.1 Subd. 3. **Application procedure; documentation; initial inspection.** (a) An applicant  
112.2 for a license to operate a natural organic reduction facility shall submit a completed  
112.3 application to the commissioner. A completed application includes:

112.4 (1) a completed application form, as provided by the commissioner;

112.5 (2) proof of business form and ownership; and

112.6 (3) proof of liability insurance coverage or other financial documentation, as determined  
112.7 by the commissioner, that demonstrates the applicant's ability to respond in damages for  
112.8 liability arising from the ownership, maintenance, management, or operation of a natural  
112.9 organic reduction facility.

112.10 (b) Upon receipt of the application and appropriate fee, the commissioner shall review  
112.11 and verify all information. Upon completion of the verification process and resolution of  
112.12 any deficiencies in the application information, the commissioner shall conduct an initial  
112.13 inspection of the premises to be licensed. After the inspection and resolution of any  
112.14 deficiencies found and any reinspections as may be necessary, the commissioner shall make  
112.15 a determination, based on all the information available, to grant or deny licensure. If the  
112.16 commissioner's determination is to grant the license, the applicant shall be notified and the  
112.17 license shall issue and remain valid for a period prescribed on the license, but not to exceed  
112.18 one calendar year from the date of issuance of the license. If the commissioner's determination  
112.19 is to deny the license, the commissioner must notify the applicant, in writing, of the denial  
112.20 and provide the specific reason for denial.

112.21 Subd. 4. **Nontransferability of license.** A license to operate a natural organic reduction  
112.22 facility is not assignable or transferable and shall not be valid for any entity other than the  
112.23 one named. Each license issued to operate a natural organic reduction facility is valid only  
112.24 for the location identified on the license. A 50 percent or more change in ownership or  
112.25 location of the natural organic reduction facility automatically terminates the license. Separate  
112.26 licenses shall be required of two or more persons or other legal entities operating from the  
112.27 same location.

112.28 Subd. 5. **Display of license.** Each license to operate a natural organic reduction facility  
112.29 must be conspicuously displayed in the natural organic reduction facility at all times.  
112.30 "Conspicuous display" means in a location where a member of the general public within  
112.31 the natural organic reduction facility is able to observe and read the license.

112.32 Subd. 6. **Period of licensure.** All licenses to operate a natural organic reduction facility  
112.33 issued by the commissioner are valid for a period of one calendar year beginning on July 1  
112.34 and ending on June 30, regardless of the date of issuance.

113.1 Subd. 7. **Reporting changes in license information.** Any change of license information  
113.2 must be reported to the commissioner, on forms provided by the commissioner, no later  
113.3 than 30 calendar days after the change occurs. Failure to report changes is grounds for  
113.4 disciplinary action.

113.5 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained  
113.6 by the commissioner pursuant to this section.

113.7 Sec. 34. **[149A.57] RENEWAL OF LICENSE TO OPERATE A NATURAL**  
113.8 **ORGANIC REDUCTION FACILITY.**

113.9 Subdivision 1. **Renewal required.** This section is effective July 1, 2025. All licenses  
113.10 to operate a natural organic reduction facility issued by the commissioner expire on June  
113.11 30 following the date of issuance of the license and must be renewed to remain valid.

113.12 Subd. 2. **Renewal procedure and documentation.** (a) Licensees who wish to renew  
113.13 their licenses must submit to the commissioner a completed renewal application no later  
113.14 than June 30 following the date the license was issued. A completed renewal application  
113.15 includes:

113.16 (1) a completed renewal application form, as provided by the commissioner; and

113.17 (2) proof of liability insurance coverage or other financial documentation, as determined  
113.18 by the commissioner, that demonstrates the applicant's ability to respond in damages for  
113.19 liability arising from the ownership, maintenance, management, or operation of a natural  
113.20 organic reduction facility.

113.21 (b) Upon receipt of the completed renewal application, the commissioner shall review  
113.22 and verify the information. Upon completion of the verification process and resolution of  
113.23 any deficiencies in the renewal application information, the commissioner shall make a  
113.24 determination, based on all the information available, to reissue or refuse to reissue the  
113.25 license. If the commissioner's determination is to reissue the license, the applicant shall be  
113.26 notified and the license shall issue and remain valid for a period prescribed on the license,  
113.27 but not to exceed one calendar year from the date of issuance of the license. If the  
113.28 commissioner's determination is to refuse to reissue the license, section 149A.09, subdivision  
113.29 2, applies.

113.30 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration date  
113.31 of a license will result in the assessment of a late filing penalty. The late filing penalty must  
113.32 be paid before the reissuance of the license and received by the commissioner no later than  
113.33 31 calendar days after the expiration date of the license.

114.1 Subd. 4. **Lapse of license.** A license to operate a natural organic reduction facility shall  
114.2 automatically lapse when a completed renewal application is not received by the  
114.3 commissioner within 31 calendar days after the expiration date of a license, or a late filing  
114.4 penalty assessed under subdivision 3 is not received by the commissioner within 31 calendar  
114.5 days after the expiration of a license.

114.6 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom the  
114.7 license was issued is no longer licensed to operate a natural organic reduction facility in  
114.8 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed  
114.9 license holder from operating a natural organic reduction facility in Minnesota and may  
114.10 pursue any additional lawful remedies as justified by the case.

114.11 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed license  
114.12 upon receipt and review of a completed renewal application, receipt of the late filing penalty,  
114.13 and reinspection of the premises, provided that the receipt is made within one calendar year  
114.14 from the expiration date of the lapsed license and the cease and desist order issued by the  
114.15 commissioner has not been violated. If a lapsed license is not restored within one calendar  
114.16 year from the expiration date of the lapsed license, the holder of the lapsed license cannot  
114.17 be relicensed until the requirements in section 149A.56 are met.

114.18 Subd. 7. **Reporting changes in license information.** Any change of license information  
114.19 must be reported to the commissioner, on forms provided by the commissioner, no later  
114.20 than 30 calendar days after the change occurs. Failure to report changes is grounds for  
114.21 disciplinary action.

114.22 Subd. 8. **Licensing information.** Section 13.41 applies to data collected and maintained  
114.23 by the commissioner pursuant to this section.

114.24 Sec. 35. Minnesota Statutes 2022, section 149A.65, is amended by adding a subdivision  
114.25 to read:

114.26 Subd. 6a. **Natural organic reduction facilities.** This subdivision is effective July 1,  
114.27 2025. The initial and renewal fee for a natural organic reduction facility is \$425. The late  
114.28 fee charge for a license renewal is \$100.

114.29 Sec. 36. Minnesota Statutes 2022, section 149A.70, subdivision 1, is amended to read:

114.30 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice mortuary  
114.31 science issued by the commissioner may use the title of mortician, funeral director, or any  
114.32 other title implying that the licensee is engaged in the business or practice of mortuary

115.1 science. Only the holder of a valid license to operate an alkaline hydrolysis facility issued  
115.2 by the commissioner may use the title of alkaline hydrolysis facility, water cremation,  
115.3 water-reduction, biocremation, green-cremation, resomation, dissolution, or any other title,  
115.4 word, or term implying that the licensee operates an alkaline hydrolysis facility. Only the  
115.5 holder of a valid license to operate a funeral establishment issued by the commissioner may  
115.6 use the title of funeral home, funeral chapel, funeral service, or any other title, word, or  
115.7 term implying that the licensee is engaged in the business or practice of mortuary science.  
115.8 Only the holder of a valid license to operate a crematory issued by the commissioner may  
115.9 use the title of crematory, crematorium, green-cremation, or any other title, word, or term  
115.10 implying that the licensee operates a crematory or crematorium. Effective July 1, 2025,  
115.11 only the holder of a valid license to operate a natural organic reduction facility issued by  
115.12 the commissioner may use the title of natural organic reduction facility, human composting,  
115.13 or any other title, word, or term implying that the licensee operates a natural organic reduction  
115.14 facility.

115.15 Sec. 37. Minnesota Statutes 2022, section 149A.70, subdivision 2, is amended to read:

115.16 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, ~~or~~  
115.17 crematory, or, effective July 1, 2025, natural organic reduction facility shall not do business  
115.18 in a location that is not licensed as a funeral establishment, alkaline hydrolysis facility, ~~or~~  
115.19 crematory, or natural organic reduction facility and shall not advertise a service that is  
115.20 available from an unlicensed location.

115.21 Sec. 38. Minnesota Statutes 2022, section 149A.70, subdivision 3, is amended to read:

115.22 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern shall  
115.23 publish or disseminate false, misleading, or deceptive advertising. False, misleading, or  
115.24 deceptive advertising includes, but is not limited to:

115.25 (1) identifying, by using the names or pictures of, persons who are not licensed to practice  
115.26 mortuary science in a way that leads the public to believe that those persons will provide  
115.27 mortuary science services;

115.28 (2) using any name other than the names under which the funeral establishment, alkaline  
115.29 hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural organic reduction facility  
115.30 is known to or licensed by the commissioner;

115.31 (3) using a surname not directly, actively, or presently associated with a licensed funeral  
115.32 establishment, alkaline hydrolysis facility, ~~or~~ crematory, or, effective July 1, 2025, natural  
115.33 organic reduction facility, unless the surname had been previously and continuously used

116.1 by the licensed funeral establishment, alkaline hydrolysis facility, ~~or~~ crematory, or natural  
116.2 organic reduction facility; and

116.3 (4) using a founding or establishing date or total years of service not directly or  
116.4 continuously related to a name under which the funeral establishment, alkaline hydrolysis  
116.5 facility, ~~or~~ crematory, or, effective July 1, 2025, natural organic reduction facility is currently  
116.6 or was previously licensed.

116.7 Any advertising or other printed material that contains the names or pictures of persons  
116.8 affiliated with a funeral establishment, alkaline hydrolysis facility, ~~or~~ crematory, or, effective  
116.9 July 1, 2025, natural organic reduction facility shall state the position held by the persons  
116.10 and shall identify each person who is licensed or unlicensed under this chapter.

116.11 Sec. 39. Minnesota Statutes 2022, section 149A.70, subdivision 5, is amended to read:

116.12 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student,  
116.13 or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other  
116.14 reimbursement in consideration for recommending or causing a dead human body to be  
116.15 disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis  
116.16 facility, crematory, mausoleum, ~~or~~ cemetery, or, effective July 1, 2025, natural organic  
116.17 reduction facility.

116.18 Sec. 40. Minnesota Statutes 2022, section 149A.71, subdivision 2, is amended to read:

116.19 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices,  
116.20 the requirements of this subdivision must be met. This subdivision applies to natural organic  
116.21 reduction and naturally reduced remains goods and services effective July 1, 2025.

116.22 (b) Funeral providers must tell persons who ask by telephone about the funeral provider's  
116.23 offerings or prices any accurate information from the price lists described in paragraphs (c)  
116.24 to (e) and any other readily available information that reasonably answers the questions  
116.25 asked.

116.26 (c) Funeral providers must make available for viewing to people who inquire in person  
116.27 about the offerings or prices of funeral goods or burial site goods, separate printed or  
116.28 typewritten price lists using a ten-point font or larger. Each funeral provider must have a  
116.29 separate price list for each of the following types of goods that are sold or offered for sale:

116.30 (1) caskets;

116.31 (2) alternative containers;

- 117.1 (3) outer burial containers;
- 117.2 (4) alkaline hydrolysis containers;
- 117.3 (5) cremation containers;
- 117.4 (6) hydrolyzed remains containers;
- 117.5 (7) cremated remains containers;
- 117.6 (8) markers; ~~and~~
- 117.7 (9) headstones; and
- 117.8 (10) naturally reduced remains containers.

117.9 (d) Each separate price list must contain the name of the funeral provider's place of  
117.10 business, address, and telephone number and a caption describing the list as a price list for  
117.11 one of the types of funeral goods or burial site goods described in paragraph (c), clauses  
117.12 (1) to ~~(9)~~ (10). The funeral provider must offer the list upon beginning discussion of, but  
117.13 in any event before showing, the specific funeral goods or burial site goods and must provide  
117.14 a photocopy of the price list, for retention, if so asked by the consumer. The list must contain,  
117.15 at least, the retail prices of all the specific funeral goods and burial site goods offered which  
117.16 do not require special ordering, enough information to identify each, and the effective date  
117.17 for the price list. However, funeral providers are not required to make a specific price list  
117.18 available if the funeral providers place the information required by this paragraph on the  
117.19 general price list described in paragraph (e).

117.20 (e) Funeral providers must give a printed price list, for retention, to persons who inquire  
117.21 in person about the funeral goods, funeral services, burial site goods, or burial site services  
117.22 or prices offered by the funeral provider. The funeral provider must give the list upon  
117.23 beginning discussion of either the prices of or the overall type of funeral service or disposition  
117.24 or specific funeral goods, funeral services, burial site goods, or burial site services offered  
117.25 by the provider. This requirement applies whether the discussion takes place in the funeral  
117.26 establishment or elsewhere. However, when the deceased is removed for transportation to  
117.27 the funeral establishment, an in-person request for authorization to embalm does not, by  
117.28 itself, trigger the requirement to offer the general price list. If the provider, in making an  
117.29 in-person request for authorization to embalm, discloses that embalming is not required by  
117.30 law except in certain special cases, the provider is not required to offer the general price  
117.31 list. Any other discussion during that time about prices or the selection of funeral goods,  
117.32 funeral services, burial site goods, or burial site services triggers the requirement to give

118.1 the consumer a general price list. The general price list must contain the following  
118.2 information:

118.3 (1) the name, address, and telephone number of the funeral provider's place of business;

118.4 (2) a caption describing the list as a "general price list";

118.5 (3) the effective date for the price list;

118.6 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per hour,  
118.7 mile, or other unit of computation, and other information described as follows:

118.8 (i) forwarding of remains to another funeral establishment, together with a list of the  
118.9 services provided for any quoted price;

118.10 (ii) receiving remains from another funeral establishment, together with a list of the  
118.11 services provided for any quoted price;

118.12 (iii) separate prices for each alkaline hydrolysis, natural organic reduction, or cremation  
118.13 offered by the funeral provider, with the price including an alternative container or alkaline  
118.14 hydrolysis facility or cremation container; any alkaline hydrolysis, natural organic reduction  
118.15 facility, or crematory charges; and a description of the services and container included in  
118.16 the price, where applicable, and the price of alkaline hydrolysis or cremation where the  
118.17 purchaser provides the container;

118.18 (iv) separate prices for each immediate burial offered by the funeral provider, including  
118.19 a casket or alternative container, and a description of the services and container included  
118.20 in that price, and the price of immediate burial where the purchaser provides the casket or  
118.21 alternative container;

118.22 (v) transfer of remains to the funeral establishment or other location;

118.23 (vi) embalming;

118.24 (vii) other preparation of the body;

118.25 (viii) use of facilities, equipment, or staff for viewing;

118.26 (ix) use of facilities, equipment, or staff for funeral ceremony;

118.27 (x) use of facilities, equipment, or staff for memorial service;

118.28 (xi) use of equipment or staff for graveside service;

118.29 (xii) hearse or funeral coach;

118.30 (xiii) limousine; and

119.1 (xiv) separate prices for all cemetery-specific goods and services, including all goods  
119.2 and services associated with interment and burial site goods and services and excluding  
119.3 markers and headstones;

119.4 (5) the price range for the caskets offered by the funeral provider, together with the  
119.5 statement "A complete price list will be provided at the funeral establishment or casket sale  
119.6 location." or the prices of individual caskets, as disclosed in the manner described in  
119.7 paragraphs (c) and (d);

119.8 (6) the price range for the alternative containers or shrouds offered by the funeral provider,  
119.9 together with the statement "A complete price list will be provided at the funeral  
119.10 establishment or alternative container sale location." or the prices of individual alternative  
119.11 containers, as disclosed in the manner described in paragraphs (c) and (d);

119.12 (7) the price range for the outer burial containers offered by the funeral provider, together  
119.13 with the statement "A complete price list will be provided at the funeral establishment or  
119.14 outer burial container sale location." or the prices of individual outer burial containers, as  
119.15 disclosed in the manner described in paragraphs (c) and (d);

119.16 (8) the price range for the alkaline hydrolysis container offered by the funeral provider,  
119.17 together with the statement "A complete price list will be provided at the funeral  
119.18 establishment or alkaline hydrolysis container sale location." or the prices of individual  
119.19 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c) and  
119.20 (d);

119.21 (9) the price range for the hydrolyzed remains container offered by the funeral provider,  
119.22 together with the statement "A complete price list will be provided at the funeral  
119.23 establishment or hydrolyzed remains container sale location." or the prices of individual  
119.24 hydrolyzed remains container, as disclosed in the manner described in paragraphs (c) and  
119.25 (d);

119.26 (10) the price range for the cremation containers offered by the funeral provider, together  
119.27 with the statement "A complete price list will be provided at the funeral establishment or  
119.28 cremation container sale location." or the prices of individual cremation containers, as  
119.29 disclosed in the manner described in paragraphs (c) and (d);

119.30 (11) the price range for the cremated remains containers offered by the funeral provider,  
119.31 together with the statement, "A complete price list will be provided at the funeral  
119.32 establishment or cremated remains container sale location," or the prices of individual  
119.33 cremation containers as disclosed in the manner described in paragraphs (c) and (d);

120.1 (12) the price range for the naturally reduced remains containers offered by the funeral  
 120.2 provider, together with the statement, "A complete price list will be provided at the funeral  
 120.3 establishment or naturally reduced remains container sale location," or the prices of individual  
 120.4 naturally reduced remains containers as disclosed in the manner described in paragraphs  
 120.5 (c) and (d);

120.6 ~~(12)~~ (13) the price for the basic services of funeral provider and staff, together with a  
 120.7 list of the principal basic services provided for any quoted price and, if the charge cannot  
 120.8 be declined by the purchaser, the statement "This fee for our basic services will be added  
 120.9 to the total cost of the funeral arrangements you select. (This fee is already included in our  
 120.10 charges for alkaline hydrolysis, natural organic reduction, direct cremations, immediate  
 120.11 burials, and forwarding or receiving remains.)" If the charge cannot be declined by the  
 120.12 purchaser, the quoted price shall include all charges for the recovery of unallocated funeral  
 120.13 provider overhead, and funeral providers may include in the required disclosure the phrase  
 120.14 "and overhead" after the word "services." This services fee is the only funeral provider fee  
 120.15 for services, facilities, or unallocated overhead permitted by this subdivision to be  
 120.16 nondeclinable, unless otherwise required by law;

120.17 ~~(13)~~ (14) the price range for the markers and headstones offered by the funeral provider,  
 120.18 together with the statement "A complete price list will be provided at the funeral  
 120.19 establishment or marker or headstone sale location." or the prices of individual markers and  
 120.20 headstones, as disclosed in the manner described in paragraphs (c) and (d); and

120.21 ~~(14)~~ (15) any package priced funerals offered must be listed in addition to and following  
 120.22 the information required in paragraph (e) and must clearly state the funeral goods and  
 120.23 services being offered, the price being charged for those goods and services, and the  
 120.24 discounted savings.

120.25 (f) Funeral providers must give an itemized written statement, for retention, to each  
 120.26 consumer who arranges an at-need funeral or other disposition of human remains at the  
 120.27 conclusion of the discussion of the arrangements. The itemized written statement must be  
 120.28 signed by the consumer selecting the goods and services as required in section 149A.80. If  
 120.29 the statement is provided by a funeral establishment, the statement must be signed by the  
 120.30 licensed funeral director or mortician planning the arrangements. If the statement is provided  
 120.31 by any other funeral provider, the statement must be signed by an authorized agent of the  
 120.32 funeral provider. The statement must list the funeral goods, funeral services, burial site  
 120.33 goods, or burial site services selected by that consumer and the prices to be paid for each  
 120.34 item, specifically itemized cash advance items (these prices must be given to the extent then  
 120.35 known or reasonably ascertainable if the prices are not known or reasonably ascertainable,

121.1 a good faith estimate shall be given and a written statement of the actual charges shall be  
121.2 provided before the final bill is paid), and the total cost of goods and services selected. At  
121.3 the conclusion of an at-need arrangement, the funeral provider is required to give the  
121.4 consumer a copy of the signed itemized written contract that must contain the information  
121.5 required in this paragraph.

121.6 (g) Upon receiving actual notice of the death of an individual with whom a funeral  
121.7 provider has entered a preneed funeral agreement, the funeral provider must provide a copy  
121.8 of all preneed funeral agreement documents to the person who controls final disposition of  
121.9 the human remains or to the designee of the person controlling disposition. The person  
121.10 controlling final disposition shall be provided with these documents at the time of the  
121.11 person's first in-person contact with the funeral provider, if the first contact occurs in person  
121.12 at a funeral establishment, alkaline hydrolysis facility, crematory, natural organic reduction  
121.13 facility, or other place of business of the funeral provider. If the contact occurs by other  
121.14 means or at another location, the documents must be provided within 24 hours of the first  
121.15 contact.

121.16 Sec. 41. Minnesota Statutes 2022, section 149A.71, subdivision 4, is amended to read:

121.17 Subd. 4. **Casket, alternate container, alkaline hydrolysis container, naturally reduced**  
121.18 **remains container, and cremation container sales; records; required disclosures.** Any  
121.19 funeral provider who sells or offers to sell a casket, alternate container, alkaline hydrolysis  
121.20 container, hydrolyzed remains container, cremation container, ~~or~~ cremated remains container,  
121.21 or, effective July 1, 2025, naturally reduced remains container to the public must maintain  
121.22 a record of each sale that includes the name of the purchaser, the purchaser's mailing address,  
121.23 the name of the decedent, the date of the decedent's death, and the place of death. These  
121.24 records shall be open to inspection by the regulatory agency. Any funeral provider selling  
121.25 a casket, alternate container, or cremation container to the public, and not having charge of  
121.26 the final disposition of the dead human body, shall provide a copy of the statutes and rules  
121.27 controlling the removal, preparation, transportation, arrangements for disposition, and final  
121.28 disposition of a dead human body. This subdivision does not apply to morticians, funeral  
121.29 directors, funeral establishments, crematories, or wholesale distributors of caskets, alternate  
121.30 containers, alkaline hydrolysis containers, or cremation containers.

121.31 Sec. 42. Minnesota Statutes 2022, section 149A.72, subdivision 3, is amended to read:

121.32 Subd. 3. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**  
121.33 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods or

122.1 funeral services to the public, it is a deceptive act or practice for a funeral provider to  
122.2 represent that a casket is required for alkaline hydrolysis ~~or~~, cremations, or, effective July  
122.3 1, 2025, natural organic reduction by state or local law or otherwise.

122.4 Sec. 43. Minnesota Statutes 2022, section 149A.72, subdivision 9, is amended to read:

122.5 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods, funeral  
122.6 services, burial site goods, or burial site services to the public, it is a deceptive act or practice  
122.7 for a funeral provider to represent that federal, state, or local laws, or particular cemeteries,  
122.8 alkaline hydrolysis facilities, ~~or~~ crematories, or, effective July 1, 2025, natural organic  
122.9 reduction facilities require the purchase of any funeral goods, funeral services, burial site  
122.10 goods, or burial site services when that is not the case.

122.11 Sec. 44. Minnesota Statutes 2022, section 149A.73, subdivision 1, is amended to read:

122.12 Subdivision 1. **Casket for alkaline hydrolysis, natural organic reduction, or cremation**  
122.13 **provisions; deceptive acts or practices.** In selling or offering to sell funeral goods, funeral  
122.14 services, burial site goods, or burial site services to the public, it is a deceptive act or practice  
122.15 for a funeral provider to require that a casket be purchased for alkaline hydrolysis ~~or~~,  
122.16 cremation, or, effective July 1, 2025, natural organic reduction.

122.17 Sec. 45. Minnesota Statutes 2022, section 149A.74, subdivision 1, is amended to read:

122.18 Subdivision 1. **Services provided without prior approval; deceptive acts or**  
122.19 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it is  
122.20 a deceptive act or practice for any funeral provider to embalm a dead human body unless  
122.21 state or local law or regulation requires embalming in the particular circumstances regardless  
122.22 of any funeral choice which might be made, or prior approval for embalming has been  
122.23 obtained from an individual legally authorized to make such a decision. In seeking approval  
122.24 to embalm, the funeral provider must disclose that embalming is not required by law except  
122.25 in certain circumstances; that a fee will be charged if a funeral is selected which requires  
122.26 embalming, such as a funeral with viewing; and that no embalming fee will be charged if  
122.27 the family selects a service which does not require embalming, such as direct alkaline  
122.28 hydrolysis, direct cremation, ~~or~~ immediate burial, or, effective July 1, 2025, natural organic  
122.29 reduction.

123.1 Sec. 46. Minnesota Statutes 2022, section 149A.93, subdivision 3, is amended to read:

123.2 Subd. 3. **Disposition permit.** A disposition permit is required before a body can be  
123.3 buried, entombed, alkaline hydrolyzed, ~~or cremated~~, or, effective July 1, 2025, naturally  
123.4 reduced. No disposition permit shall be issued until a fact of death record has been completed  
123.5 and filed with the state registrar of vital records.

123.6 Sec. 47. Minnesota Statutes 2022, section 149A.94, subdivision 1, is amended to read:

123.7 Subdivision 1. **Generally.** Every dead human body lying within the state, except  
123.8 unclaimed bodies delivered for dissection by the medical examiner, those delivered for  
123.9 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through  
123.10 the state for the purpose of disposition elsewhere; and the remains of any dead human body  
123.11 after dissection or anatomical study, shall be decently buried or entombed in a public or  
123.12 private cemetery, alkaline hydrolyzed, ~~or cremated~~, or, effective July 1, 2025, naturally  
123.13 reduced within a reasonable time after death. Where final disposition of a body will not be  
123.14 accomplished, or, effective July 1, 2025, when natural organic reduction will not be initiated,  
123.15 within 72 hours following death or release of the body by a competent authority with  
123.16 jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed  
123.17 with dry ice. A body may not be kept in refrigeration for a period exceeding six calendar  
123.18 days, or packed in dry ice for a period that exceeds four calendar days, from the time of  
123.19 death or release of the body from the coroner or medical examiner.

123.20 Sec. 48. Minnesota Statutes 2022, section 149A.94, subdivision 3, is amended to read:

123.21 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, ~~or cremated~~,  
123.22 alkaline hydrolyzed, or, effective July 1, 2025, naturally reduced without a disposition  
123.23 permit. The disposition permit must be filed with the person in charge of the place of final  
123.24 disposition. Where a dead human body will be transported out of this state for final  
123.25 disposition, the body must be accompanied by a certificate of removal.

123.26 Sec. 49. Minnesota Statutes 2022, section 149A.94, subdivision 4, is amended to read:

123.27 Subd. 4. **Alkaline hydrolysis ~~or~~, cremation, or natural organic reduction.** Inurnment  
123.28 of alkaline hydrolyzed ~~or remains~~, cremated remains, or, effective July 1, 2025, naturally  
123.29 reduced remains and release to an appropriate party is considered final disposition and no  
123.30 further permits or authorizations are required for transportation, interment, entombment, or  
123.31 placement of the ~~cremated~~ remains, except as provided in section 149A.95, subdivision 16.

124.1 Sec. 50. [149A.955] NATURAL ORGANIC REDUCTION FACILITIES AND  
124.2 NATURAL ORGANIC REDUCTION.

124.3 Subdivision 1. License required. This section is effective July 1, 2025. A dead human  
124.4 body may only undergo natural organic reduction in this state at a natural organic reduction  
124.5 facility licensed by the commissioner of health.

124.6 Subd. 2. General requirements. Any building to be used as a natural organic reduction  
124.7 facility must comply with all applicable local and state building codes, zoning laws and  
124.8 ordinances, and environmental standards. A natural organic reduction facility must have on  
124.9 site a natural organic reduction system approved by the commissioner and a motorized  
124.10 mechanical device for processing the remains in natural reduction and must have in the  
124.11 building a refrigerated holding facility for the retention of dead human bodies awaiting  
124.12 natural organic reduction. The holding facility must be secure from access by anyone except  
124.13 the authorized personnel of the natural organic reduction facility, preserve the dignity of  
124.14 the remains, and protect the health and safety of the natural organic reduction facility  
124.15 personnel.

124.16 Subd. 3. Aerobic reduction vessel. A natural organic reduction facility must use as a  
124.17 natural organic reduction vessel a contained reduction vessel that is designed to promote  
124.18 aerobic reduction and that minimizes odors.

124.19 Subd. 4. Any room where body is prepared. Any room where the deceased will be  
124.20 prepared for natural organic reduction must be properly lit and ventilated with an exhaust  
124.21 fan. It must be equipped with a functional sink with hot and cold running water. It must  
124.22 have nonporous flooring, such that a sanitary condition is provided. The walls and ceiling  
124.23 of the room must run from floor to ceiling and be covered with tile, or by plaster or sheetrock  
124.24 painted with washable paint or other appropriate material, such that a sanitary condition is  
124.25 provided. The doors, walls, ceiling, and windows must be constructed to prevent odors from  
124.26 entering any other part of the building.

124.27 Subd. 5. Access and privacy. (a) The room where a licensed mortician prepares a body  
124.28 must be private and must not have a general passageway through it. All windows or other  
124.29 openings to the outside must be treated in a manner that prevents viewing into the room  
124.30 where the deceased will be prepared for natural organic reduction. A viewing window for  
124.31 authorized family members or their designees is not a violation of this subdivision.

124.32 (b) The room must, at all times, be secure from the entrance of unauthorized persons.

124.33 (c) For purposes of this section, "authorized persons" are:

- 125.1 (1) licensed morticians;  
125.2 (2) registered interns or students as described in section 149A.91, subdivision 6;  
125.3 (3) public officials or representatives in the discharge of their official duties;  
125.4 (4) trained natural organic reduction facility operators; and  
125.5 (5) the person or persons with the right to control the dead human body as defined in  
125.6 section 149A.80, subdivision 2, and their designees.

125.7 (d) Each door allowing ingress or egress must carry a sign that indicates that the room  
125.8 is private and access is limited. All authorized persons who are present in or enter the room  
125.9 while a body is being prepared for final disposition must be attired according to all applicable  
125.10 state and federal regulations regarding the control of infectious disease and occupational  
125.11 and workplace health and safety.

125.12 Subd. 6. **Areas for vessels or naturally organic reduction operations.** Any rooms or  
125.13 areas where the vessels reside or where any operation takes place involving the handling  
125.14 of the vessels or the remains must be ventilated with exhaust fans. The doors, walls, ceiling,  
125.15 and windows shall be constructed to prevent odors from entering any other part of the  
125.16 building. All windows must be treated in a manner that maintains privacy when the remains  
125.17 are handled. A sanitary condition must be provided. Any area where human remains are  
125.18 transferred, prepared, or processed must have nonpourous flooring, and the walls and ceiling  
125.19 of the rooms must run from floor to ceiling and be covered with tile, or by plaster, sheetrock,  
125.20 or concrete painted with washable paint or other appropriate material, such that a sanitary  
125.21 condition is provided. Access to the vessel holding area must only be granted to individuals  
125.22 outlined in subdivision 5 and to authorized visitors at the discretion of the licensed facility  
125.23 under the direct supervision of trained facility staff, provided that such access does not  
125.24 violate subdivision 18.

125.25 Subd. 7. **Equipment and supplies.** The natural organic reduction facility must have a  
125.26 functional emergency eye wash and quick drench shower.

125.27 Subd. 8. **Sanitary conditions and permitted use.** The room where the deceased will  
125.28 be prepared for natural organic reduction, the area where the natural organic reduction  
125.29 vessels are located or where the natural organic reduction operations are undertaken, and  
125.30 all fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies  
125.31 stored or used in these operations must be maintained in a clean and sanitary condition at  
125.32 all times.

126.1 Subd. 9. **Occupational and workplace safety.** All applicable provisions of state and  
126.2 federal regulations regarding exposure to workplace hazards and accidents must be followed  
126.3 to protect the health and safety of all authorized persons at the natural organic reduction  
126.4 facility.

126.5 Subd. 10. **Unlicensed personnel.** A licensed natural organic reduction facility may  
126.6 employ unlicensed personnel, provided that all applicable provisions of this chapter are  
126.7 followed. It is the duty of the licensed natural organic reduction facility to provide proper  
126.8 training for all unlicensed personnel, and the licensed natural organic reduction facility shall  
126.9 be strictly accountable for compliance with this chapter and other applicable state and federal  
126.10 regulations regarding occupational and workplace health and safety.

126.11 Subd. 11. **Authorization to naturally reduce.** No natural organic reduction facility  
126.12 shall naturally reduce or cause to be naturally reduced any dead human body or identifiable  
126.13 body part without receiving written authorization to do so from the person or persons who  
126.14 have the legal right to control disposition as described in section 149A.80 or the person's  
126.15 legal designee. The written authorization must include:

126.16 (1) the name of the deceased and the date of death of the deceased;

126.17 (2) a statement authorizing the natural organic reduction facility to naturally reduce the  
126.18 body;

126.19 (3) the name, address, phone number, relationship to the deceased, and signature of the  
126.20 person or persons with the legal right to control final disposition or a legal designee;

126.21 (4) directions for the disposition of any non-naturally reduced materials or items recovered  
126.22 from the natural organic reduction vessel;

126.23 (5) acknowledgment that some of the remains will be mechanically reduced to a  
126.24 granulated appearance and returned to the natural reduction vessel with the remains for final  
126.25 reduction; and

126.26 (6) directions for the ultimate disposition of the naturally reduced remains.

126.27 Subd. 12. **Limitation of liability.** The limitations in section 149A.95, subdivision 5,  
126.28 apply to natural organic reduction facilities.

126.29 Subd. 13. **Acceptance of delivery of body.** (a) No dead human body shall be accepted  
126.30 for final disposition by natural organic reduction unless the body is:

126.31 (1) wrapped in a container, such as a pouch, that is impermeable or leak-resistant;

127.1 (2) accompanied by a disposition permit issued pursuant to section 149A.93, subdivision  
127.2 3, including a photocopy of the complete death record or a signed release authorizing natural  
127.3 organic reduction received from a coroner or medical examiner; and

127.4 (3) accompanied by a natural organic reduction authorization that complies with  
127.5 subdivision 5.

127.6 (b) A natural organic reduction facility shall refuse to accept delivery of the dead human  
127.7 body:

127.8 (1) where there is a known dispute concerning natural organic reduction of the body  
127.9 delivered;

127.10 (2) where there is a reasonable basis for questioning any of the representations made on  
127.11 the written authorization to naturally reduce; or

127.12 (3) for any other lawful reason.

127.13 (c) When a container or pouch containing a dead human body shows evidence of leaking  
127.14 bodily fluid, the container or pouch and the body must be returned to the contracting funeral  
127.15 establishment, or the body must be transferred to a new container or pouch by a licensed  
127.16 mortician.

127.17 (d) If a dead human body is delivered to a natural organic reduction facility in a container  
127.18 or pouch that is not suitable for placement in a natural organic reduction vessel, the transfer  
127.19 of the body to the vessel must be performed by a licensed mortician.

127.20 Subd. 14. **Bodies awaiting natural organic reduction.** A dead human body must be  
127.21 placed in the natural organic reduction vessel to initiate the natural reduction process within  
127.22 24 hours after the natural organic reduction facility accepts legal and physical custody of  
127.23 the body.

127.24 Subd. 15. **Handling of dead human bodies.** All natural organic reduction facility  
127.25 employees handling the containers or pouches for dead human bodies shall use universal  
127.26 precautions and otherwise exercise all reasonable precautions to minimize the risk of  
127.27 transmitting any communicable disease from the body. No dead human body shall be  
127.28 removed from the container or pouch in which it is delivered to the natural organic reduction  
127.29 facility without express written authorization of the person or persons with legal right to  
127.30 control the disposition and only by a licensed mortician. The remains shall be considered  
127.31 a dead human body until after the final reduction. The person or persons with the legal right  
127.32 to control the body may be involved with preparation of the body pursuant to section  
127.33 149A.01, subdivision 3, paragraph (c).

128.1 Subd. 16. **Identification of the body.** All licensed natural organic reduction facilities  
128.2 shall develop, implement, and maintain an identification procedure whereby dead human  
128.3 bodies can be identified from the time the natural organic reduction facility accepts delivery  
128.4 of the body until the naturally reduced remains are released to an authorized party. After  
128.5 natural organic reduction, an identifying disk, tab, or other permanent label shall be placed  
128.6 within the naturally reduced remains container or containers before the remains are released  
128.7 from the natural organic reduction facility. Each identification disk, tab, or label shall have  
128.8 a number that shall be recorded on all paperwork regarding the decedent. This procedure  
128.9 shall be designed to reasonably ensure that the proper body is naturally reduced and that  
128.10 the remains are returned to the appropriate party. Loss of all or part of the remains or the  
128.11 inability to individually identify the remains is a violation of this subdivision.

128.12 Subd. 17. **Natural organic reduction vessel for human remains.** A licensed natural  
128.13 organic reduction facility shall knowingly naturally reduce only dead human bodies or  
128.14 human remains in a natural organic reduction vessel.

128.15 Subd. 18. **Natural organic reduction procedures; privacy.** The final disposition of  
128.16 dead human bodies by natural organic reduction shall be done in privacy. Unless there is  
128.17 written authorization from the person with the legal right to control the final disposition,  
128.18 only authorized natural organic reduction facility personnel shall be permitted in the natural  
128.19 organic reduction area while any human body is awaiting placement or being placed in a  
128.20 natural organic reduction vessel, being removed from the vessel, or being processed for  
128.21 placement for final reduction. This does not prohibit an in-person laying-in ceremony to  
128.22 honor the deceased and the transition prior to the placement.

128.23 Subd. 19. **Natural organic reduction procedures; commingling of bodies**  
128.24 **prohibited.** Except with the express written permission of the person with the legal right  
128.25 to control the final disposition, no natural organic reduction facility shall naturally reduce  
128.26 more than one dead human body at the same time and in the same natural organic reduction  
128.27 vessel or introduce a second dead human body into same natural organic reduction vessel  
128.28 until reasonable efforts have been employed to remove all fragments of remains from the  
128.29 preceding natural organic reduction. This subdivision does not apply where commingling  
128.30 of human remains during natural organic reduction is otherwise provided by law. The fact  
128.31 that there is incidental and unavoidable residue in the natural organic reduction vessel used  
128.32 in a prior natural organic reduction is not a violation of this subdivision.

128.33 Subd. 20. **Natural organic reduction procedures; removal from natural organic**  
128.34 **reduction vessel.** Upon completion of the natural organic reduction process, reasonable  
128.35 efforts shall be made to remove from the natural organic reduction vessel all the recoverable

129.1 remains. The remains shall be transported to the processing area, and any non-naturally  
129.2 reducible materials or items shall be separated from the remains and disposed of, in any  
129.3 lawful manner, by the natural organic reduction facility.

129.4 Subd. 21. **Natural organic reduction procedures; processing remains.** The remains  
129.5 that remain intact shall be reduced by a motorized mechanical processor to a granulated  
129.6 appearance. The granulated remains and the rest of the naturally reduced remains shall be  
129.7 returned to a natural organic reduction vessel for final reduction. The remains shall be  
129.8 considered a dead human body until after the final reduction.

129.9 Subd. 22. **Natural organic reduction procedures; commingling of remains**  
129.10 **prohibited.** Except with the express written permission of the person with the legal right  
129.11 to control the final deposition or otherwise provided by law, no natural organic reduction  
129.12 facility shall mechanically process the remains of more than one body at a time in the same  
129.13 mechanical processor or introduce the remains of a second body into a mechanical processor  
129.14 until reasonable efforts have been employed to remove all fragments of remains already in  
129.15 the processor. The fact that there is incidental and unavoidable residue in the mechanical  
129.16 processor is not a violation of this subdivision.

129.17 Subd. 23. **Natural organic reduction procedures; testing naturally reduced**  
129.18 **remains.** A natural organic reduction facility must:

129.19 (1) ensure that the material in the natural organic reduction vessel naturally reaches and  
129.20 maintains a minimum temperature of 131 degrees Fahrenheit for a minimum of 72  
129.21 consecutive hours during the process of natural organic reduction;

129.22 (2) analyze each instance of the naturally reduced remains for physical contaminants,  
129.23 including but not limited to intact bone, dental fillings, and medical implants, and ensure  
129.24 naturally reduced remains have less than 0.01 mg/kg dry weight of any physical contaminants;

129.25 (3) collect material samples for analysis that are representative of each instance of natural  
129.26 organic reduction, using a sampling method such as those described in the U.S. Composting  
129.27 Council 2002 Test Methods for the Examination of Composting and Compost, method  
129.28 02.01-A through E;

129.29 (4) develop and use a natural organic reduction process in which the naturally reduced  
129.30 remains from the process do not exceed the following limits:

129.31 <u><b>Metals and other testing</b></u>	129.31 <u><b>Limit (mg/kg dry weight), unless otherwise</b></u>
129.32 <u><b>parameters</b></u>	129.32 <u><b>specified</b></u>
129.33 <u>Fecal coliform</u>	129.33 <u>Less than 1,000 most probable number per gram</u>
129.34 <u>Fecal coliform</u>	129.34 <u>of total solids (dry weight)</u>

130.1		<u>Less than 3 most probable number per 4 grams</u>
130.2	<u>Salmonella</u>	<u>of total solids (dry weight)</u>
130.3	<u>Arsenic</u>	<u>Less than or equal to 11 ppm</u>
130.4	<u>Cadmium</u>	<u>Less than or equal to 7.1 ppm</u>
130.5	<u>Lead</u>	<u>Less than or equal to 150 ppm</u>
130.6	<u>Mercury</u>	<u>Less than or equal to 5 ppm</u>
130.7	<u>Selenium</u>	<u>Less than or equal to 18 ppm;</u>

130.8 (5) analyze, using a third-party laboratory, the natural organic reduction facility's material  
130.9 samples of naturally reduced remains according to the following schedule:

130.10 (i) the natural organic reduction facility must analyze each of the first 20 instances of  
130.11 naturally reduced remains for the parameters in clause (4);

130.12 (ii) if any of the first 20 instances of naturally reduced remains yield results exceeding  
130.13 the limits in clause (4), the natural organic reduction facility must conduct appropriate  
130.14 processes to correct the levels of the substances in clause (4) and have the resultant remains  
130.15 tested to ensure they fall within the identified limits;

130.16 (iii) if any of the first 20 instances of naturally reduced remains yield results exceeding  
130.17 the limits in clause (4), the natural organic reduction facility must analyze each additional  
130.18 instance of naturally reduced remains for the parameters in clause (4) until a total of 20  
130.19 samples, not including those from remains that were reprocessed as required in item (ii),  
130.20 have yielded results within the limits in clause (4) on initial testing;

130.21 (iv) after 20 material samples of naturally reduced remains have met the limits in clause  
130.22 (4), the natural organic reduction facility must analyze at least 25 percent of the natural  
130.23 organic reduction facility's monthly instances of naturally reduced remains for the parameters  
130.24 in clause (4) until 80 total material samples of naturally reduced remains are found to meet  
130.25 the limits in clause (4), not including any samples that required reprocessing to meet those  
130.26 limits; and

130.27 (v) after 80 material samples of naturally reduced remains are found to meet the limits  
130.28 in clause (4), the natural organic reduction facility must analyze at least one randomly chosen  
130.29 instance of naturally reduced remains each month for the parameters in clause (4). If fecal  
130.30 coliform or salmonella in the tested remains exceeds the limit for that substance in clause  
130.31 (4), the natural organic reduction facility must analyze each subsequent instance of naturally  
130.32 reduced remains for fecal coliform and salmonella until ten total material samples are found  
130.33 to meet the limits for those substances in clause (4) on initial testing, demonstrating the  
130.34 natural organic reduction process was effectively corrected;

131.1 (6) comply with any testing requirements established by the commissioner for content  
131.2 parameters in addition to those specified in clause (4);

131.3 (7) not release any naturally reduced remains that exceed the limits in clause (4); and

131.4 (8) prepare, maintain, and provide to the commissioner upon request, a report for each  
131.5 calendar year detailing the natural organic reduction facility's activities during the previous  
131.6 calendar year. The report must include the following information:

131.7 (i) the name and address of the natural organic reduction facility;

131.8 (ii) the calendar year covered by the report;

131.9 (iii) the annual quantity of naturally reduced remains;

131.10 (iv) the results of any laboratory analyses of naturally reduced remains; and

131.11 (v) any additional information required by the commissioner.

131.12 **Subd. 24. Natural organic reduction procedures; use of more than one naturally**  
131.13 **reduced remains container.** If the naturally reduced remains are to be separated into two  
131.14 or more naturally reduced remains containers according to the directives provided in the  
131.15 written authorization for natural organic reduction, all of the containers shall contain duplicate  
131.16 identification disks, tabs, or permanent labels and all paperwork regarding the given body  
131.17 shall include a notation of the number of and disposition of each container, as provided in  
131.18 the written authorization.

131.19 **Subd. 25. Natural organic reduction procedures; disposition of accumulated**  
131.20 **residue.** Every natural organic reduction facility shall provide for the removal and disposition  
131.21 of any accumulated residue from any natural organic reduction vessel, mechanical processor,  
131.22 or other equipment used in natural organic reduction. Disposition of accumulated residue  
131.23 shall be by any lawful manner deemed appropriate.

131.24 **Subd. 26. Natural organic reduction procedures; release of naturally reduced**  
131.25 **remains.** Following completion of the natural organic reduction process, the inurned naturally  
131.26 reduced remains shall be released according to the instructions given on the written  
131.27 authorization for natural organic reduction. If the remains are to be shipped, they must be  
131.28 securely packaged and transported by a method that has an internal tracing system available  
131.29 and which provides a receipt signed by the person accepting delivery. Where there is a  
131.30 dispute over release or disposition of the naturally reduced remains, a natural organic  
131.31 reduction facility may deposit the naturally reduced remains in accordance with the directives  
131.32 of a court of competent jurisdiction pending resolution of the dispute or retain the naturally  
131.33 reduced remains until the person with the legal right to control disposition presents

132.1 satisfactory indication that the dispute is resolved. A natural organic reduction facility must  
132.2 make every effort to ensure naturally reduced remains are not sold or used for commercial  
132.3 purposes.

132.4 Subd. 27. **Unclaimed naturally reduced remains.** If, after 30 calendar days following  
132.5 the inurnment, the naturally reduced remains are not claimed or disposed of according to  
132.6 the written authorization for natural organic reduction, the natural organic reduction facility  
132.7 shall give written notice, by certified mail, to the person with the legal right to control the  
132.8 final disposition or a legal designee, that the naturally reduced remains are unclaimed and  
132.9 requesting further release directions. Should the naturally reduced remains be unclaimed  
132.10 120 calendar days following the mailing of the written notification, the natural organic  
132.11 reduction facility may return the remains to the earth respectfully in any lawful manner  
132.12 deemed appropriate.

132.13 Subd. 28. **Required records.** Every natural organic reduction facility shall create and  
132.14 maintain on its premises or other business location in Minnesota an accurate record of every  
132.15 natural organic reduction provided. The record shall include all of the following information  
132.16 for each natural organic reduction:

132.17 (1) the name of the person or funeral establishment delivering the body for natural  
132.18 organic reduction;

132.19 (2) the name of the deceased and the identification number assigned to the body;

132.20 (3) the date of acceptance of delivery;

132.21 (4) the names of the operator of the natural organic reduction process and mechanical  
132.22 processor operator;

132.23 (5) the times and dates that the body was placed in and removed from the natural organic  
132.24 reduction vessel;

132.25 (6) the time and date that processing and inurnment of the naturally reduced remains  
132.26 was completed;

132.27 (7) the time, date, and manner of release of the naturally reduced remains;

132.28 (8) the name and address of the person who signed the authorization for natural organic  
132.29 reduction;

132.30 (9) all supporting documentation, including any transit or disposition permits, a photocopy  
132.31 of the death record, and the authorization for natural organic reduction; and

132.32 (10) the type of natural organic reduction vessel.

133.1 Subd. 29. **Retention of records.** Records required under subdivision 28 shall be  
133.2 maintained for a period of three calendar years after the release of the naturally reduced  
133.3 remains. Following this period and subject to any other laws requiring retention of records,  
133.4 the natural organic reduction facility may then place the records in storage or reduce them  
133.5 to microfilm, a digital format, or any other method that can produce an accurate reproduction  
133.6 of the original record, for retention for a period of ten calendar years from the date of release  
133.7 of the naturally reduced remains. At the end of this period and subject to any other laws  
133.8 requiring retention of records, the natural organic reduction facility may destroy the records  
133.9 by shredding, incineration, or any other manner that protects the privacy of the individuals  
133.10 identified.

133.11 Sec. 51. **STILLBIRTH PREVENTION THROUGH TRACKING FETAL**  
133.12 **MOVEMENT PILOT PROGRAM.**

133.13 Subdivision 1. **Grant.** The commissioner of health shall issue a grant to a grant recipient  
133.14 to support a stillbirth prevention through tracking fetal movement pilot program and to  
133.15 provide evidence of the efficacy of tracking fetal movements in preventing stillbirths in  
133.16 Minnesota. The pilot program shall operate in fiscal years 2025, 2026, and 2027.

133.17 Subd. 2. **Use of grant funds.** The grant recipient must use grant funds:

133.18 (1) for activities to ensure that expectant parents in Minnesota receive information about  
133.19 the importance of tracking fetal movement in the third trimester of pregnancy, by providing  
133.20 evidence-based information to organizations that include but are not limited to community  
133.21 organizations, hospitals, birth centers, maternal health providers, and higher education  
133.22 institutions that educate maternal health providers;

133.23 (2) to provide maternal health providers and expectant parents in Minnesota with access  
133.24 to free, evidence-based educational materials on fetal movement tracking, including  
133.25 brochures, posters, reminder cards, continuing education materials, and digital resources;

133.26 (3) to assist in raising awareness with health care providers about:

133.27 (i) the availability of free fetal movement tracking education for providers through an  
133.28 initial education campaign;

133.29 (ii) the importance of tracking fetal movement in the third trimester of pregnancy by  
133.30 offering at least three to five webinars and conferences per year; and

133.31 (iii) the importance of tracking fetal movement in the third trimester of pregnancy through  
133.32 provider participation in a public relations campaign; and

134.1 (4) to assist in raising public awareness about the availability of free fetal movement  
134.2 tracking resources through social media marketing and traditional marketing throughout  
134.3 Minnesota.

134.4 Subd. 3. **Data-sharing and monitoring.** (a) During the operation of the pilot program,  
134.5 the grant recipient shall provide the following information to the commissioner on at least  
134.6 a quarterly basis:

134.7 (1) the number of educational materials distributed under the pilot program, broken  
134.8 down by zip code and the type of facility or organization that ordered the materials, including  
134.9 hospitals, birth centers, maternal health clinics, WIC clinics, and community organizations;

134.10 (2) the number of fetal movement tracking application downloads that may be attributed  
134.11 to the pilot program, broken down by zip code;

134.12 (3) the reach of and engagement with marketing materials provided under the pilot  
134.13 program; and

134.14 (4) provider attendance and participation in awareness-raising events under the pilot  
134.15 program, such as webinars and conferences.

134.16 (b) Each year during the pilot program and at the conclusion of the pilot program, the  
134.17 grant recipient shall provide the commissioner with an annual report that includes information  
134.18 on how the pilot program has affected:

134.19 (1) fetal death rates in Minnesota;

134.20 (2) fetal death rates in Minnesota among American Indian, Black, Hispanic, and Asian  
134.21 Pacific Islander populations; and

134.22 (3) fetal death rates by region in Minnesota.

134.23 Subd. 4. **Reports.** The commissioner must submit to the legislative committees with  
134.24 jurisdiction over public health an interim report and a final report on the operation of the  
134.25 pilot program. The interim report must be submitted by December 1, 2025, and the final  
134.26 report must be submitted by December 1, 2027. Each report must at least describe the pilot  
134.27 program's operations and provide information, to the extent available, on the effectiveness  
134.28 of the pilot program in preventing stillbirths in Minnesota, including lessons learned in  
134.29 implementing the pilot program and recommendations for future action.

135.1 **ARTICLE 6**

135.2 **DEPARTMENT OF HEALTH POLICY**

135.3 Section 1. Minnesota Statutes 2022, section 62D.14, subdivision 1, is amended to read:

135.4 Subdivision 1. **Examination authority.** The commissioner of health may make an  
135.5 examination of the affairs of any health maintenance organization and its contracts,  
135.6 agreements, or other arrangements with any participating entity as often as the commissioner  
135.7 of health deems necessary for the protection of the interests of the people of this state, but  
135.8 not less frequently than once every ~~three~~ five years. Examinations of participating entities  
135.9 pursuant to this subdivision shall be limited to their dealings with the health maintenance  
135.10 organization and its enrollees, except that examinations of major participating entities may  
135.11 include inspection of the entity's financial statements kept in the ordinary course of business.  
135.12 The commissioner may require major participating entities to submit the financial statements  
135.13 directly to the commissioner. Financial statements of major participating entities are subject  
135.14 to the provisions of section 13.37, subdivision 1, clause (b), upon request of the major  
135.15 participating entity or the health maintenance organization with which it contracts.

135.16 Sec. 2. **[62J.461] 340B COVERED ENTITY REPORT.**

135.17 Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions  
135.18 apply.

135.19 (b) "340B covered entity" or "covered entity" means a covered entity as defined in United  
135.20 States Code, title 42, section 256b(a)(4), with a service address in Minnesota as of January  
135.21 1 of the reporting year. 340B covered entity includes all entity types and grantees. All  
135.22 facilities that are identified as child sites or grantee associated sites under the federal 340B  
135.23 Drug Pricing Program are considered part of the 340B covered entity.

135.24 (c) "340B Drug Pricing Program" or "340B program" means the drug discount program  
135.25 established under United States Code, title 42, section 256b.

135.26 (d) "340B entity type" is the designation of the 340B covered entity according to the  
135.27 entity types specified in United States Code, title 42, section 256b(a)(4).

135.28 (e) "340B ID" is the unique identification number provided by the Health Resources  
135.29 and Services Administration to identify a 340B-eligible entity in the 340B Office of Pharmacy  
135.30 Affairs Information System.

135.31 (f) "Contract pharmacy" means a pharmacy with which a 340B covered entity has an  
135.32 arrangement to dispense drugs purchased under the 340B Drug Pricing Program.

136.1 (g) "Pricing unit" means the smallest dispensable amount of a prescription drug product  
136.2 that can be dispensed or administered.

136.3 Subd. 2. **Current registration.** Beginning April 1, 2024, each 340B covered entity must  
136.4 maintain a current registration with the commissioner in a form and manner prescribed by  
136.5 the commissioner. The registration must include the following information:

136.6 (1) the name of the 340B covered entity;

136.7 (2) the 340B ID of the 340B covered entity;

136.8 (3) the servicing address of the 340B covered entity; and

136.9 (4) the 340B entity type of the 340B covered entity.

136.10 Subd. 3. **Reporting by covered entities to the commissioner.** (a) Each 340B covered  
136.11 entity shall report to the commissioner by April 1 of each year the following information  
136.12 for transactions conducted by the 340B covered entity or on its behalf, and related to its  
136.13 participation in the federal 340B program for the previous calendar year:

136.14 (1) the aggregated acquisition cost for prescription drugs obtained under the 340B  
136.15 program;

136.16 (2) the aggregated payment amount received for drugs obtained under the 340B program  
136.17 and dispensed or administered to patients;

136.18 (3) the number of pricing units dispensed or administered for prescription drugs described  
136.19 in clause (2); and

136.20 (4) the aggregated payments made:

136.21 (i) to contract pharmacies to dispense drugs obtained under the 340B program;

136.22 (ii) to any other entity that is not the covered entity and is not a contract pharmacy for  
136.23 managing any aspect of the covered entity's 340B program; and

136.24 (iii) for all other expenses related to administering the 340B program.

136.25 The information under clauses (2) and (3) must be reported by payer type, including but  
136.26 not limited to commercial insurance, medical assistance, MinnesotaCare, and Medicare, in  
136.27 the form and manner prescribed by the commissioner.

136.28 (b) For covered entities that are hospitals, the information required under paragraph (a),  
136.29 clauses (1) to (3), must also be reported at the national drug code level for the 50 most  
136.30 frequently dispensed or administered drugs by the facility under the 340B program.

137.1 (c) Data submitted to the commissioner under paragraphs (a) and (b) are classified as  
137.2 nonpublic data, as defined in section 13.02, subdivision 9.

137.3 Subd. 4. **Enforcement and exceptions.** (a) Any health care entity subject to reporting  
137.4 under this section that fails to provide data in the form and manner prescribed by the  
137.5 commissioner is subject to a fine paid to the commissioner of up to \$500 for each day the  
137.6 data are past due. Any fine levied against the entity under this subdivision is subject to the  
137.7 contested case and judicial review provisions of sections 14.57 and 14.69.

137.8 (b) The commissioner may grant an entity an extension of or exemption from the reporting  
137.9 obligations under this subdivision, upon a showing of good cause by the entity.

137.10 Subd. 5. **Reports to the legislature.** By November 15, 2024, and by November 15 of  
137.11 each year thereafter, the commissioner shall submit to the chairs and ranking minority  
137.12 members of the legislative committees with jurisdiction over health care finance and policy,  
137.13 a report that aggregates the data submitted under subdivision 3, paragraphs (a) and (b). The  
137.14 following information must be included in the report for all 340B entities whose net 340B  
137.15 revenue constitutes a significant share, as determined by the commissioner, of all net 340B  
137.16 revenue across all 340B covered entities in Minnesota:

137.17 (1) the information submitted under subdivision 2; and

137.18 (2) for each 340B entity identified in subdivision 2, that entity's 340B net revenue as  
137.19 calculated using the data submitted under subdivision 3, paragraph (a), with net revenue  
137.20 being subdivision 3, paragraph (a), clause (2), less the sum of subdivision 3, paragraph (a),  
137.21 clauses (1) and (4).

137.22 For all other entities, the data in the report must be aggregated to the entity type or groupings  
137.23 of entity types in a manner that prevents the identification of an individual entity and any  
137.24 entity's specific data value reported for an individual data element.

137.25 Sec. 3. Minnesota Statutes 2022, section 62J.61, subdivision 5, is amended to read:

137.26 Subd. 5. ~~Biennial review of rulemaking procedures and rules~~ Opportunity for  
137.27 comment. The commissioner shall ~~biennially seek comments from affected parties~~ maintain  
137.28 an email address for submission of comments from interested parties to provide input about  
137.29 the effectiveness of and continued need for the rulemaking procedures set out in subdivision  
137.30 2 and about the quality and effectiveness of rules adopted using these procedures. The  
137.31 commissioner shall seek comments by holding a meeting and by publishing a notice in the  
137.32 State Register that contains the date, time, and location of the meeting and a statement that  
137.33 invites oral or written comments. The notice must be published at least 30 days before the

138.1 ~~meeting date. The commissioner shall write a report summarizing the comments and shall~~  
138.2 ~~submit the report to the Minnesota Health Data Institute and to the Minnesota Administrative~~  
138.3 ~~Uniformity Committee by January 15 of every even-numbered year~~ may seek additional  
138.4 input and provide additional opportunities for input as needed.

138.5 Sec. 4. Minnesota Statutes 2023 Supplement, section 62J.84, subdivision 10, is amended  
138.6 to read:

138.7 Subd. 10. **Notice of prescription drugs of substantial public interest.** (a) No later than  
138.8 January 31, 2024, and quarterly thereafter, the commissioner shall produce and post on the  
138.9 department's website a list of prescription drugs that the commissioner determines to represent  
138.10 a substantial public interest and for which the commissioner intends to request data under  
138.11 subdivisions 11 to 14, subject to paragraph (c). The commissioner shall base its inclusion  
138.12 of prescription drugs on any information the commissioner determines is relevant to providing  
138.13 greater consumer awareness of the factors contributing to the cost of prescription drugs in  
138.14 the state, and the commissioner shall consider drug product families that include prescription  
138.15 drugs:

138.16 (1) that triggered reporting under subdivision 3 or 4 during the previous calendar quarter;

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

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

138.21 (b) Not sooner than 30 days after publicly posting the list of prescription drugs under  
138.22 paragraph (a), the department shall notify, via email, reporting entities registered with the  
138.23 department of the requirement to report under subdivisions 11 to 14.

138.24 (c) The commissioner must not designate more than 500 prescription drugs as having a  
138.25 substantial public interest in any one notice.

138.26 (d) Notwithstanding subdivision 16, the commissioner is exempt from chapter 14,  
138.27 including section 14.386, in implementing this subdivision.

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

138.29 Sec. 5. Minnesota Statutes 2022, section 144.05, subdivision 6, is amended to read:

138.30 Subd. 6. **Reports on interagency agreements and intra-agency transfers.** The  
138.31 commissioner of health shall provide quarterly reports to the chairs and ranking minority

139.1 members of the legislative committees with jurisdiction over health and human services  
139.2 policy and finance on:

139.3 (1) interagency agreements or service-level agreements and any renewals or extensions  
139.4 of existing interagency or service-level agreements with a state department under section  
139.5 15.01, state agency under section 15.012, or the Department of Information Technology  
139.6 Services, with a value of more than \$100,000, or related agreements with the same department  
139.7 or agency with a cumulative value of more than \$100,000; and

139.8 (2) transfers of appropriations of more than \$100,000 between accounts within or between  
139.9 agencies.

139.10 The report must include the statutory citation authorizing the agreement, transfer or dollar  
139.11 amount, purpose, and effective date of the agreement, and duration of the agreement, ~~and~~  
139.12 ~~a copy of the agreement.~~

139.13 Sec. 6. Minnesota Statutes 2022, section 144.05, subdivision 7, is amended to read:

139.14 Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the  
139.15 commissioner of health to the legislature is mandated by statute and the enabling legislation  
139.16 does not include a date for the submission of a final report, the mandate to submit the report  
139.17 shall expire in accordance with this section.

139.18 (b) If the mandate requires the submission of an annual report and the mandate was  
139.19 enacted before January 1, 2021, the mandate shall expire on January 1, 2023. If the mandate  
139.20 requires the submission of a biennial or less frequent report and the mandate was enacted  
139.21 before January 1, 2021, the mandate shall expire on January 1, 2024.

139.22 (c) Any reporting mandate enacted on or after January 1, 2021, shall expire three years  
139.23 after the date of enactment if the mandate requires the submission of an annual report and  
139.24 shall expire five years after the date of enactment if the mandate requires the submission  
139.25 of a biennial or less frequent report, unless the enacting legislation provides for a different  
139.26 expiration date.

139.27 (d) The commissioner shall submit a list to the chairs and ranking minority members of  
139.28 the legislative committees with jurisdiction over health by February 15 of each year,  
139.29 beginning February 15, 2022, of all reports set to expire during the following calendar year  
139.30 in accordance with this section. The mandate to submit a report to the legislature under this  
139.31 paragraph does not expire.

139.32 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2024.

140.1 Sec. 7. Minnesota Statutes 2023 Supplement, section 144.0526, subdivision 1, is amended  
140.2 to read:

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

140.6 Sec. 8. Minnesota Statutes 2022, section 144.058, is amended to read:

140.7 **144.058 INTERPRETER SERVICES QUALITY INITIATIVE.**

140.8 (a) The commissioner of health shall establish a voluntary statewide roster, and develop  
140.9 a plan for a registry and certification process for interpreters who provide high quality,  
140.10 spoken language health care interpreter services. The roster, registry, and certification  
140.11 process shall be based on the findings and recommendations set forth by the Interpreter  
140.12 Services Work Group required under Laws 2007, chapter 147, article 12, section 13.

140.13 (b) By January 1, 2009, the commissioner shall establish a roster of all available  
140.14 interpreters to address access concerns, particularly in rural areas.

140.15 (c) By January 15, 2010, the commissioner shall:

140.16 (1) develop a plan for a registry of spoken language health care interpreters, including:

140.17 (i) development of standards for registration that set forth educational requirements,  
140.18 training requirements, demonstration of language proficiency and interpreting skills,  
140.19 agreement to abide by a code of ethics, and a criminal background check;

140.20 (ii) recommendations for appropriate alternate requirements in languages for which  
140.21 testing and training programs do not exist;

140.22 (iii) recommendations for appropriate fees; and

140.23 (iv) recommendations for establishing and maintaining the standards for inclusion in  
140.24 the registry; and

140.25 (2) develop a plan for implementing a certification process based on national testing and  
140.26 certification processes for spoken language interpreters 12 months after the establishment  
140.27 of a national certification process.

140.28 (d) The commissioner shall consult with the Interpreter Stakeholder Group of the Upper  
140.29 Midwest Translators and Interpreters Association for advice on the standards required to  
140.30 plan for the development of a registry and certification process.

141.1 (e) The commissioner shall charge an annual fee of \$50 to include an interpreter in the  
141.2 roster. Fee revenue shall be deposited in the state government special revenue fund. All fees  
141.3 are nonrefundable.

141.4 Sec. 9. Minnesota Statutes 2022, section 144.0724, subdivision 2, is amended to read:

141.5 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings  
141.6 given.

141.7 (a) "Assessment reference date" or "ARD" means the specific end point for look-back  
141.8 periods in the MDS assessment process. This look-back period is also called the observation  
141.9 or assessment period.

141.10 (b) "Case mix index" means the weighting factors assigned to the ~~RUG-IV~~ case mix  
141.11 reimbursement classifications determined by an assessment.

141.12 (c) "Index maximization" means classifying a resident who could be assigned to more  
141.13 than one category, to the category with the highest case mix index.

141.14 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,  
141.15 and functional status elements, that include common definitions and coding categories  
141.16 specified by the Centers for Medicare and Medicaid Services and designated by the  
141.17 Department of Health.

141.18 (e) "Representative" means a person who is the resident's guardian or conservator, the  
141.19 person authorized to pay the nursing home expenses of the resident, a representative of the  
141.20 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any  
141.21 other individual designated by the resident.

141.22 ~~(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing~~  
141.23 ~~facility's residents according to their clinical and functional status identified in data supplied~~  
141.24 ~~by the facility's Minimum Data Set.~~

141.25 ~~(g)~~ (f) "Activities of daily living" includes personal hygiene, dressing, bathing,  
141.26 transferring, bed mobility, locomotion, eating, and toileting.

141.27 ~~(h)~~ (g) "Nursing facility level of care determination" means the assessment process that  
141.28 results in a determination of a resident's or prospective resident's need for nursing facility  
141.29 level of care as established in subdivision 11 for purposes of medical assistance payment  
141.30 of long-term care services for:

141.31 (1) nursing facility services under ~~section 256B.434~~ or chapter 256R;

141.32 (2) elderly waiver services under chapter 256S;

142.1 (3) CADI and BI waiver services under section 256B.49; and

142.2 (4) state payment of alternative care services under section 256B.0913.

142.3 Sec. 10. Minnesota Statutes 2022, section 144.0724, subdivision 3a, is amended to read:

142.4 Subd. 3a. **Resident reimbursement case mix reimbursement classifications beginning**  
142.5 **January 1, 2012.** (a) ~~Beginning January 1, 2012,~~ Resident reimbursement case mix  
142.6 reimbursement classifications shall be based on the Minimum Data Set, version 3.0  
142.7 assessment instrument, or its successor version mandated by the Centers for Medicare and  
142.8 Medicaid Services that nursing facilities are required to complete for all residents. ~~The~~  
142.9 ~~commissioner of health shall establish resident classifications according to the RUG-IV,~~  
142.10 ~~48 group, resource utilization groups. Resident classification must be established based on~~  
142.11 ~~the individual items on the Minimum Data Set, which must be completed according to the~~  
142.12 ~~Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its~~  
142.13 ~~successor issued by the Centers for Medicare and Medicaid Services.~~ Case mix  
142.14 reimbursement classifications shall also be based on assessments required under subdivision  
142.15 4. Assessments must be completed according to the Long Term Care Facility Resident  
142.16 Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the  
142.17 Centers for Medicare and Medicaid Services. The optional state assessment must be  
142.18 completed according to the OSA Manual Version 1.0 v.2.

142.19 (b) Each resident must be classified based on the information from the Minimum Data  
142.20 Set according to the general categories issued by the Minnesota Department of Health,  
142.21 utilized for reimbursement purposes.

142.22 Sec. 11. Minnesota Statutes 2022, section 144.0724, subdivision 4, is amended to read:

142.23 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically  
142.24 submit to the federal database MDS assessments that conform with the assessment schedule  
142.25 defined by the Long Term Care Facility Resident Assessment Instrument User's Manual,  
142.26 version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The  
142.27 commissioner of health may substitute successor manuals or question and answer documents  
142.28 published by the United States Department of Health and Human Services, Centers for  
142.29 Medicare and Medicaid Services, to replace or supplement the current version of the manual  
142.30 or document.

142.31 (b) The assessments required under the Omnibus Budget Reconciliation Act of 1987  
142.32 (OBRA) used to determine a case mix reimbursement classification ~~for reimbursement~~  
142.33 include:

143.1 (1) a new admission comprehensive assessment, which must have an assessment reference  
143.2 date (ARD) within 14 calendar days after admission, excluding readmissions;

143.3 (2) an annual comprehensive assessment, which must have an ARD within 92 days of  
143.4 a previous quarterly review assessment or a previous comprehensive assessment, which  
143.5 must occur at least once every 366 days;

143.6 (3) a significant change in status comprehensive assessment, which must have an ARD  
143.7 within 14 days after the facility determines, or should have determined, that there has been  
143.8 a significant change in the resident's physical or mental condition, whether an improvement  
143.9 or a decline, and regardless of the amount of time since the last comprehensive assessment  
143.10 or quarterly review assessment;

143.11 (4) a quarterly review assessment must have an ARD within 92 days of the ARD of the  
143.12 previous quarterly review assessment or a previous comprehensive assessment;

143.13 (5) any significant correction to a prior comprehensive assessment, if the assessment  
143.14 being corrected is the current one being used for RUG reimbursement classification;

143.15 (6) any significant correction to a prior quarterly review assessment, if the assessment  
143.16 being corrected is the current one being used for RUG reimbursement classification; and

143.17 ~~(7) a required significant change in status assessment when:~~

143.18 ~~(i) all speech, occupational, and physical therapies have ended. If the most recent OBRA~~  
143.19 ~~comprehensive or quarterly assessment completed does not result in a rehabilitation case~~  
143.20 ~~mix classification, then the significant change in status assessment is not required. The ARD~~  
143.21 ~~of this assessment must be set on day eight after all therapy services have ended; and~~

143.22 ~~(ii) isolation for an infectious disease has ended. If isolation was not coded on the most~~  
143.23 ~~recent OBRA comprehensive or quarterly assessment completed, then the significant change~~  
143.24 ~~in status assessment is not required. The ARD of this assessment must be set on day 15 after~~  
143.25 ~~isolation has ended; and~~

143.26 (8) (7) any modifications to the most recent assessments under clauses (1) to ~~(7)~~ (6).

143.27 (c) The optional state assessment must accompany all OBRA assessments. The optional  
143.28 state assessment is also required to determine reimbursement when:

143.29 (i) all speech, occupational, and physical therapies have ended. If the most recent optional  
143.30 state assessment completed does not result in a rehabilitation case mix reimbursement  
143.31 classification, then the optional state assessment is not required. The ARD of this assessment  
143.32 must be set on day eight after all therapy services have ended; and

144.1 (ii) isolation for an infectious disease has ended. If isolation was not coded on the most  
144.2 recent optional state assessment completed, then the optional state assessment is not required.  
144.3 The ARD of this assessment must be set on day 15 after isolation has ended.

144.4 ~~(e)~~ (d) In addition to the assessments listed in ~~paragraph~~ paragraphs (b) and (c), the  
144.5 assessments used to determine nursing facility level of care include the following:

144.6 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by  
144.7 the Senior LinkAge Line or other organization under contract with the Minnesota Board on  
144.8 Aging; and

144.9 (2) a nursing facility level of care determination as provided for under section 256B.0911,  
144.10 subdivision 26, as part of a face-to-face long-term care consultation assessment completed  
144.11 under section 256B.0911, by a county, tribe, or managed care organization under contract  
144.12 with the Department of Human Services.

144.13 Sec. 12. Minnesota Statutes 2022, section 144.0724, subdivision 6, is amended to read:

144.14 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or  
144.15 submit an assessment according to subdivisions 4 and 5 for a ~~RUG-IV~~ case mix  
144.16 reimbursement classification within seven days of the time requirements listed in the  
144.17 ~~Long-Term Care Facility Resident Assessment Instrument User's Manual~~ when the  
144.18 assessment is due is subject to a reduced rate for that resident. The reduced rate shall be the  
144.19 lowest rate for that facility. The reduced rate is effective on the day of admission for new  
144.20 admission assessments, on the ARD for significant change in status assessments, or on the  
144.21 day that the assessment was due for all other assessments and continues in effect until the  
144.22 first day of the month following the date of submission and acceptance of the resident's  
144.23 assessment.

144.24 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days  
144.25 are equal to or greater than 0.1 percent of the total operating costs on the facility's most  
144.26 recent annual statistical and cost report, a facility may apply to the commissioner of human  
144.27 services for a reduction in the total penalty amount. The commissioner of human services,  
144.28 in consultation with the commissioner of health, may, at the sole discretion of the  
144.29 commissioner of human services, limit the penalty for residents covered by medical assistance  
144.30 to ten days.

145.1 Sec. 13. Minnesota Statutes 2022, section 144.0724, subdivision 7, is amended to read:

145.2 Subd. 7. **Notice of resident ~~reimbursement~~ case mix reimbursement classification.** (a)

145.3 The commissioner of health shall provide to a nursing facility a notice for each resident of  
145.4 the classification established under subdivision 1. The notice must inform the resident of  
145.5 the case mix reimbursement classification assigned, the opportunity to review the  
145.6 documentation supporting the classification, the opportunity to obtain clarification from the  
145.7 commissioner, ~~and~~ the opportunity to request a reconsideration of the classification, and  
145.8 the address and telephone number of the Office of Ombudsman for Long-Term Care. The  
145.9 commissioner must transmit the notice of resident classification by electronic means to the  
145.10 nursing facility. The nursing facility is responsible for the distribution of the notice to each  
145.11 resident or the resident's representative. This notice must be distributed within three business  
145.12 days after the facility's receipt.

145.13 (b) If a facility submits a ~~modifying~~ modified assessment resulting in a change in the  
145.14 case mix reimbursement classification, the facility must provide a written notice to the  
145.15 resident or the resident's representative regarding the item or items that were modified and  
145.16 the reason for the modifications. The written notice must be provided within three business  
145.17 days after distribution of the resident case mix reimbursement classification notice.

145.18 Sec. 14. Minnesota Statutes 2022, section 144.0724, subdivision 8, is amended to read:

145.19 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, ~~or~~  
145.20 the resident's representative, ~~or~~ the nursing facility, or the boarding care home may request  
145.21 that the commissioner of health reconsider the assigned ~~reimbursement~~ case mix  
145.22 reimbursement classification and any item or items changed during the audit process. The  
145.23 request for reconsideration must be submitted in writing to the commissioner of health.

145.24 (b) For reconsideration requests initiated by the resident or the resident's representative:

145.25 (1) The resident or the resident's representative must submit in writing a reconsideration  
145.26 request to the facility administrator within 30 days of receipt of the resident classification  
145.27 notice. The written request must include the reasons for the reconsideration request.

145.28 (2) Within three business days of receiving the reconsideration request, the nursing  
145.29 facility must submit to the commissioner of health a completed reconsideration request  
145.30 form, a copy of the resident's or resident's representative's written request, and all supporting  
145.31 documentation used to complete the assessment being ~~considered~~ reconsidered. If the facility  
145.32 fails to provide the required information, the reconsideration will be completed with the

146.1 information submitted and the facility cannot make further reconsideration requests on this  
146.2 classification.

146.3 (3) Upon written request and within three business days, the nursing facility must give  
146.4 the resident or the resident's representative a copy of the assessment being reconsidered and  
146.5 all supporting documentation used to complete the assessment. Notwithstanding any law  
146.6 to the contrary, the facility may not charge a fee for providing copies of the requested  
146.7 documentation. If a facility fails to provide the required documents within this time, it is  
146.8 subject to the issuance of a correction order and penalty assessment under sections 144.653  
146.9 and 144A.10. Notwithstanding those sections, any correction order issued under this  
146.10 subdivision must require that the nursing facility immediately comply with the request for  
146.11 information, and as of the date of the issuance of the correction order, the facility shall  
146.12 forfeit to the state a \$100 fine for the first day of noncompliance, and an increase in the  
146.13 \$100 fine by \$50 increments for each day the noncompliance continues.

146.14 (c) For reconsideration requests initiated by the facility:

146.15 (1) The facility is required to inform the resident or the resident's representative in writing  
146.16 that a reconsideration of the resident's case mix reimbursement classification is being  
146.17 requested. The notice must inform the resident or the resident's representative:

146.18 (i) of the date and reason for the reconsideration request;

146.19 (ii) of the potential for a case mix reimbursement classification change and subsequent  
146.20 rate change;

146.21 (iii) of the extent of the potential rate change;

146.22 (iv) that copies of the request and supporting documentation are available for review;

146.23 and

146.24 (v) that the resident or the resident's representative has the right to request a  
146.25 reconsideration also.

146.26 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the  
146.27 facility must submit to the commissioner of health a completed reconsideration request  
146.28 form, all supporting documentation used to complete the assessment being reconsidered,  
146.29 and a copy of the notice informing the resident or the resident's representative that a  
146.30 reconsideration of the resident's classification is being requested.

146.31 (3) If the facility fails to provide the required information, the reconsideration request  
146.32 may be denied and the facility may not make further reconsideration requests on this  
146.33 classification.

147.1 (d) Reconsideration by the commissioner must be made by individuals not involved in  
147.2 reviewing the assessment, audit, or reconsideration that established the disputed classification.  
147.3 The reconsideration must be based upon the assessment that determined the classification  
147.4 and upon the information provided to the commissioner of health under paragraphs (a) to  
147.5 (c). If necessary for evaluating the reconsideration request, the commissioner may conduct  
147.6 on-site reviews. Within 15 business days of receiving the request for reconsideration, the  
147.7 commissioner shall affirm or modify the original resident classification. The original  
147.8 classification must be modified if the commissioner determines that the assessment resulting  
147.9 in the classification did not accurately reflect characteristics of the resident at the time of  
147.10 the assessment. The commissioner must transmit the reconsideration classification notice  
147.11 by electronic means to the nursing facility. The nursing facility is responsible for the  
147.12 distribution of the notice to the resident or the resident's representative. The notice must be  
147.13 distributed by the nursing facility within three business days after receipt. A decision by  
147.14 the commissioner under this subdivision is the final administrative decision of the agency  
147.15 for the party requesting reconsideration.

147.16 (e) The case mix reimbursement classification established by the commissioner shall be  
147.17 the classification which applies to the resident while the request for reconsideration is  
147.18 pending. If a request for reconsideration applies to an assessment used to determine nursing  
147.19 facility level of care under subdivision 4, paragraph ~~(e)~~ (d), the resident shall continue to  
147.20 be eligible for nursing facility level of care while the request for reconsideration is pending.

147.21 (f) The commissioner may request additional documentation regarding a reconsideration  
147.22 necessary to make an accurate reconsideration determination.

147.23 (g) Data collected as part of the reconsideration process under this section is classified  
147.24 as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding  
147.25 the classification of these data as private or nonpublic, the commissioner is authorized to  
147.26 share these data with the U.S. Centers for Medicare and Medicaid Services and the  
147.27 commissioner of human services as necessary for reimbursement purposes.

147.28 Sec. 15. Minnesota Statutes 2022, section 144.0724, subdivision 9, is amended to read:

147.29 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident  
147.30 assessments performed under section 256R.17 through any of the following: desk audits;  
147.31 on-site review of residents and their records; and interviews with staff, residents, or residents'  
147.32 families. The commissioner shall reclassify a resident if the commissioner determines that  
147.33 the resident was incorrectly classified.

147.34 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

148.1 (c) A facility must grant the commissioner access to examine the medical records relating  
148.2 to the resident assessments selected for audit under this subdivision. The commissioner may  
148.3 also observe and speak to facility staff and residents.

148.4 (d) The commissioner shall consider documentation under the time frames for coding  
148.5 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment  
148.6 Instrument User's Manual or OSA Manual version 1.0 v.2 published by the Centers for  
148.7 Medicare and Medicaid Services.

148.8 (e) The commissioner shall develop an audit selection procedure that includes the  
148.9 following factors:

148.10 (1) Each facility shall be audited annually. If a facility has two successive audits in which  
148.11 the percentage of change is five percent or less and the facility has not been the subject of  
148.12 a special audit in the past 36 months, the facility may be audited biannually. A stratified  
148.13 sample of 15 percent, with a minimum of ten assessments, of the most current assessments  
148.14 shall be selected for audit. If more than 20 percent of the ~~RUG-IV~~ case mix reimbursement  
148.15 classifications are changed as a result of the audit, the audit shall be expanded to a second  
148.16 15 percent sample, with a minimum of ten assessments. If the total change between the first  
148.17 and second samples is 35 percent or greater, the commissioner may expand the audit to all  
148.18 of the remaining assessments.

148.19 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility  
148.20 again within six months. If a facility has two expanded audits within a 24-month period,  
148.21 that facility will be audited at least every six months for the next 18 months.

148.22 (3) The commissioner may conduct special audits if the commissioner determines that  
148.23 circumstances exist that could alter or affect the validity of case mix reimbursement  
148.24 classifications of residents. These circumstances include, but are not limited to, the following:

148.25 (i) frequent changes in the administration or management of the facility;

148.26 (ii) an unusually high percentage of residents in a specific case mix reimbursement  
148.27 classification;

148.28 (iii) a high frequency in the number of reconsideration requests received from a facility;

148.29 (iv) frequent adjustments of case mix reimbursement classifications as the result of  
148.30 reconsiderations or audits;

148.31 (v) a criminal indictment alleging provider fraud;

148.32 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

149.1 (vii) an atypical pattern of scoring minimum data set items;

149.2 (viii) nonsubmission of assessments;

149.3 (ix) late submission of assessments; or

149.4 (x) a previous history of audit changes of 35 percent or greater.

149.5 (f) If the audit results in a case mix reimbursement classification change, the  
149.6 commissioner must transmit the audit classification notice by electronic means to the nursing  
149.7 facility within 15 business days of completing an audit. The nursing facility is responsible  
149.8 for distribution of the notice to each resident or the resident's representative. This notice  
149.9 must be distributed by the nursing facility within three business days after receipt. The  
149.10 notice must inform the resident of the case mix reimbursement classification assigned, the  
149.11 opportunity to review the documentation supporting the classification, the opportunity to  
149.12 obtain clarification from the commissioner, the opportunity to request a reconsideration of  
149.13 the classification, and the address and telephone number of the Office of Ombudsman for  
149.14 Long-Term Care.

149.15 Sec. 16. Minnesota Statutes 2022, section 144.0724, subdivision 11, is amended to read:

149.16 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment  
149.17 of long-term care services, a recipient must be determined, using assessments defined in  
149.18 subdivision 4, to meet one of the following nursing facility level of care criteria:

149.19 (1) the person requires formal clinical monitoring at least once per day;

149.20 (2) the person needs the assistance of another person or constant supervision to begin  
149.21 and complete at least four of the following activities of living: bathing, bed mobility, dressing,  
149.22 eating, grooming, toileting, transferring, and walking;

149.23 (3) the person needs the assistance of another person or constant supervision to begin  
149.24 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

149.25 (4) the person has significant difficulty with memory, using information, daily decision  
149.26 making, or behavioral needs that require intervention;

149.27 (5) the person has had a qualifying nursing facility stay of at least 90 days;

149.28 (6) the person meets the nursing facility level of care criteria determined 90 days after  
149.29 admission or on the first quarterly assessment after admission, whichever is later; or

149.30 (7) the person is determined to be at risk for nursing facility admission or readmission  
149.31 through a face-to-face long-term care consultation assessment as specified in section

150.1 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, tribe, or managed care  
150.2 organization under contract with the Department of Human Services. The person is  
150.3 considered at risk under this clause if the person currently lives alone or will live alone or  
150.4 be homeless without the person's current housing and also meets one of the following criteria:

150.5 (i) the person has experienced a fall resulting in a fracture;

150.6 (ii) the person has been determined to be at risk of maltreatment or neglect, including  
150.7 self-neglect; or

150.8 (iii) the person has a sensory impairment that substantially impacts functional ability  
150.9 and maintenance of a community residence.

150.10 (b) The assessment used to establish medical assistance payment for nursing facility  
150.11 services must be the most recent assessment performed under subdivision 4, ~~paragraph~~  
150.12 paragraphs (b) and (c), that occurred no more than 90 calendar days before the effective  
150.13 date of medical assistance eligibility for payment of long-term care services. In no case  
150.14 shall medical assistance payment for long-term care services occur prior to the date of the  
150.15 determination of nursing facility level of care.

150.16 (c) The assessment used to establish medical assistance payment for long-term care  
150.17 services provided under chapter 256S and section 256B.49 and alternative care payment  
150.18 for services provided under section 256B.0913 must be the most recent face-to-face  
150.19 assessment performed under section 256B.0911, subdivisions 17 to 21, 23, 24, 27, or 28,  
150.20 that occurred no more than 60 calendar days before the effective date of medical assistance  
150.21 eligibility for payment of long-term care services.

150.22 Sec. 17. Minnesota Statutes 2022, section 144.1464, subdivision 1, is amended to read:

150.23 Subdivision 1. **Summer internships.** The commissioner of health, through a contract  
150.24 with a nonprofit organization as required by subdivision 4, shall award grants, within  
150.25 available appropriations, to hospitals, clinics, nursing facilities, assisted living facilities,  
150.26 and home care providers to establish a secondary and postsecondary summer health care  
150.27 intern program. The purpose of the program is to expose interested secondary and  
150.28 postsecondary pupils to various careers within the health care profession.

150.29 Sec. 18. Minnesota Statutes 2022, section 144.1464, subdivision 2, is amended to read:

150.30 Subd. 2. **Criteria.** (a) The commissioner, through the organization under contract, shall  
150.31 award grants to hospitals, clinics, nursing facilities, assisted living facilities, and home care  
150.32 providers that agree to:

151.1 (1) provide secondary and postsecondary summer health care interns with formal exposure  
151.2 to the health care profession;

151.3 (2) provide an orientation for the secondary and postsecondary summer health care  
151.4 interns;

151.5 (3) pay one-half the costs of employing the secondary and postsecondary summer health  
151.6 care intern;

151.7 (4) interview and hire secondary and postsecondary pupils for a minimum of six weeks  
151.8 and a maximum of 12 weeks; and

151.9 (5) employ at least one secondary student for each postsecondary student employed, to  
151.10 the extent that there are sufficient qualifying secondary student applicants.

151.11 (b) In order to be eligible to be hired as a secondary summer health intern by a hospital,  
151.12 clinic, nursing facility, assisted living facility, or home care provider, a pupil must:

151.13 (1) intend to complete high school graduation requirements and be between the junior  
151.14 and senior year of high school; and

151.15 (2) be from a school district in proximity to the facility.

151.16 (c) In order to be eligible to be hired as a postsecondary summer health care intern by  
151.17 a hospital or clinic, a pupil must:

151.18 (1) intend to complete a health care training program or a two-year or four-year degree  
151.19 program and be planning on enrolling in or be enrolled in that training program or degree  
151.20 program; and

151.21 (2) be enrolled in a Minnesota educational institution or be a resident of the state of  
151.22 Minnesota; priority must be given to applicants from a school district or an educational  
151.23 institution in proximity to the facility.

151.24 (d) Hospitals, clinics, nursing facilities, assisted living facilities, and home care providers  
151.25 awarded grants may employ pupils as secondary and postsecondary summer health care  
151.26 interns ~~beginning on or after June 15, 1993~~, if they agree to pay the intern, during the period  
151.27 before disbursement of state grant money, with money designated as the facility's 50 percent  
151.28 contribution towards internship costs.

151.29 Sec. 19. Minnesota Statutes 2022, section 144.1464, subdivision 3, is amended to read:

151.30 Subd. 3. **Grants.** The commissioner, through the organization under contract, shall  
151.31 award separate grants to hospitals, clinics, nursing facilities, assisted living facilities, and

152.1 home care providers meeting the requirements of subdivision 2. The grants must be used  
152.2 to pay one-half of the costs of employing secondary and postsecondary pupils in a hospital,  
152.3 clinic, nursing facility, assisted living facility, or home care setting during the course of the  
152.4 program. No more than 50 percent of the participants may be postsecondary students, unless  
152.5 the program does not receive enough qualified secondary applicants per fiscal year. No  
152.6 more than five pupils may be selected from any secondary or postsecondary institution to  
152.7 participate in the program and no more than one-half of the number of pupils selected may  
152.8 be from the seven-county metropolitan area.

152.9 Sec. 20. Minnesota Statutes 2023 Supplement, section 144.1505, subdivision 2, is amended  
152.10 to read:

152.11 Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants,  
152.12 the commissioner of health shall award health professional training site grants to eligible  
152.13 physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental  
152.14 health professional programs to plan and implement expanded clinical training. A planning  
152.15 grant shall not exceed \$75,000, and a three-year training grant shall not exceed ~~\$150,000~~  
152.16 ~~for the first year, \$100,000 for the second year, and \$50,000 for the third year~~ \$300,000 per  
152.17 program project. The commissioner may provide a one-year, no-cost extension for grants.

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

152.27 (c) Funds may be used for:

152.28 (1) establishing or expanding rotations and clinical training;

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

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

152.32 (4) travel and lodging for students;

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

- 153.1 (6) development and implementation of cultural competency training;
- 153.2 (7) evaluations;
- 153.3 (8) training site improvements, fees, equipment, and supplies required to establish,
- 153.4 maintain, or expand a training program; and
- 153.5 (9) supporting clinical education in which trainees are part of a primary care team model.

153.6 Sec. 21. Minnesota Statutes 2022, section 144.1911, subdivision 2, is amended to read:

153.7 Subd. 2. **Definitions.** (a) For the purposes of this section, the following terms have the

153.8 meanings given.

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

153.10 (c) "Immigrant international medical graduate" means an international medical graduate

153.11 who was born outside the United States, now resides permanently in the United States or

153.12 who has entered the United States on a temporary status based on urgent humanitarian or

153.13 significant public benefit reasons, and who did not enter the United States on a J1 or similar

153.14 nonimmigrant visa following acceptance into a United States medical residency or fellowship

153.15 program.

153.16 (d) "International medical graduate" means a physician who received a basic medical

153.17 degree or qualification from a medical school located outside the United States and Canada.

153.18 (e) "Minnesota immigrant international medical graduate" means an immigrant

153.19 international medical graduate who has lived in Minnesota for at least two years.

153.20 (f) "Rural community" means a statutory and home rule charter city or township that is

153.21 outside the seven-county metropolitan area as defined in section 473.121, subdivision 2,

153.22 excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

153.23 (g) "Underserved community" means a Minnesota area or population included in the

153.24 list of designated primary medical care health professional shortage areas, medically

153.25 underserved areas, or medically underserved populations (MUPs) maintained and updated

153.26 by the United States Department of Health and Human Services.

153.27 Sec. 22. Minnesota Statutes 2022, section 144.212, is amended by adding a subdivision

153.28 to read:

153.29 Subd. 5a. **Replacement.** "Replacement" means a completion, addition, removal, or

153.30 change made to certification items on a vital record after a vital event is registered and a

154.1 record is established that has no notation of a change on a certificate and seals the prior vital  
154.2 record.

154.3 Sec. 23. Minnesota Statutes 2022, section 144.216, subdivision 2, is amended to read:

154.4 Subd. 2. **Status of foundling reports.** A report registered under subdivision 1 shall  
154.5 constitute the record of birth for the child. Information about the newborn shall be registered  
154.6 by the state registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item  
154.7 C. If the child is identified and a record of birth is found or obtained, the report registered  
154.8 under subdivision 1 shall be confidential pursuant to section 13.02, subdivision 3, and shall  
154.9 not be disclosed except pursuant to court order.

154.10 Sec. 24. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision  
154.11 to read:

154.12 Subd. 3. **Reporting safe place newborns.** Hospitals that receive a newborn under section  
154.13 145.902 shall report the birth of the newborn to the Office of Vital Records within five days  
154.14 after receiving the newborn. Information about the newborn shall be registered by the state  
154.15 registrar in accordance with Minnesota Rules, part 4601.0600, subpart 4, item C.

154.16 Sec. 25. Minnesota Statutes 2022, section 144.216, is amended by adding a subdivision  
154.17 to read:

154.18 Subd. 4. **Status of safe place birth reports and registrations.** (a) Information about a  
154.19 safe place newborn registered under subdivision 3 shall constitute the record of birth for  
154.20 the child. The record shall be confidential pursuant to section 13.02, subdivision 3.  
154.21 Information on the birth record or a birth certificate issued from the birth record shall be  
154.22 disclosed only to the responsible social services agency or pursuant to a court order.

154.23 (b) Information about a safe place newborn registered under subdivision 3 shall constitute  
154.24 the record of birth for the child. If the safe place newborn was born in a hospital and it is  
154.25 known that a record of birth was registered, filed, or amended, the original birth record  
154.26 registered under section 144.215 shall be replaced pursuant to section 144.218, subdivision  
154.27 6.

154.28 Sec. 26. Minnesota Statutes 2022, section 144.218, is amended by adding a subdivision  
154.29 to read:

154.30 Subd. 6. **Safe place newborn; birth record.** If a safe place infant birth is registered  
154.31 pursuant to section 144.216, subdivision 4, paragraph (b), the state registrar shall issue a

155.1 replacement birth record free of information that identifies a parent. The prior vital record  
155.2 shall be confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed  
155.3 except pursuant to a court order.

155.4 Sec. 27. Minnesota Statutes 2022, section 144.493, is amended by adding a subdivision  
155.5 to read:

155.6 Subd. 2a. **Thrombectomy-capable stroke center.** A hospital meets the criteria for a  
155.7 thrombectomy-capable stroke center if the hospital has been certified as a  
155.8 thrombectomy-capable stroke center by the joint commission or another nationally recognized  
155.9 accreditation entity, or is a primary stroke center that is not certified as a thrombectomy-based  
155.10 capable stroke center but the hospital has attained a level of stroke care distinction by offering  
155.11 mechanical endovascular therapies and has been certified by a department approved certifying  
155.12 body that is a nationally recognized guidelines-based organization.

155.13 Sec. 28. Minnesota Statutes 2022, section 144.494, subdivision 2, is amended to read:

155.14 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive  
155.15 stroke center, thrombectomy-capable stroke center, primary stroke center, or acute stroke  
155.16 ready hospital may apply to the commissioner for designation, and upon the commissioner's  
155.17 review and approval of the application, shall be designated as a comprehensive stroke center,  
155.18 a thrombectomy-capable stroke center, a primary stroke center, or an acute stroke ready  
155.19 hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke  
155.20 center or primary stroke center from the joint commission or other nationally recognized  
155.21 accreditation entity, or no longer participates in the Minnesota stroke registry program, its  
155.22 Minnesota designation shall be immediately withdrawn. Prior to the expiration of the  
155.23 ~~three-year~~ designation period, a hospital seeking to remain part of the voluntary acute stroke  
155.24 system may reapply to the commissioner for designation.

155.25 Sec. 29. Minnesota Statutes 2022, section 144.551, subdivision 1, is amended to read:

155.26 Subdivision 1. **Restricted construction or modification.** (a) The following construction  
155.27 or modification may not be commenced:

155.28 (1) any erection, building, alteration, reconstruction, modernization, improvement,  
155.29 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed  
155.30 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site  
155.31 to another, or otherwise results in an increase or redistribution of hospital beds within the  
155.32 state; and

156.1 (2) the establishment of a new hospital.

156.2 (b) This section does not apply to:

156.3 (1) construction or relocation within a county by a hospital, clinic, or other health care  
156.4 facility that is a national referral center engaged in substantial programs of patient care,  
156.5 medical research, and medical education meeting state and national needs that receives more  
156.6 than 40 percent of its patients from outside the state of Minnesota;

156.7 (2) a project for construction or modification for which a health care facility held an  
156.8 approved certificate of need on May 1, 1984, regardless of the date of expiration of the  
156.9 certificate;

156.10 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely  
156.11 appeal results in an order reversing the denial;

156.12 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,  
156.13 section 2;

156.14 (5) a project involving consolidation of pediatric specialty hospital services within the  
156.15 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number  
156.16 of pediatric specialty hospital beds among the hospitals being consolidated;

156.17 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to  
156.18 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,  
156.19 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in  
156.20 the number of hospital beds. Upon completion of the reconstruction, the licenses of both  
156.21 hospitals must be reinstated at the capacity that existed on each site before the relocation;

156.22 (7) the relocation or redistribution of hospital beds within a hospital building or  
156.23 identifiable complex of buildings provided the relocation or redistribution does not result  
156.24 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from  
156.25 one physical site or complex to another; or (iii) redistribution of hospital beds within the  
156.26 state or a region of the state;

156.27 (8) relocation or redistribution of hospital beds within a hospital corporate system that  
156.28 involves the transfer of beds from a closed facility site or complex to an existing site or  
156.29 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is  
156.30 transferred; (ii) the capacity of the site or complex to which the beds are transferred does  
156.31 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal  
156.32 health systems agency boundary in place on July 1, 1983; (iv) the relocation or redistribution  
156.33 does not involve the construction of a new hospital building; and (v) the transferred beds

157.1 are used first to replace within the hospital corporate system the total number of beds  
157.2 previously used in the closed facility site or complex for mental health services and substance  
157.3 use disorder services. Only after the hospital corporate system has fulfilled the requirements  
157.4 of this item may the remainder of the available capacity of the closed facility site or complex  
157.5 be transferred for any other purpose;

157.6 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice  
157.7 County that primarily serves adolescents and that receives more than 70 percent of its  
157.8 patients from outside the state of Minnesota;

157.9 (10) a project to replace a hospital or hospitals with a combined licensed capacity of  
157.10 130 beds or less if: (i) the new hospital site is located within five miles of the current site;  
157.11 and (ii) the total licensed capacity of the replacement hospital, either at the time of  
157.12 construction of the initial building or as the result of future expansion, will not exceed ~~70~~  
157.13 100 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever  
157.14 is less;

157.15 (11) the relocation of licensed hospital beds from an existing state facility operated by  
157.16 the commissioner of human services to a new or existing facility, building, or complex  
157.17 operated by the commissioner of human services; from one regional treatment center site  
157.18 to another; or from one building or site to a new or existing building or site on the same  
157.19 campus;

157.20 (12) the construction or relocation of hospital beds operated by a hospital having a  
157.21 statutory obligation to provide hospital and medical services for the indigent that does not  
157.22 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27  
157.23 beds, of which 12 serve mental health needs, may be transferred from Hennepin County  
157.24 Medical Center to Regions Hospital under this clause;

157.25 (13) a construction project involving the addition of up to 31 new beds in an existing  
157.26 nonfederal hospital in Beltrami County;

157.27 (14) a construction project involving the addition of up to eight new beds in an existing  
157.28 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

157.29 (15) a construction project involving the addition of 20 new hospital beds in an existing  
157.30 hospital in Carver County serving the southwest suburban metropolitan area;

157.31 (16) a project for the construction or relocation of up to 20 hospital beds for the operation  
157.32 of up to two psychiatric facilities or units for children provided that the operation of the  
157.33 facilities or units have received the approval of the commissioner of human services;

158.1 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation  
158.2 services in an existing hospital in Itasca County;

158.3 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County  
158.4 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for  
158.5 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another  
158.6 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

158.7 (19) a critical access hospital established under section 144.1483, clause (9), and section  
158.8 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that  
158.9 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,  
158.10 to the extent that the critical access hospital does not seek to exceed the maximum number  
158.11 of beds permitted such hospital under federal law;

158.12 (20) notwithstanding section 144.552, a project for the construction of a new hospital  
158.13 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

158.14 (i) the project, including each hospital or health system that will own or control the entity  
158.15 that will hold the new hospital license, is approved by a resolution of the Maple Grove City  
158.16 Council as of March 1, 2006;

158.17 (ii) the entity that will hold the new hospital license will be owned or controlled by one  
158.18 or more not-for-profit hospitals or health systems that have previously submitted a plan or  
158.19 plans for a project in Maple Grove as required under section 144.552, and the plan or plans  
158.20 have been found to be in the public interest by the commissioner of health as of April 1,  
158.21 2005;

158.22 (iii) the new hospital's initial inpatient services must include, but are not limited to,  
158.23 medical and surgical services, obstetrical and gynecological services, intensive care services,  
158.24 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health  
158.25 services, and emergency room services;

158.26 (iv) the new hospital:

158.27 (A) will have the ability to provide and staff sufficient new beds to meet the growing  
158.28 needs of the Maple Grove service area and the surrounding communities currently being  
158.29 served by the hospital or health system that will own or control the entity that will hold the  
158.30 new hospital license;

158.31 (B) will provide uncompensated care;

158.32 (C) will provide mental health services, including inpatient beds;

159.1 (D) will be a site for workforce development for a broad spectrum of health-care-related  
159.2 occupations and have a commitment to providing clinical training programs for physicians  
159.3 and other health care providers;

159.4 (E) will demonstrate a commitment to quality care and patient safety;

159.5 (F) will have an electronic medical records system, including physician order entry;

159.6 (G) will provide a broad range of senior services;

159.7 (H) will provide emergency medical services that will coordinate care with regional  
159.8 providers of trauma services and licensed emergency ambulance services in order to enhance  
159.9 the continuity of care for emergency medical patients; and

159.10 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond  
159.11 the control of the entity holding the new hospital license; and

159.12 (v) as of 30 days following submission of a written plan, the commissioner of health  
159.13 has not determined that the hospitals or health systems that will own or control the entity  
159.14 that will hold the new hospital license are unable to meet the criteria of this clause;

159.15 (21) a project approved under section 144.553;

159.16 (22) a project for the construction of a hospital with up to 25 beds in Cass County within  
159.17 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder  
159.18 is approved by the Cass County Board;

159.19 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity  
159.20 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing  
159.21 a separately licensed 13-bed skilled nursing facility;

159.22 (24) notwithstanding section 144.552, a project for the construction and expansion of a  
159.23 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients  
159.24 who are under 21 years of age on the date of admission. The commissioner conducted a  
159.25 public interest review of the mental health needs of Minnesota and the Twin Cities  
159.26 metropolitan area in 2008. No further public interest review shall be conducted for the  
159.27 construction or expansion project under this clause;

159.28 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the  
159.29 commissioner finds the project is in the public interest after the public interest review  
159.30 conducted under section 144.552 is complete;

159.31 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city  
159.32 of Maple Grove, exclusively for patients who are under 21 years of age on the date of

160.1 admission, if the commissioner finds the project is in the public interest after the public  
160.2 interest review conducted under section 144.552 is complete;

160.3 (ii) this project shall serve patients in the continuing care benefit program under section  
160.4 256.9693. The project may also serve patients not in the continuing care benefit program;  
160.5 and

160.6 (iii) if the project ceases to participate in the continuing care benefit program, the  
160.7 commissioner must complete a subsequent public interest review under section 144.552. If  
160.8 the project is found not to be in the public interest, the license must be terminated six months  
160.9 from the date of that finding. If the commissioner of human services terminates the contract  
160.10 without cause or reduces per diem payment rates for patients under the continuing care  
160.11 benefit program below the rates in effect for services provided on December 31, 2015, the  
160.12 project may cease to participate in the continuing care benefit program and continue to  
160.13 operate without a subsequent public interest review;

160.14 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital  
160.15 in Hennepin County that is exclusively for patients who are under 21 years of age on the  
160.16 date of admission;

160.17 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center  
160.18 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which  
160.19 15 beds are to be used for inpatient mental health and 40 are to be used for other services.  
160.20 In addition, five unlicensed observation mental health beds shall be added;

160.21 (29) upon submission of a plan to the commissioner for public interest review under  
160.22 section 144.552 and the addition of the 15 inpatient mental health beds specified in clause  
160.23 (28), to its bed capacity, a project to add 45 licensed beds in an existing safety net, level I  
160.24 trauma center hospital in Ramsey County as designated under section 383A.91, subdivision  
160.25 5. Five of the 45 additional beds authorized under this clause must be designated for use  
160.26 for inpatient mental health and must be added to the hospital's bed capacity before the  
160.27 remaining 40 beds are added. Notwithstanding section 144.552, the hospital may add licensed  
160.28 beds under this clause prior to completion of the public interest review, provided the hospital  
160.29 submits its plan by the 2021 deadline and adheres to the timelines for the public interest  
160.30 review described in section 144.552;

160.31 (30) upon submission of a plan to the commissioner for public interest review under  
160.32 section 144.552, a project to add up to 30 licensed beds in an existing psychiatric hospital  
160.33 in Hennepin County that exclusively provides care to patients who are under 21 years of  
160.34 age on the date of admission. Notwithstanding section 144.552, the psychiatric hospital

161.1 may add licensed beds under this clause prior to completion of the public interest review,  
161.2 provided the hospital submits its plan by the 2021 deadline and adheres to the timelines for  
161.3 the public interest review described in section 144.552;

161.4 (31) any project to add licensed beds in a hospital located in Cook County or Mahanomen  
161.5 County that: (i) is designated as a critical access hospital under section 144.1483, clause  
161.6 (9), and United States Code, title 42, section 1395i-4; (ii) has a licensed bed capacity of  
161.7 fewer than 25 beds; and (iii) has an attached nursing home, so long as the total number of  
161.8 licensed beds in the hospital after the bed addition does not exceed 25 beds. Notwithstanding  
161.9 section 144.552, a public interest review is not required for a project authorized under this  
161.10 clause;

161.11 (32) upon submission of a plan to the commissioner for public interest review under  
161.12 section 144.552, a project to add 22 licensed beds at a Minnesota freestanding children's  
161.13 hospital in St. Paul that is part of an independent pediatric health system with freestanding  
161.14 inpatient hospitals located in Minneapolis and St. Paul. The beds shall be utilized for pediatric  
161.15 inpatient behavioral health services. Notwithstanding section 144.552, the hospital may add  
161.16 licensed beds under this clause prior to completion of the public interest review, provided  
161.17 the hospital submits its plan by the 2022 deadline and adheres to the timelines for the public  
161.18 interest review described in section 144.552; ~~or~~

161.19 (33) a project for a 144-bed psychiatric hospital on the site of the former Bethesda  
161.20 hospital in the city of Saint Paul, Ramsey County, if the commissioner finds the project is  
161.21 in the public interest after the public interest review conducted under section 144.552 is  
161.22 complete. Following the completion of the construction project, the commissioner of health  
161.23 shall monitor the hospital, including by assessing the hospital's case mix and payer mix,  
161.24 patient transfers, and patient diversions. The hospital must have an intake and assessment  
161.25 area. The hospital must accommodate patients with acute mental health needs, whether they  
161.26 walk up to the facility, are delivered by ambulances or law enforcement, or are transferred  
161.27 from other facilities. The hospital must comply with subdivision 1a, paragraph (b). The  
161.28 hospital must annually submit de-identified data to the department in the format and manner  
161.29 defined by the commissioner; or

161.30 (34) a project involving the relocation of up to 26 licensed long-term acute care hospital  
161.31 beds from an existing long-term care hospital located in Hennepin County with a licensed  
161.32 capacity prior to the relocation of 92 beds to dedicated space on the campus of an existing  
161.33 safety net, level I trauma center hospital in Ramsey County as designated under section  
161.34 383A.91, subdivision 5, provided both the commissioner finds the project is in the public  
161.35 interest after the public interest review conducted under section 144.552 is complete and

162.1 the relocated beds continue to be used as long-term acute care hospital beds after the  
162.2 relocation.

162.3 Sec. 30. Minnesota Statutes 2022, section 144.605, is amended by adding a subdivision  
162.4 to read:

162.5 Subd. 10. **Chapter 16C waiver.** Pursuant to subdivisions 4, paragraph (b), and 5,  
162.6 paragraph (b), the commissioner of administration may waive provisions of chapter 16C  
162.7 for the purposes of approving contracts for independent clinical teams.

162.8 Sec. 31. Minnesota Statutes 2023 Supplement, section 144.651, subdivision 10a, is amended  
162.9 to read:

162.10 Subd. 10a. **Designated support person for pregnant patient or other patient.** (a)  
162.11 Subject to paragraph (c), a health care provider and a health care facility must allow, at a  
162.12 minimum, one designated support person ~~of a pregnant patient's choosing~~ chosen by a  
162.13 patient, including but not limited to a pregnant patient, to be physically present while the  
162.14 patient is receiving health care services including during a hospital stay.

162.15 (b) For purposes of this subdivision, "designated support person" means any person  
162.16 chosen by the patient to provide comfort to the patient including but not limited to the  
162.17 patient's spouse, partner, family member, or another person related by affinity. Certified  
162.18 doulas and traditional midwives may not be counted toward the limit of one designated  
162.19 support person.

162.20 (c) A facility may restrict or prohibit the presence of a designated support person in  
162.21 treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition  
162.22 is strictly necessary to meet the appropriate standard of care. A facility may also restrict or  
162.23 prohibit the presence of a designated support person if the designated support person is  
162.24 acting in a violent or threatening manner toward others. Any restriction or prohibition of a  
162.25 designated support person by the facility is subject to the facility's written internal grievance  
162.26 procedure required by subdivision 20.

162.27 Sec. 32. [144.6985] **COMMUNITY HEALTH NEEDS ASSESSMENT; COMMUNITY**  
162.28 **HEALTH IMPROVEMENT SERVICES; IMPLEMENTATION.**

162.29 Subdivision 1. **Community health needs assessment.** A nonprofit hospital that is exempt  
162.30 from taxation under section 501(c)(3) of the Internal Revenue Code must make available  
162.31 to the public and submit to the commissioner of health, by January 15, 2026, the most recent  
162.32 community health needs assessment submitted by the hospital to the Internal Revenue

163.1 Service. Each time the hospital conducts a subsequent community health needs assessment,  
163.2 the hospital must, within 15 business days after submitting the subsequent community health  
163.3 needs assessment to the Internal Revenue Service, make the subsequent assessment available  
163.4 to the public and submit the subsequent assessment to the commissioner.

163.5 Subd. 2. **Description of community.** A nonprofit hospital subject to subdivision 1 must  
163.6 make available to the public and submit to the commissioner of health a description of the  
163.7 community served by the hospital. The description must include a geographic description  
163.8 of the area where the hospital is located, a description of the general population served by  
163.9 the hospital, and demographic information about the community served by the hospital,  
163.10 such as leading causes of death, levels of chronic illness, and descriptions of the medically  
163.11 underserved, low-income, minority, or chronically ill populations in the community. A  
163.12 hospital is not required to separately make the information available to the public or  
163.13 separately submit the information to the commissioner if the information is included in the  
163.14 hospital's community health needs assessment made available and submitted under  
163.15 subdivision 1.

163.16 Subd. 3. **Addendum; community health improvement services.** (a) A nonprofit hospital  
163.17 subject to subdivision 1 must annually submit to the commissioner an addendum which  
163.18 details information about hospital activities identified as community health improvement  
163.19 services with a cost of \$5,000 or more. The addendum must include the type of activity, the  
163.20 method through which the activity was delivered, how the activity relates to an identified  
163.21 community need in the community health needs assessment, the target population for the  
163.22 activity, strategies to reach the target population, identified outcome metrics, the cost to the  
163.23 hospital to provide the activity, the methodology used to calculate the hospital's costs, and  
163.24 the number of people served by the activity. If a community health improvement service is  
163.25 administered by an entity other than the hospital, the administering entity must be identified  
163.26 in the addendum. This paragraph does not apply to hospitals required to submit an addendum  
163.27 under paragraph (b).

163.28 (b) A nonprofit hospital subject to subdivision 1 must annually submit to the  
163.29 commissioner an addendum which details information about the ten highest-cost activities  
163.30 of the hospital identified as community health improvement services if the nonprofit hospital:

163.31 (1) is designated as a critical access hospital under section 144.1483, clause (9), and  
163.32 United States Code, title 42, section 1395i-4;

163.33 (2) meets the definition of sole community hospital in section 62Q.19, subdivision 1,  
163.34 paragraph (a), clause (5); or

164.1 (3) meets the definition of rural emergency hospital in United States Code, title 42,  
164.2 section 1395x(kkk)(2).

164.3 The addendum must include the type of activity, the method in which the activity was  
164.4 delivered, how the activity relates to an identified community need in the community health  
164.5 needs assessment, the target population for the activity, strategies to reach the target  
164.6 population, identified outcome metrics, the cost to the hospital to provide the activity, the  
164.7 methodology used to calculate the hospital's costs, and the number of people served by the  
164.8 activity. If a community health improvement service is administered by an entity other than  
164.9 the hospital, the administering entity must be identified in the addendum.

164.10 Subd. 4. **Community benefit implementation strategy.** A nonprofit hospital subject  
164.11 to subdivision 1 must make available to the public, within one year after completing each  
164.12 community health needs assessment, a community benefit implementation strategy. In  
164.13 developing the community benefit implementation strategy, the hospital must consult with  
164.14 community-based organizations, stakeholders, local public health organizations, and others  
164.15 as determined by the hospital. The implementation strategy must include how the hospital  
164.16 shall address the top three community health priorities identified in the community health  
164.17 needs assessment. Implementation strategies must be evidence-based, when available, and  
164.18 development and implementation of innovative programs and strategies may be supported  
164.19 by evaluation measures.

164.20 Subd. 5. **Information made available to the public.** A nonprofit hospital required to  
164.21 make information available to the public under this section may do so by posting the  
164.22 information on the hospital's website in a consolidated location and with clear labeling.  
164.23 This section is effective January 1, 2026.

164.24 Sec. 33. Minnesota Statutes 2022, section 144.7067, subdivision 2, is amended to read:

164.25 Subd. 2. **Duty to analyze reports; communicate findings.** (a) The commissioner shall:

164.26 (1) analyze adverse event reports, corrective action plans, and findings of the root cause  
164.27 analyses to determine patterns of systemic failure in the health care system and successful  
164.28 methods to correct these failures;

164.29 (2) communicate to individual facilities the commissioner's conclusions, if any, regarding  
164.30 an adverse event reported by the facility;

164.31 (3) communicate with relevant health care facilities any recommendations for corrective  
164.32 action resulting from the commissioner's analysis of submissions from facilities; and

165.1 (4) publish an annual report:

165.2 (i) describing, by institution, adverse events reported;

165.3 (ii) outlining, in aggregate, corrective action plans and the findings of root cause analyses;

165.4 and

165.5 (iii) making recommendations for modifications of state health care operations.

165.6 (b) Notwithstanding section 144.05, subdivision 7, the mandate to publish an annual  
165.7 report under this subdivision does not expire.

165.8 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2023.

165.9 Sec. 34. Minnesota Statutes 2022, section 144.99, subdivision 3, is amended to read:

165.10 Subd. 3. **Correction orders.** (a) The commissioner may issue correction orders that  
165.11 require a person to correct a violation of the statutes, rules, and other actions listed in  
165.12 subdivision 1. The correction order must state the deficiencies that constitute the violation;  
165.13 the specific statute, rule, or other action; and the time by which the violation must be  
165.14 corrected.

165.15 (b) If the person believes that the information contained in the commissioner's correction  
165.16 order is in error, the person may ask the commissioner to reconsider the parts of the order  
165.17 that are alleged to be in error. The request must be in writing, delivered to the commissioner  
165.18 by certified mail within ~~seven~~ 15 calendar days after receipt of the order, and:

165.19 (1) specify which parts of the order for corrective action are alleged to be in error;

165.20 (2) explain why they are in error; and

165.21 (3) provide documentation to support the allegation of error.

165.22 The commissioner must respond to requests made under this paragraph within 15 calendar  
165.23 days after receiving a request. A request for reconsideration does not stay the correction  
165.24 order; however, after reviewing the request for reconsideration, the commissioner may  
165.25 provide additional time to comply with the order if necessary. The commissioner's disposition  
165.26 of a request for reconsideration is final.

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

165.28 Sec. 35. Minnesota Statutes 2022, section 144A.10, subdivision 15, is amended to read:

165.29 Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to  
165.30 a request from a nursing facility certified under the federal Medicare and Medicaid programs

166.1 for an informal dispute resolution within ~~30 days of the exit date of the facility's survey~~ ten  
166.2 calendar days of the facility's receipt of the notice of deficiencies. The commissioner's  
166.3 response shall identify the commissioner's decision regarding ~~the continuation of each~~  
166.4 deficiency citation challenged by the nursing facility, as well as a statement of any changes  
166.5 in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency  
166.6 citation.

166.7 **EFFECTIVE DATE.** This section is effective August 1, 2024.

166.8 Sec. 36. Minnesota Statutes 2022, section 144A.10, subdivision 16, is amended to read:

166.9 Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision  
166.10 15, a facility certified under the federal Medicare or Medicaid programs that has been  
166.11 assessed a civil money penalty as provided by Code of Federal Regulations, title 42, section  
166.12 488.430, may request from the commissioner, in writing, an independent informal dispute  
166.13 resolution process regarding any deficiency ~~citation issued to the facility.~~ The facility must  
166.14 ~~specify in its written request each deficiency citation that it disputes.~~ The commissioner  
166.15 ~~shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility,~~  
166.16 ~~the parties must submit the issues raised to arbitration by an administrative law judge~~ submit  
166.17 its request in writing within ten calendar days of receiving notice that a civil money penalty  
166.18 will be imposed.

166.19 (b) The facility and commissioner have the right to be represented by an attorney at the  
166.20 hearing.

166.21 (c) An independent informal dispute resolution may not be requested for any deficiency  
166.22 that is the subject of an active informal dispute resolution requested under subdivision 15.  
166.23 The facility must withdraw its informal dispute resolution prior to requesting independent  
166.24 informal dispute resolution.

166.25 ~~(b) Upon~~ (d) Within five calendar days of receipt of a written request for an arbitration  
166.26 proceeding independent informal dispute resolution, the commissioner shall file with the  
166.27 Office of Administrative Hearings a request for the appointment of an ~~arbitrator~~  
166.28 administrative law judge from the Office of Administrative Hearings and simultaneously  
166.29 serve the facility with notice of the request. ~~The arbitrator for the dispute shall be an~~  
166.30 ~~administrative law judge appointed by the Office of Administrative Hearings. The disclosure~~  
166.31 ~~provisions of section 572B.12 and the notice provisions of section 572B.15, subsection (c),~~  
166.32 ~~apply. The facility and the commissioner have the right to be represented by an attorney.~~

167.1 (e) An independent informal dispute resolution proceeding shall be scheduled to occur  
167.2 within 30 calendar days of the commissioner's request to the Office of Administrative  
167.3 Hearings, unless the parties agree otherwise or the chief administrative law judge deems  
167.4 the timing to be unreasonable. The independent informal dispute resolution process must  
167.5 be completed within 60 calendar days of the facility's request.

167.6 ~~(e)~~ (f) Five working days in advance of the scheduled proceeding, the commissioner  
167.7 and the facility may present must submit written statements and arguments, documentary  
167.8 evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral  
167.9 statements and arguments may be made by telephone any other materials supporting their  
167.10 position to the administrative law judge.

167.11 (g) The independent informal dispute resolution proceeding shall be informal and  
167.12 conducted in a manner so as to allow the parties to fully present their positions and respond  
167.13 to the opposing party's positions. This may include presentation of oral statements and  
167.14 arguments at the proceeding.

167.15 ~~(d)~~ (h) Within ten working days of the close of the arbitration proceeding, the  
167.16 administrative law judge shall issue findings and recommendations regarding each of the  
167.17 deficiencies in dispute. The findings shall be one or more of the following:

167.18 (1) Supported in full. The citation is supported in full, with no deletion of findings and  
167.19 no change in the scope or severity assigned to the deficiency citation.

167.20 (2) Supported in substance. The citation is supported, but one or more findings are  
167.21 deleted without any change in the scope or severity assigned to the deficiency.

167.22 (3) Deficient practice cited under wrong requirement of participation. The citation is  
167.23 amended by moving it to the correct requirement of participation.

167.24 (4) Scope not supported. The citation is amended through a change in the scope assigned  
167.25 to the citation.

167.26 (5) Severity not supported. The citation is amended through a change in the severity  
167.27 assigned to the citation.

167.28 (6) No deficient practice. The citation is deleted because the findings did not support  
167.29 the citation or the negative resident outcome was unavoidable. The findings of the arbitrator  
167.30 are not binding on the commissioner.

167.31 (i) The findings and recommendations of the administrative law judge are not binding  
167.32 on the commissioner.

168.1 (j) Within ten calendar days of receiving the administrative law judge's findings and  
168.2 recommendations, the commissioner shall issue a recommendation to the Center for Medicare  
168.3 and Medicaid Services.

168.4 ~~(e)(k) The commissioner shall reimburse the Office of Administrative Hearings for the~~  
168.5 ~~costs incurred by that office for the arbitration proceeding. The facility shall reimburse the~~  
168.6 ~~commissioner for the proportion of the costs that represent the sum of deficiency citations~~  
168.7 ~~supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause~~  
168.8 ~~(2), divided by the total number of deficiencies disputed. A deficiency citation for which~~  
168.9 ~~the administrative law judge's sole finding is that the deficient practice was cited under the~~  
168.10 ~~wrong requirements of participation shall not be counted in the numerator or denominator~~  
168.11 ~~in the calculation of the proportion of costs.~~

168.12 **EFFECTIVE DATE.** This section is effective October 1, 2024, or upon federal approval,  
168.13 whichever is later, and applies to appeals of deficiencies which are issued after October 1,  
168.14 2024, or on or after the date upon which federal approval is obtained, whichever is later.  
168.15 The commissioner of health shall notify the revisor of statutes when federal approval is  
168.16 obtained.

168.17 Sec. 37. Minnesota Statutes 2022, section 144A.471, is amended by adding a subdivision  
168.18 to read:

168.19 Subd. 1a. **Licensure under other law.** A home care licensee must not provide sleeping  
168.20 accommodations as a provision of home care services. For purposes of this subdivision, the  
168.21 provision of sleeping accommodations and assisted living services under section 144G.08,  
168.22 subdivision 9, requires assisted living facility licensure under chapter 144G. This subdivision  
168.23 does not apply to those settings exempt from assisted living facility licensure under section  
168.24 144G.08, subdivision 7.

168.25 Sec. 38. Minnesota Statutes 2022, section 144A.474, subdivision 13, is amended to read:

168.26 Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey,  
168.27 each home care surveyor must receive training on the following topics:

168.28 (1) Minnesota home care licensure requirements;

168.29 (2) Minnesota home care bill of rights;

168.30 (3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

168.31 (4) principles of documentation;

169.1 (5) survey protocol and processes;

169.2 (6) Offices of the Ombudsman roles;

169.3 (7) Office of Health Facility Complaints;

169.4 (8) Minnesota landlord-tenant ~~and housing with services~~ laws;

169.5 (9) types of payors for home care services; and

169.6 (10) Minnesota Nurse Practice Act for nurse surveyors.

169.7 (b) Materials used for the training in paragraph (a) shall be posted on the department  
169.8 website. Requisite understanding of these topics will be reviewed as part of the quality  
169.9 improvement plan in section 144A.483.

169.10 Sec. 39. Minnesota Statutes 2023 Supplement, section 144A.4791, subdivision 10, is  
169.11 amended to read:

169.12 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service  
169.13 plan with a client, and the client continues to need home care services, the home care provider  
169.14 shall provide the client and the client's representative, if any, with a written notice of  
169.15 termination which includes the following information:

169.16 (1) the effective date of termination;

169.17 (2) the reason for termination;

169.18 (3) for clients age 18 or older, a statement that the client may contact the Office of  
169.19 Ombudsman for Long-Term Care to request an advocate to assist regarding the termination  
169.20 and contact information for the office, including the office's central telephone number;

169.21 (4) a list of known licensed home care providers in the client's immediate geographic  
169.22 area;

169.23 (5) a statement that the home care provider will participate in a coordinated transfer of  
169.24 care of the client to another home care provider, health care provider, or caregiver, as  
169.25 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); and

169.26 (6) the name and contact information of a person employed by the home care provider  
169.27 with whom the client may discuss the notice of termination; ~~and.~~

169.28 ~~(7) if applicable, a statement that the notice of termination of home care services does~~  
169.29 ~~not constitute notice of termination of any housing contract.~~

170.1 (b) When the home care provider voluntarily discontinues services to all clients, the  
170.2 home care provider must notify the commissioner, lead agencies, and ombudsman for  
170.3 long-term care about its clients and comply with the requirements in this subdivision.

170.4 Sec. 40. Minnesota Statutes 2022, section 144E.16, subdivision 7, is amended to read:

170.5 Subd. 7. **Stroke transport protocols.** Regional emergency medical services programs  
170.6 and any ambulance service licensed under this chapter must develop stroke transport  
170.7 protocols. The protocols must include standards of care for triage and transport of acute  
170.8 stroke patients within a specific time frame from symptom onset until transport to the most  
170.9 appropriate designated acute stroke ready hospital, primary stroke center,  
170.10 thrombectomy-capable stroke center, or comprehensive stroke center.

170.11 Sec. 41. Minnesota Statutes 2022, section 144G.08, subdivision 29, is amended to read:

170.12 Subd. 29. **Licensed health professional.** "Licensed health professional" means a person  
170.13 ~~licensed in Minnesota to practice a profession described in section 214.01, subdivision 2,~~  
170.14 other than a registered nurse or licensed practical nurse, who provides assisted living services  
170.15 within the scope of practice of that person's health occupation license, registration, or  
170.16 certification as a regulated person who is licensed by an appropriate Minnesota state board  
170.17 or agency.

170.18 Sec. 42. Minnesota Statutes 2022, section 144G.10, is amended by adding a subdivision  
170.19 to read:

170.20 Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, 2026, no person  
170.21 or entity may use the phrase "assisted living," whether alone or in combination with other  
170.22 words and whether orally or in writing, to: advertise; market; or otherwise describe, offer,  
170.23 or promote itself, or any housing, service, service package, or program that it provides  
170.24 within this state, unless the person or entity is a licensed assisted living facility that meets  
170.25 the requirements of this chapter. A person or entity entitled to use the phrase "assisted living"  
170.26 shall use the phrase only in the context of its participation that meets the requirements of  
170.27 this chapter.

170.28 (b) Effective January 1, 2026, the licensee's name for a new assisted living facility may  
170.29 not include the terms "home care" or "nursing home."

171.1 Sec. 43. Minnesota Statutes 2022, section 144G.16, subdivision 6, is amended to read:

171.2 Subd. 6. **Requirements for notice and transfer.** A provisional licensee whose license  
171.3 is denied must comply with the requirements for notification and the coordinated move of  
171.4 residents in sections 144G.52 and 144G.55. If the license denial is upheld by the  
171.5 reconsideration process, the licensee must submit a draft closure plan as required by section  
171.6 144G.57 within ten calendar days of receipt of the reconsideration decision, must work with  
171.7 the commissioner on any revisions needed to the draft plan, and must have a final closure  
171.8 plan submitted and approved within 30 calendar days of receipt of the reconsideration  
171.9 decision.

171.10 Sec. 44. Minnesota Statutes 2023 Supplement, section 145.561, subdivision 4, is amended  
171.11 to read:

171.12 Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide  
171.13 Hotline Designation Act of 2020, ~~the commissioner shall impose a monthly statewide fee~~  
171.14 ~~on~~ each subscriber of a wireline, wireless, or IP-enabled voice service ~~at a rate that provides~~  
171.15 must pay a monthly fee to provide for the robust creation, operation, and maintenance of a  
171.16 statewide 988 suicide prevention and crisis system.

171.17 ~~(b) The commissioner shall annually recommend to the Public Utilities Commission an~~  
171.18 ~~adequate and appropriate fee to implement this section. The amount of the fee must comply~~  
171.19 ~~with the limits in paragraph (c). The commissioner shall provide telecommunication service~~  
171.20 ~~providers and carriers a minimum of 45 days' notice of each fee change.~~

171.21 ~~(e)~~ (b) The amount of the 988 telecommunications fee ~~must not be more than 25~~ is 12  
171.22 cents per month on or after January 1, 2024, for each consumer access line, including trunk  
171.23 equivalents as designated by the ~~commission~~ Public Utilities Commission pursuant to section  
171.24 403.11, subdivision 1. The 988 telecommunications fee must be the same for all subscribers.

171.25 ~~(d)~~ (c) Each wireline, wireless, and IP-enabled voice telecommunication service provider  
171.26 shall collect the 988 telecommunications fee and transfer the amounts collected to the  
171.27 commissioner of public safety in the same manner as provided in section 403.11, subdivision  
171.28 1, paragraph (d).

171.29 ~~(e)~~ (d) The commissioner of public safety shall deposit the money collected from the  
171.30 988 telecommunications fee to the 988 special revenue account established in subdivision  
171.31 3.

171.32 ~~(f)~~ (e) All 988 telecommunications fee revenue must be used to supplement, and not  
171.33 supplant, federal, state, and local funding for suicide prevention.

172.1 ~~(g)~~ (f) The 988 telecommunications fee amount shall be adjusted as needed to provide  
172.2 for continuous operation of the lifeline centers and 988 hotline, volume increases, and  
172.3 maintenance.

172.4 ~~(h)~~ (g) The commissioner shall annually report to the Federal Communications  
172.5 Commission on revenue generated by the 988 telecommunications fee.

172.6 **EFFECTIVE DATE.** This section is effective September 1, 2024.

172.7 Sec. 45. Minnesota Statutes 2022, section 146B.03, subdivision 7a, is amended to read:

172.8 Subd. 7a. **Supervisors.** (a) A technician must have been licensed in Minnesota or in a  
172.9 jurisdiction with which Minnesota has reciprocity for at least:

172.10 (1) two years as a tattoo technician licensed under section 146B.03, subdivision 4, 6, or  
172.11 8, in order to supervise a temporary tattoo technician; or

172.12 (2) one year as a body piercing technician licensed under section 146B.03, subdivision  
172.13 4, 6, or 8, or must have performed at least 500 body piercings, in order to supervise a  
172.14 temporary body piercing technician.

172.15 (b) Any technician who agrees to supervise more than two temporary tattoo technicians  
172.16 during the same time period, or more than four body piercing technicians during the same  
172.17 time period, must provide to the commissioner a supervisory plan that describes how the  
172.18 technician will provide supervision to each temporary technician in accordance with section  
172.19 146B.01, subdivision 28.

172.20 (c) The supervisory plan must include, at a minimum:

172.21 (1) the areas of practice under supervision;

172.22 (2) the anticipated supervision hours per week;

172.23 (3) the anticipated duration of the training period; and

172.24 (4) the method of providing supervision if there are multiple technicians being supervised  
172.25 during the same time period.

172.26 (d) If the supervisory plan is terminated before completion of the technician's supervised  
172.27 practice, the supervisor must notify the commissioner in writing within 14 days of the change  
172.28 in supervision and include an explanation of why the plan was not completed.

172.29 (e) The commissioner may refuse to approve as a supervisor a technician who has been  
172.30 disciplined in Minnesota or in another jurisdiction after considering the criteria in section  
172.31 146B.02, subdivision 10, paragraph (b).

173.1 Sec. 46. Minnesota Statutes 2022, section 146B.10, subdivision 1, is amended to read:

173.2 Subdivision 1. **Licensing fees.** (a) The fee for the initial technician licensure application  
173.3 and biennial licensure renewal application is \$420.

173.4 (b) The fee for temporary technician licensure application is \$240.

173.5 (c) The fee for the temporary guest artist license application is \$140.

173.6 (d) The fee for a dual body art technician license application is \$420.

173.7 (e) The fee for a provisional establishment license application required in section 146B.02,  
173.8 subdivision 5, paragraph (c), is \$1,500.

173.9 (f) The fee for an initial establishment license application and the two-year license  
173.10 renewal period application required in section 146B.02, subdivision 2, paragraph (b), is  
173.11 \$1,500.

173.12 (g) The fee for a temporary body art establishment event permit application is \$200.

173.13 (h) The commissioner shall prorate the initial two-year technician license fee based on  
173.14 the number of months in the initial licensure period. The commissioner shall prorate the  
173.15 first renewal fee for the establishment license based on the number of months from issuance  
173.16 of the provisional license to the first renewal.

173.17 (i) The fee for verification of licensure to other states is \$25.

173.18 ~~(j) The fee to reissue a provisional establishment license that relocates prior to inspection~~  
173.19 ~~and removal of provisional status is \$350. The expiration date of the provisional license~~  
173.20 ~~does not change.~~

173.21 ~~(k)~~ (j) The fee to change an establishment name or establishment type, such as tattoo,  
173.22 piercing, or dual, is \$50.

173.23 Sec. 47. Minnesota Statutes 2022, section 146B.10, subdivision 3, is amended to read:

173.24 Subd. 3. **Deposit.** Fees collected by the commissioner under this section must be deposited  
173.25 in the state government special revenue fund. All fees are nonrefundable.

173.26 Sec. 48. Minnesota Statutes 2022, section 149A.02, subdivision 3b, is amended to read:

173.27 Subd. 3b. **Burial site services.** "Burial site services" means any services sold or offered  
173.28 for sale directly to the public for use in connection with the final disposition of a dead human  
173.29 body but does not include services provided under a transportation protection agreement.

174.1 Sec. 49. Minnesota Statutes 2022, section 149A.02, subdivision 23, is amended to read:

174.2 Subd. 23. **Funeral services.** (a) "Funeral services" means any services which may be  
174.3 used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis, cremation,  
174.4 or other final disposition; and (2) arrange, supervise, or conduct the funeral ceremony or  
174.5 the final disposition of dead human bodies.

174.6 (b) Funeral service does not include a transportation protection agreement.

174.7 Sec. 50. Minnesota Statutes 2022, section 149A.02, is amended by adding a subdivision  
174.8 to read:

174.9 Subd. 38a. **Transportation protection agreement.** "Transportation protection agreement"  
174.10 means an agreement that is primarily for the purpose of transportation and subsequent  
174.11 transportation of the remains of a dead human body.

174.12 Sec. 51. Minnesota Statutes 2022, section 149A.65, is amended to read:

174.13 **149A.65 FEES.**

174.14 Subdivision 1. **Generally.** This section establishes the application fees for registrations,  
174.15 examinations, initial and renewal licenses, and late fees authorized under the provisions of  
174.16 this chapter.

174.17 Subd. 2. **Mortuary science fees.** Fees for mortuary science are:

174.18 (1) \$75 for the initial and renewal registration of a mortuary science intern;

174.19 (2) \$125 for the mortuary science examination;

174.20 (3) \$200 for ~~issuance of~~ initial and renewal mortuary science ~~licenses~~ license applications;

174.21 (4) \$100 late fee charge for a license renewal application; and

174.22 (5) \$250 for ~~issuing a~~ an application for mortuary science license by endorsement.

174.23 Subd. 3. **Funeral directors.** The license renewal application fee for funeral directors is  
174.24 \$200. The late fee charge for a license renewal is \$100.

174.25 Subd. 4. **Funeral establishments.** The initial and renewal application fee for funeral  
174.26 establishments is \$425. The late fee charge for a license renewal is \$100.

174.27 Subd. 5. **Crematories.** The initial and renewal application fee for a crematory is \$425.  
174.28 The late fee charge for a license renewal is \$100.

175.1 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal application fee for an  
175.2 alkaline hydrolysis facility is \$425. The late fee charge for a license renewal is \$100.

175.3 Subd. 7. **State government special revenue fund.** Fees collected by the commissioner  
175.4 under this section must be deposited in the state treasury and credited to the state government  
175.5 special revenue fund. All fees are nonrefundable.

175.6 Sec. 52. Minnesota Statutes 2022, section 149A.97, subdivision 2, is amended to read:

175.7 Subd. 2. **Scope and requirements.** This section shall not apply to a transportation  
175.8 protection agreement or to any funeral goods or burial site goods purchased and delivered,  
175.9 either at purchase or within a commercially reasonable amount of time thereafter. When  
175.10 prior to the death of any person, that person or another, on behalf of that person, enters into  
175.11 any transaction, makes a contract, or any series or combination of transactions or contracts  
175.12 with a funeral provider lawfully doing business in Minnesota, other than an insurance  
175.13 company licensed to do business in Minnesota selling approved insurance or annuity  
175.14 products, by the terms of which, goods or services related to the final disposition of that  
175.15 person will be furnished at-need, then the total of all money paid by the terms of the  
175.16 transaction, contract, or series or combination of transactions or contracts shall be held in  
175.17 trust for the purpose for which it has been paid. The person for whose benefit the money  
175.18 was paid shall be known as the beneficiary, the person or persons who paid the money shall  
175.19 be known as the purchaser, and the funeral provider shall be known as the depositor.

175.20 Sec. 53. Minnesota Statutes 2022, section 256R.02, subdivision 20, is amended to read:

175.21 Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI"  
175.22 means a numerical score that describes the relative resource use for all residents within the  
175.23 case mix ~~classifications under the resource utilization group (RUG)~~ classification system  
175.24 prescribed by the commissioner based on an assessment of each resident. The facility average  
175.25 CMI shall be computed as the standardized days divided by the sum of the facility's resident  
175.26 days. The case mix indices used shall be based on the system prescribed in section 256R.17.

175.27 Sec. 54. Minnesota Statutes 2022, section 259.52, subdivision 2, is amended to read:

175.28 Subd. 2. **Requirement to search registry before adoption petition can be granted;**  
175.29 **proof of search.** No petition for adoption may be granted unless the agency supervising  
175.30 the adoptive placement, the birth mother of the child, the putative father who registered or  
175.31 the legal father, or, in the case of a stepparent or relative adoption, the county agency  
175.32 responsible for the report required under section 259.53, subdivision 1, requests that the

176.1 commissioner of health search the registry to determine whether a putative father is registered  
176.2 in relation to a child who is or may be the subject of an adoption petition. The search required  
176.3 by this subdivision must be conducted no sooner than 31 days following the birth of the  
176.4 child. A search of the registry may be proven by the production of a certified copy of the  
176.5 registration form or by a certified statement of the commissioner of health that after a search  
176.6 no registration of a putative father in relation to a child who is or may be the subject of an  
176.7 adoption petition could be located. The filing of a certified copy of an order from a juvenile  
176.8 protection matter under chapter 260C containing a finding that certification of the requisite  
176.9 search of the Minnesota Fathers' Adoption Registry was filed with the court in that matter  
176.10 shall also constitute proof of search. Certification that the Minnesota Fathers' Adoption  
176.11 Registry has been searched must be filed with the court prior to entry of any final order of  
176.12 adoption. In addition to the search required by this subdivision, the agency supervising the  
176.13 adoptive placement, the birth mother of the child, or, in the case of a stepparent or relative  
176.14 adoption, the social services agency responsible for the report under section 259.53,  
176.15 subdivision 1, or the responsible social services agency that is a petitioner in a juvenile  
176.16 protection matter under chapter 260C may request that the commissioner of health search  
176.17 the registry at any time. Search requirements of this section do not apply when the responsible  
176.18 social services agency is proceeding under Safe Place for Newborns, section 260C.139.

176.19 Sec. 55. Minnesota Statutes 2022, section 259.52, subdivision 4, is amended to read:

176.20 Subd. 4. **Classification of registry data.** (a) Data in the fathers' adoption registry,  
176.21 including all data provided in requesting the search of the registry, are private data on  
176.22 individuals, as defined in section 13.02, subdivision 2, and are nonpublic data with respect  
176.23 to data not on individuals, as defined in section 13.02, subdivision 9. Data in the registry  
176.24 may be released to:

176.25 (1) a person who is required to search the registry under subdivision 2, if the data relate  
176.26 to the child who is or may be the subject of the adoption petition;

176.27 (2) the mother of the child listed on the putative father's registration form who the  
176.28 commissioner of health is required to notify under subdivision 1, paragraph (c);

176.29 (3) the putative father who registered himself or the legal father;

176.30 (4) a public authority as provided in subdivision 3; or

176.31 ~~(4)~~ (5) an attorney who has signed an affidavit from the commissioner of health attesting  
176.32 that the attorney represents the birth mother, the putative or legal father, or the prospective  
176.33 adoptive parents.

177.1 (b) A person who receives data under this subdivision may use the data only for purposes  
177.2 authorized under this section or other law.

177.3 Sec. 56. REVISOR INSTRUCTION.

177.4 The revisor of statutes shall substitute the term "employee" with the term "staff" in the  
177.5 following sections of Minnesota Statutes and make any grammatical changes needed without  
177.6 changing the meaning of the sentence: Minnesota Statutes, sections 144G.08, subdivisions  
177.7 18 and 36; 144G.13, subdivision 1, paragraph (c); 144G.20, subdivisions 1, 2, and 21;  
177.8 144G.30, subdivision 5; 144G.42, subdivision 8; 144G.45, subdivision 2; 144G.60,  
177.9 subdivisions 1, paragraph (c), and 3, paragraph (a); 144G.63, subdivision 2, paragraph (a),  
177.10 clause (9); 144G.64, paragraphs (a), clauses (2), (3), and (5), and (c); 144G.70, subdivision  
177.11 7; and 144G.92, subdivisions 1 and 3.

177.12 Sec. 57. REPEALER.

177.13 (a) Minnesota Statutes 2022, sections 144.218, subdivision 3; 144.497; and 256R.02,  
177.14 subdivision 46, are repealed.

177.15 (b) Minnesota Statutes 2023 Supplement, section 62J.312, subdivision 6, is repealed.

177.16 **ARTICLE 7**

177.17 **PHARMACY BOARD AND PRACTICE**

177.18 Section 1. Minnesota Statutes 2023 Supplement, section 62Q.46, subdivision 1, is amended  
177.19 to read:

177.20 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and  
177.21 services" has the meaning specified in the Affordable Care Act. Preventive items and services  
177.22 includes:

177.23 (1) evidence-based items or services that have in effect a rating of A or B in the current  
177.24 recommendations of the United States Preventive Services Task Force with respect to the  
177.25 individual involved;

177.26 (2) immunizations for routine use in children, adolescents, and adults that have in effect  
177.27 a recommendation from the Advisory Committee on Immunization Practices of the Centers  
177.28 for Disease Control and Prevention with respect to the individual involved. For purposes  
177.29 of this clause, a recommendation from the Advisory Committee on Immunization Practices  
177.30 of the Centers for Disease Control and Prevention is considered in effect after the  
177.31 recommendation has been adopted by the Director of the Centers for Disease Control and

178.1 Prevention, and a recommendation is considered to be for routine use if the recommendation  
178.2 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

178.3 (3) with respect to infants, children, and adolescents, evidence-informed preventive care  
178.4 and screenings provided for in comprehensive guidelines supported by the Health Resources  
178.5 and Services Administration;

178.6 (4) with respect to women, additional preventive care and screenings that are not listed  
178.7 with a rating of A or B by the United States Preventive Services Task Force but that are  
178.8 provided for in comprehensive guidelines supported by the Health Resources and Services  
178.9 Administration;

178.10 (5) all contraceptive methods established in guidelines published by the United States  
178.11 Food and Drug Administration;

178.12 (6) screenings for human immunodeficiency virus for:

178.13 (i) all individuals at least 15 years of age but less than 65 years of age; and

178.14 (ii) all other individuals with increased risk of human immunodeficiency virus infection  
178.15 according to guidance from the Centers for Disease Control;

178.16 (7) all preexposure prophylaxis when used for the prevention or treatment of human  
178.17 immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined  
178.18 in any guidance by the United States Preventive Services Task Force or the Centers for  
178.19 Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention  
178.20 of HIV Infection United States Preventive Services Task Force Recommendation Statement;  
178.21 and

178.22 (8) all postexposure prophylaxis when used for the prevention or treatment of human  
178.23 immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined  
178.24 in any guidance by the United States Preventive Services Task Force or the Centers for  
178.25 Disease Control.

178.26 (b) A health plan company must provide coverage for preventive items and services at  
178.27 a participating provider without imposing cost-sharing requirements, including a deductible,  
178.28 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that  
178.29 has a network of providers from excluding coverage or imposing cost-sharing requirements  
178.30 for preventive items or services that are delivered by an out-of-network provider.

178.31 (c) A health plan company is not required to provide coverage for any items or services  
178.32 specified in any recommendation or guideline described in paragraph (a) if the  
178.33 recommendation or guideline is no longer included as a preventive item or service as defined

179.1 in paragraph (a). Annually, a health plan company must determine whether any additional  
179.2 items or services must be covered without cost-sharing requirements or whether any items  
179.3 or services are no longer required to be covered.

179.4 (d) Nothing in this section prevents a health plan company from using reasonable medical  
179.5 management techniques to determine the frequency, method, treatment, or setting for a  
179.6 preventive item or service to the extent not specified in the recommendation or guideline.

179.7 (e) A health plan shall not require prior authorization or step therapy for preexposure  
179.8 prophylaxis or postexposure prophylaxis, except that: if the United States Food and Drug  
179.9 Administration has approved one or more therapeutic equivalents of a drug, device, or  
179.10 product for the prevention of HIV, this paragraph does not require a health plan to cover  
179.11 all of the therapeutically equivalent versions without prior authorization or step therapy, if  
179.12 at least one therapeutically equivalent version is covered without prior authorization or step  
179.13 therapy.

179.14 ~~(e)~~ (f) This section does not apply to grandfathered plans.

179.15 ~~(f)~~ (g) This section does not apply to plans offered by the Minnesota Comprehensive  
179.16 Health Association.

179.17 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health  
179.18 plans offered, issued, or renewed on or after that date.

179.19 Sec. 2. Minnesota Statutes 2022, section 151.01, subdivision 23, is amended to read:

179.20 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed  
179.21 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of  
179.22 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed  
179.23 advanced practice registered nurse, or licensed physician assistant. For purposes of sections  
179.24 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision  
179.25 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to  
179.26 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision  
179.27 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe  
179.28 self-administered hormonal contraceptives, nicotine replacement medications, or opiate  
179.29 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs  
179.30 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,  
179.31 subdivision 17.

179.32 **EFFECTIVE DATE.** This section is effective January 1, 2025.

180.1 Sec. 3. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

180.2 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

180.3 (1) interpretation and evaluation of prescription drug orders;

180.4 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a  
180.5 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs  
180.6 and devices);

180.7 (3) participation in clinical interpretations and monitoring of drug therapy for assurance  
180.8 of safe and effective use of drugs, including ~~the performance of~~ ordering and performing  
180.9 laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of  
180.10 1988, United States Code, title 42, section 263a et seq., ~~provided that a pharmacist may~~  
180.11 ~~interpret the results of laboratory tests but may modify~~ A pharmacist may collect specimens,  
180.12 interpret results, notify the patient of results, and refer the patient to other health care  
180.13 providers for follow-up care and may initiate, modify, or discontinue drug therapy only  
180.14 pursuant to a protocol or collaborative practice agreement. A pharmacist may delegate the  
180.15 authority to administer tests under this clause to a pharmacy technician or pharmacy intern.  
180.16 A pharmacy technician or pharmacy intern may perform tests authorized under this clause  
180.17 if the technician or intern is working under the direct supervision of a pharmacist;

180.18 (4) participation in drug and therapeutic device selection; drug administration for first  
180.19 dosage and medical emergencies; intramuscular and subcutaneous drug administration under  
180.20 a prescription drug order; drug regimen reviews; and drug or drug-related research;

180.21 (5) drug administration, through intramuscular and subcutaneous administration used  
180.22 to treat mental illnesses as permitted under the following conditions:

180.23 (i) upon the order of a prescriber and the prescriber is notified after administration is  
180.24 complete; or

180.25 (ii) pursuant to a protocol or collaborative practice agreement as defined by section  
180.26 151.01, subdivisions 27b and 27c, and participation in the initiation, management,  
180.27 modification, administration, and discontinuation of drug therapy is according to the protocol  
180.28 or collaborative practice agreement between the pharmacist and a dentist, optometrist,  
180.29 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered  
180.30 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes  
180.31 in drug therapy or medication administration made pursuant to a protocol or collaborative  
180.32 practice agreement must be documented by the pharmacist in the patient's medical record  
180.33 or reported by the pharmacist to a practitioner responsible for the patient's care;

181.1 (6) ~~participation in administration of influenza vaccines and~~ initiating, ordering, and  
181.2 administering influenza and COVID-19 or SARS-CoV-2 vaccines authorized or approved  
181.3 by the United States Food and Drug Administration related to COVID-19 or SARS-CoV-2  
181.4 to all eligible individuals ~~six~~ three years of age and older and all other United States Food  
181.5 and Drug Administration-approved vaccines to patients ~~13~~ six years of age and older by  
181.6 written protocol with a physician licensed under chapter 147, a physician assistant authorized  
181.7 to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized  
181.8 to prescribe drugs under section 148.235, provided that according to the federal Advisory  
181.9 Committee on Immunization Practices recommendations. A pharmacist may delegate the  
181.10 authority to administer vaccines under this clause to a pharmacy technician or pharmacy  
181.11 intern who has completed training in vaccine administration if:

181.12 (i) ~~the protocol includes, at a minimum:~~

181.13 (A) ~~the name, dose, and route of each vaccine that may be given;~~

181.14 (B) ~~the patient population for whom the vaccine may be given;~~

181.15 (C) ~~contraindications and precautions to the vaccine;~~

181.16 (D) ~~the procedure for handling an adverse reaction;~~

181.17 (E) ~~the name, signature, and address of the physician, physician assistant, or advanced~~  
181.18 ~~practice registered nurse;~~

181.19 (F) ~~a telephone number at which the physician, physician assistant, or advanced practice~~  
181.20 ~~registered nurse can be contacted; and~~

181.21 (G) ~~the date and time period for which the protocol is valid;~~

181.22 (ii) (i) ~~the pharmacist has~~ and the pharmacy technician or pharmacy intern have

181.23 successfully completed a program approved by the Accreditation Council for Pharmacy  
181.24 Education (ACPE) specifically for the administration of immunizations or a program  
181.25 approved by the board;

181.26 (iii) (ii) ~~the pharmacist utilizes the Minnesota Immunization Information Connection to~~  
181.27 ~~assess the immunization status of individuals prior to the administration of vaccines, except~~  
181.28 ~~when administering influenza vaccines to individuals age nine and older;~~

181.29 (iv) (iii) ~~the pharmacist reports the administration of the immunization to the Minnesota~~  
181.30 ~~Immunization Information Connection; and~~

181.31 (v) ~~the pharmacist complies with guidelines for vaccines and immunizations established~~  
181.32 ~~by the federal Advisory Committee on Immunization Practices, except that a pharmacist~~

182.1 ~~does not need to comply with those portions of the guidelines that establish immunization~~  
182.2 ~~schedules when administering a vaccine pursuant to a valid, patient-specific order issued~~  
182.3 ~~by a physician licensed under chapter 147, a physician assistant authorized to prescribe~~  
182.4 ~~drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe~~  
182.5 ~~drugs under section 148.235, provided that the order is consistent with the United States~~  
182.6 ~~Food and Drug Administration approved labeling of the vaccine;~~

182.7 (iv) if the patient is 18 years of age or younger, the pharmacist, pharmacy technician,  
182.8 or pharmacy intern informs the patient and any adult caregiver accompanying the patient  
182.9 of the importance of a well-child visit with a pediatrician or other licensed primary care  
182.10 provider; and

182.11 (v) in the case of a pharmacy technician administering vaccinations while being  
182.12 supervised by a licensed pharmacist:

182.13 (A) the supervision is in-person and must not be done through telehealth as defined  
182.14 under section 62A.673, subdivision 2;

182.15 (B) the pharmacist is readily and immediately available to the immunizing pharmacy  
182.16 technician;

182.17 (C) the pharmacy technician has a current certificate in basic cardiopulmonary  
182.18 resuscitation;

182.19 (D) the pharmacy technician has completed a minimum of two hours of ACPE-approved,  
182.20 immunization-related continuing pharmacy education as part of the pharmacy technician's  
182.21 two-year continuing education schedule; and

182.22 (E) the pharmacy technician has completed one of two training programs listed under  
182.23 Minnesota Rules, part 6800.3850, subpart 1h, item B;

182.24 (7) participation in the initiation, management, modification, and discontinuation of  
182.25 drug therapy according to a written protocol or collaborative practice agreement between:

182.26 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician  
182.27 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more  
182.28 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,  
182.29 or advanced practice registered nurses authorized to prescribe, dispense, and administer  
182.30 under section 148.235. Any changes in drug therapy made pursuant to a protocol or  
182.31 collaborative practice agreement must be documented by the pharmacist in the patient's  
182.32 medical record or reported by the pharmacist to a practitioner responsible for the patient's  
182.33 care;

183.1 (8) participation in the storage of drugs and the maintenance of records;

183.2 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and  
183.3 devices;

183.4 (10) offering or performing those acts, services, operations, or transactions necessary  
183.5 in the conduct, operation, management, and control of a pharmacy;

183.6 (11) participation in the initiation, management, modification, and discontinuation of  
183.7 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

183.8 (i) a written protocol as allowed under clause (7); or

183.9 (ii) a written protocol with a community health board medical consultant or a practitioner  
183.10 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

183.11 (12) prescribing self-administered hormonal contraceptives; nicotine replacement  
183.12 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant  
183.13 to section 151.37, subdivision 14, 15, or 16; ~~and~~

183.14 (13) participation in the placement of drug monitoring devices according to a prescription,  
183.15 protocol, or collaborative practice agreement;

183.16 (14) prescribing, dispensing, and administering drugs for preventing the acquisition of  
183.17 human immunodeficiency virus (HIV) if the pharmacist meets the requirements in section  
183.18 151.37, subdivision 17; and

183.19 (15) ordering, conducting, and interpreting laboratory tests necessary for therapies that  
183.20 use drugs for preventing the acquisition of HIV, if the pharmacist meets the requirements  
183.21 in section 151.37, subdivision 17.

183.22 **EFFECTIVE DATE.** This section is effective July 1, 2024, except that clauses (14)  
183.23 and (15) are effective January 1, 2026.

183.24 Sec. 4. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to  
183.25 read:

183.26 **Subd. 4a. Application and fee; relocation.** A person who is registered with or licensed  
183.27 by the board must submit a new application to the board before relocating the physical  
183.28 location of the person's business. An application must be submitted for each affected license.  
183.29 The application must set forth the proposed change of location on a form established by the  
183.30 board. If the licensee or registrant remitted payment for the full amount during the state's  
183.31 fiscal year, the relocation application fee is the same as the application fee in subdivision  
183.32 1, except that the fees in clauses (6) to (9) and (11) to (16) are reduced by \$5,000 and the

184.1 fee in clause (16) is reduced by \$55,000. If the application is made within 60 days before  
184.2 the date of the original license or registration expiration, the applicant must pay the full  
184.3 application fee provided in subdivision 1. Upon approval of an application for a relocation,  
184.4 the board shall issue a new license or registration.

184.5 Sec. 5. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to  
184.6 read:

184.7 Subd. 4b. **Application and fee; change of ownership.** A person who is registered with  
184.8 or licensed by the board must submit a new application to the board before changing the  
184.9 ownership of the licensee or registrant. An application must be submitted for each affected  
184.10 license. The application must set forth the proposed change of ownership on a form  
184.11 established by the board. If the licensee or registrant remitted payment for the full amount  
184.12 during the state's fiscal year, the application fee is the same as the application fee in  
184.13 subdivision 1, except that the fees in clauses (6) to (9) and (11) to (16) are reduced by \$5,000  
184.14 and the fee in clause (16) is reduced by \$55,000. If the application is made within 60 days  
184.15 before the date of the original license or registration expiration, the applicant must pay the  
184.16 full application fee provided in subdivision 1. Upon approval of an application for a change  
184.17 of ownership, the board shall issue a new license or registration.

184.18 Sec. 6. Minnesota Statutes 2022, section 151.065, is amended by adding a subdivision to  
184.19 read:

184.20 Subd. 8. **Transfer of licenses.** Licenses and registrations granted by the board are not  
184.21 transferable.

184.22 Sec. 7. Minnesota Statutes 2022, section 151.066, subdivision 1, is amended to read:

184.23 Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have  
184.24 the meanings given to them in this subdivision.

184.25 (b) "Manufacturer" means a manufacturer licensed under section 151.252 ~~that is engaged~~  
184.26 ~~in the manufacturing of an opiate,~~ excluding those exclusively licensed to manufacture  
184.27 medical gas.

184.28 (c) "Opiate" means any opiate-containing controlled substance listed in section 152.02,  
184.29 subdivisions 3 to 5, that is distributed, delivered, sold, or dispensed into or within this state.

184.30 (d) "Third-party logistics provider" means a third-party logistics provider licensed under  
184.31 section 151.471.

185.1 (e) "Wholesaler" means a wholesale drug distributor licensed under section 151.47 that  
185.2 is engaged in the wholesale drug distribution of an opiate, excluding those exclusively  
185.3 licensed to distribute medical gas.

185.4 Sec. 8. Minnesota Statutes 2022, section 151.066, subdivision 2, is amended to read:

185.5 Subd. 2. **Reporting requirements.** (a) By March 1 of each year, beginning March 1,  
185.6 2020, each manufacturer and each wholesaler must report to the board every sale, delivery,  
185.7 or other distribution within or into this state of any opiate that is made to any practitioner,  
185.8 pharmacy, hospital, veterinary hospital, or other person who is permitted by section 151.37  
185.9 to possess controlled substances for administration or dispensing to patients that occurred  
185.10 during the previous calendar year. Reporting must be in the automation of reports and  
185.11 consolidated orders system format unless otherwise specified by the board. If no reportable  
185.12 distributions occurred for a given year, notification must be provided to the board in a  
185.13 manner specified by the board. If a manufacturer or wholesaler fails to provide information  
185.14 required under this paragraph on a timely basis, the board may assess an administrative  
185.15 penalty of \$500 per day. This penalty shall not be considered a form of disciplinary action.

185.16 (b) By March 1 of each year, beginning March 1, 2020, each owner of a pharmacy with  
185.17 at least one location within this state must report to the board any intracompany delivery  
185.18 or distribution into this state, of any opiate, to the extent that those deliveries and distributions  
185.19 are not reported to the board by a licensed wholesaler owned by, under contract to, or  
185.20 otherwise operating on behalf of the owner of the pharmacy. Reporting must be in the  
185.21 manner and format specified by the board for deliveries and distributions that occurred  
185.22 during the previous calendar year. The report must include the name of the manufacturer  
185.23 or wholesaler from which the owner of the pharmacy ultimately purchased the opiate, and  
185.24 the amount and date that the purchase occurred.

185.25 (c) By March 1 of each year, beginning March 1, 2025, each third-party logistics provider  
185.26 must report to the board any delivery or distribution into this state of any opiate, to the  
185.27 extent that those deliveries and distributions are not reported to the board by a licensed  
185.28 wholesaler or manufacturer. Reporting must be in the manner and format specified by the  
185.29 board for deliveries and distributions that occurred during the previous calendar year.

185.30 Sec. 9. Minnesota Statutes 2022, section 151.066, subdivision 3, is amended to read:

185.31 Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall  
185.32 annually assess an opiate product registration fee on any manufacturer of an opiate that

186.1 annually sells, delivers, or distributes an opiate within or into the state in a quantity of  
186.2 2,000,000 or more units as reported to the board under subdivision 2.

186.3 (b) For purposes of assessing the annual registration fee under this section and  
186.4 determining the number of opiate units a manufacturer sold, delivered, or distributed within  
186.5 or into the state, the board shall not consider any opiate that is used for substance use disorder  
186.6 treatment with medications for opioid use disorder.

186.7 (c) The annual registration fee for each manufacturer meeting the requirement under  
186.8 paragraph (a) is \$250,000.

186.9 (d) In conjunction with the data reported under this section, and notwithstanding section  
186.10 152.126, subdivision 6, the board may use the data reported under section 152.126,  
186.11 subdivision 4, to determine which manufacturers meet the requirement under paragraph (a)  
186.12 and are required to pay the registration fees under this subdivision.

186.13 (e) By April 1 of each year, beginning April 1, 2020, the board shall notify a manufacturer  
186.14 that the manufacturer meets the requirement in paragraph (a) and is required to pay the  
186.15 annual registration fee in accordance with section 151.252, subdivision 1, paragraph (b).

186.16 (f) A manufacturer may dispute the board's determination that the manufacturer must  
186.17 pay the registration fee no later than 30 days after the date of notification. However, the  
186.18 manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph  
186.19 (b). The dispute must be filed with the board in the manner and using the forms specified  
186.20 by the board. A manufacturer must submit, with the required forms, data satisfactory to the  
186.21 board that demonstrates that the assessment of the registration fee was incorrect. The board  
186.22 must make a decision concerning a dispute no later than 60 days after receiving the required  
186.23 dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated  
186.24 that the fee was incorrectly assessed, the board must refund the amount paid in error.

186.25 (g) For purposes of this subdivision, a unit means the individual dosage form of the  
186.26 particular drug product that is prescribed to the patient. One unit equals one tablet, capsule,  
186.27 patch, syringe, milliliter, or gram.

186.28 (h) For the purposes of this subdivision, an opiate's units will be assigned to the  
186.29 manufacturer holding the New Drug Application (NDA) or Abbreviated New Drug  
186.30 Application (ANDA), as listed by the United States Food and Drug Administration.

186.31 Sec. 10. Minnesota Statutes 2022, section 151.212, is amended by adding a subdivision  
186.32 to read:

186.33 Subd. 4. Accessible prescription drug container labels. (a) A pharmacy must:

187.1 (1) make reasonable efforts to inform the public that an accessible prescription drug  
187.2 container label is available at no additional cost, upon request of the patient or the patient's  
187.3 representative, to any patient who has difficulty seeing or reading standard printed labels  
187.4 on prescription drug containers; and

187.5 (2) if the pharmacy knows that the patient has difficulty seeing or reading standard  
187.6 printed labels on prescription drug containers, inform a patient that an accessible prescription  
187.7 drug container label is available at no additional cost upon request of the patient or the  
187.8 patient's representative.

187.9 (b) Subject to paragraph (e), if a patient requests an accessible container label, the  
187.10 pharmacy must provide the patient with a prescription drug container label in large print,  
187.11 Braille, or may provide any other method included in the best practices for access to  
187.12 prescription drug labeling information by the United States Access Board, or its successor  
187.13 organization, depending on the need and preference of the patient. The pharmacy must make  
187.14 reasonable efforts to ensure patient safety and access during the time it takes to provide the  
187.15 requested method of accessibility.

187.16 (c) The accessible container label must:

187.17 (1) be affixed on the container in compliance with section 151.212, subdivision 1;

187.18 (2) last for at least the duration of the prescription;

187.19 (3) contain the information required under subdivisions 1 and 2;

187.20 (4) be available in a timely manner relative to the industry standard time required to  
187.21 produce the accessible container label; and

187.22 (5) conform with the best practices established by the United States Access Board, or  
187.23 its successor organization, for large print and Braille accessible container labels.

187.24 (d) By January 1, 2025, the commissioner of health must publish a list of pharmacies  
187.25 that have informed the commissioner that the pharmacy has the technological capacity to  
187.26 provide an accessible container label to a patient in the timely manner required by paragraph  
187.27 (c), clause (4). The commissioner must update this list on a quarterly basis until January 1,  
187.28 2026.

187.29 (e) Until January 1, 2026, if the pharmacy does not have the technological capacity to  
187.30 provide an accessible container label to a patient in the timely manner required by paragraph  
187.31 (c), clause (4), the pharmacy is not required to provide an accessible container label to a  
187.32 patient requesting such a label, but the pharmacy must inform the patient of the list of  
187.33 pharmacies with such capacity required pursuant to paragraph (d), if such list is published.

188.1 (f) On and after January 1, 2026, all pharmacies must be able to provide an accessible  
188.2 container label in the timely manner required by paragraph (c), clause (4).

188.3 (g) This subdivision does not apply to prescription drugs dispensed and administered  
188.4 by a correctional institution.

188.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

188.6 Sec. 11. Minnesota Statutes 2022, section 151.37, is amended by adding a subdivision to  
188.7 read:

188.8 **Subd. 17. Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized  
188.9 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency  
188.10 virus (HIV) in accordance with this subdivision.

188.11 (b) By January 1, 2025, the Board of Pharmacy shall develop a standardized protocol  
188.12 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing  
188.13 the protocol, the board may consult with community health advocacy groups, the Board of  
188.14 Medical Practice, the Board of Nursing, the commissioner of health, professional pharmacy  
188.15 associations, and professional associations for physicians, physician assistants, and advanced  
188.16 practice registered nurses.

188.17 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the  
188.18 pharmacist must successfully complete a training program specifically developed for  
188.19 prescribing drugs for preventing the acquisition of HIV that is offered by a college of  
188.20 pharmacy, a continuing education provider that is accredited by the Accreditation Council  
188.21 for Pharmacy Education, or a program approved by the board. To maintain authorization  
188.22 to prescribe, the pharmacist shall complete continuing education requirements as specified  
188.23 by the board.

188.24 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the  
188.25 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may  
188.26 dispense to a patient a drug described in paragraph (a).

188.27 (e) Before dispensing a drug described in paragraph (a) that is prescribed by the  
188.28 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs  
188.29 and must provide the patient with a fact sheet that includes the indications and  
188.30 contraindications for the use of these drugs, the appropriate method for using these drugs,  
188.31 the need for medical follow up, and any additional information listed in Minnesota Rules,  
188.32 part 6800.0910, subpart 2, that is required to be provided to a patient during the counseling  
188.33 process.

189.1 (f) A pharmacist is prohibited from delegating the prescribing authority provided under  
189.2 this subdivision to any other person. A pharmacist intern registered under section 151.101  
189.3 may prepare the prescription, but before the prescription is processed or dispensed, a  
189.4 pharmacist authorized to prescribe under this subdivision must review, approve, and sign  
189.5 the prescription.

189.6 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,  
189.7 management, modification, and discontinuation of drug therapy according to a protocol as  
189.8 authorized in this section and in section 151.01, subdivision 27.

189.9 **EFFECTIVE DATE.** This section is effective January 1, 2025, except that paragraph  
189.10 (b) is effective the day following final enactment.

189.11 Sec. 12. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 1, is amended  
189.12 to read:

189.13 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this  
189.14 subdivision have the meanings given.

189.15 (b) "Central repository" means a wholesale distributor that meets the requirements under  
189.16 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this  
189.17 section.

189.18 (c) "Distribute" means to deliver, other than by administering or dispensing.

189.19 (d) "Donor" means:

189.20 (1) ~~a health care facility as defined in this subdivision~~ an individual at least 18 years of  
189.21 age, provided that the drug or medical supply that is donated was obtained legally and meets  
189.22 the requirements of this section for donation; or

189.23 (2) ~~a skilled nursing facility licensed under chapter 144A;~~ any entity legally authorized  
189.24 to possess medicine with a license or permit in good standing in the state in which it is  
189.25 located, without further restrictions, including but not limited to a health care facility, skilled  
189.26 nursing facility, assisted living facility, pharmacy, wholesaler, and drug manufacturer.

189.27 (3) ~~an assisted living facility licensed under chapter 144G;~~

189.28 (4) ~~a pharmacy licensed under section 151.19, and located either in the state or outside~~  
189.29 ~~the state;~~

189.30 (5) ~~a drug wholesaler licensed under section 151.47;~~

189.31 (6) ~~a drug manufacturer licensed under section 151.252; or~~

190.1 ~~(7) an individual at least 18 years of age, provided that the drug or medical supply that~~  
190.2 ~~is donated was obtained legally and meets the requirements of this section for donation.~~

190.3 (e) "Drug" means any prescription drug that has been approved for medical use in the  
190.4 United States, is listed in the United States Pharmacopoeia or National Formulary, and  
190.5 meets the criteria established under this section for donation; or any over-the-counter  
190.6 medication that meets the criteria established under this section for donation. This definition  
190.7 includes cancer drugs and antirejection drugs, but does not include controlled substances,  
190.8 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed  
190.9 to a patient registered with the drug's manufacturer in accordance with federal Food and  
190.10 Drug Administration requirements.

190.11 (f) "Health care facility" means:

190.12 (1) a physician's office or health care clinic where licensed practitioners provide health  
190.13 care to patients;

190.14 (2) a hospital licensed under section 144.50;

190.15 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

190.16 (4) a nonprofit community clinic, including a federally qualified health center; a rural  
190.17 health clinic; public health clinic; or other community clinic that provides health care utilizing  
190.18 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

190.19 (g) "Local repository" means a health care facility that elects to accept donated drugs  
190.20 and medical supplies and meets the requirements of subdivision 4.

190.21 (h) "Medical supplies" or "supplies" means any prescription or nonprescription medical  
190.22 supplies needed to administer a drug.

190.23 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is  
190.24 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or  
190.25 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose  
190.26 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,  
190.27 part 6800.3750.

190.28 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that  
190.29 it does not include a veterinarian.

191.1 Sec. 13. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 4, is amended  
191.2 to read:

191.3 Subd. 4. **Local repository requirements.** (a) To be eligible for participation in the  
191.4 medication repository program, a health care facility must agree to comply with all applicable  
191.5 federal and state laws, rules, and regulations pertaining to the medication repository program,  
191.6 drug storage, and dispensing. The facility must also agree to maintain in good standing any  
191.7 required state license or registration that may apply to the facility.

191.8 (b) A local repository may elect to participate in the program by submitting the following  
191.9 information to the central repository on a form developed by the board and made available  
191.10 on the board's website:

191.11 (1) the name, street address, and telephone number of the health care facility and any  
191.12 state-issued license or registration number issued to the facility, including the issuing state  
191.13 agency;

191.14 (2) the name and telephone number of a responsible pharmacist or practitioner who is  
191.15 employed by or under contract with the health care facility; and

191.16 (3) a statement signed and dated by the responsible pharmacist or practitioner indicating  
191.17 that the health care facility meets the eligibility requirements under this section and agrees  
191.18 to comply with this section.

191.19 (c) Participation in the medication repository program is voluntary. A local repository  
191.20 may withdraw from participation in the medication repository program at any time by  
191.21 providing written notice to the central repository on a form developed by the board and  
191.22 made available on the board's website. ~~The central repository shall provide the board with~~  
191.23 ~~a copy of the withdrawal notice within ten business days from the date of receipt of the~~  
191.24 ~~withdrawal notice.~~

191.25 Sec. 14. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 5, is amended  
191.26 to read:

191.27 Subd. 5. **Individual eligibility and application requirements.** (a) ~~To be eligible for~~  
191.28 ~~the medication repository program~~ At the time of or before receiving donated drugs or  
191.29 supplies as a new eligible patient, an individual must submit to a local repository an electronic  
191.30 or physical intake application form that is signed by the individual and attests that the  
191.31 individual:

191.32 (1) is a resident of Minnesota;

192.1 (2) is uninsured ~~and is not enrolled in the medical assistance program under chapter~~  
192.2 ~~256B or the MinnesotaCare program under chapter 256L~~, has no prescription drug coverage,  
192.3 or is underinsured;

192.4 (3) acknowledges that the drugs or medical supplies to be received through the program  
192.5 may have been donated; and

192.6 (4) consents to a waiver of the child-resistant packaging requirements of the federal  
192.7 Poison Prevention Packaging Act.

192.8 ~~(b) Upon determining that an individual is eligible for the program, the local repository~~  
192.9 ~~shall furnish the individual with an identification card. The card shall be valid for one year~~  
192.10 ~~from the date of issuance and may be used at any local repository. A new identification card~~  
192.11 ~~may be issued upon expiration once the individual submits a new application form.~~

192.12 ~~(e)~~ (b) The local repository shall send a copy of the intake application form to the central  
192.13 repository by regular mail, facsimile, or secured email within ten days from the date the  
192.14 application is approved by the local repository.

192.15 ~~(d)~~ (c) The board shall develop and make available on the board's website an application  
192.16 form ~~and the format for the identification card.~~

192.17 Sec. 15. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 6, is amended  
192.18 to read:

192.19 Subd. 6. **Standards and procedures for accepting donations of drugs and supplies.** (a)  
192.20 Notwithstanding any other law or rule, a donor may donate drugs or medical supplies to  
192.21 the central repository or a local repository if the drug or supply meets the requirements of  
192.22 this section as determined by a pharmacist or practitioner who is employed by or under  
192.23 contract with the central repository or a local repository.

192.24 (b) A drug is eligible for donation under the medication repository program if the  
192.25 following requirements are met:

192.26 ~~(1) the donation is accompanied by a medication repository donor form described under~~  
192.27 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~  
192.28 ~~donor's knowledge in accordance with paragraph (d);~~

192.29 ~~(2)~~ (1) the drug's expiration date is at least six months after the date the drug was donated.  
192.30 If a donated drug bears an expiration date that is less than six months from the donation  
192.31 date, the drug may be accepted and distributed if the drug is in high demand and can be  
192.32 dispensed for use by a patient before the drug's expiration date;

193.1 ~~(3)~~ (2) the drug is in its original, sealed, unopened, tamper-evident packaging that includes  
193.2 the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging  
193.3 is unopened;

193.4 ~~(4)~~ (3) the drug or the packaging does not have any physical signs of tampering,  
193.5 misbranding, deterioration, compromised integrity, or adulteration;

193.6 ~~(5)~~ (4) the drug does not require storage temperatures other than normal room temperature  
193.7 as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being  
193.8 donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located  
193.9 in Minnesota; and

193.10 ~~(6)~~ (5) the drug is not a controlled substance.

193.11 (c) A medical supply is eligible for donation under the medication repository program  
193.12 if the following requirements are met:

193.13 (1) the supply has no physical signs of tampering, misbranding, or alteration and there  
193.14 is no reason to believe it has been adulterated, tampered with, or misbranded;

193.15 (2) the supply is in its original, unopened, sealed packaging; and

193.16 ~~(3) the donation is accompanied by a medication repository donor form described under~~  
193.17 ~~paragraph (d) that is signed by an individual who is authorized by the donor to attest to the~~  
193.18 ~~donor's knowledge in accordance with paragraph (d); and~~

193.19 ~~(4)~~ (3) if the supply bears an expiration date, the date is at least six months later than  
193.20 the date the supply was donated. If the donated supply bears an expiration date that is less  
193.21 than six months from the date the supply was donated, the supply may be accepted and  
193.22 distributed if the supply is in high demand and can be dispensed for use by a patient before  
193.23 the supply's expiration date.

193.24 (d) The board shall develop the medication repository donor form and make it available  
193.25 on the board's website. ~~The form must state that to the best of the donor's knowledge the~~  
193.26 ~~donated drug or supply has been properly stored under appropriate temperature and humidity~~  
193.27 ~~conditions and that the drug or supply has never been opened, used, tampered with,~~  
193.28 ~~adulterated, or misbranded.~~ Prior to the first donation from a new donor, a central repository  
193.29 or local repository shall verify and record the following information on the donor form:

193.30 (1) the donor's name, address, phone number, and license number, if applicable;

193.31 (2) that the donor will only make donations in accordance with the program;

194.1 (3) to the best of the donor's knowledge, only drugs or supplies that have been properly  
194.2 stored under appropriate temperature and humidity conditions will be donated; and

194.3 (4) to the best of the donor's knowledge, only drugs or supplies that have never been  
194.4 opened, used, tampered with, adulterated, or misbranded will be donated.

194.5 (e) Notwithstanding any other law or rule, a central repository or a local repository may  
194.6 receive donated drugs from donors. Donated drugs and supplies may be shipped or delivered  
194.7 to the premises of the central repository or a local repository, and shall be inspected by a  
194.8 pharmacist or an authorized practitioner who is employed by or under contract with the  
194.9 repository and who has been designated by the repository to accept donations prior to  
194.10 dispensing. A drop box must not be used to deliver or accept donations.

194.11 (f) The central repository and local repository shall maintain a written or electronic  
194.12 inventory of all drugs and supplies donated to the repository upon acceptance of each drug  
194.13 or supply. For each drug, the inventory must include the drug's name, strength, quantity,  
194.14 manufacturer, expiration date, and the date the drug was donated. For each medical supply,  
194.15 the inventory must include a description of the supply, its manufacturer, the date the supply  
194.16 was donated, and, if applicable, the supply's brand name and expiration date. The board  
194.17 may waive the requirement under this paragraph if an entity is under common ownership  
194.18 or control with a central repository or local repository and either the entity or the repository  
194.19 maintains an inventory containing all the information required under this paragraph.

194.20 Sec. 16. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 7, is amended  
194.21 to read:

194.22 **Subd. 7. Standards and procedures for inspecting and storing donated drugs and**  
194.23 **supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract  
194.24 with the central repository or a local repository shall inspect all donated drugs and supplies  
194.25 before the drug or supply is dispensed to determine, to the extent reasonably possible in the  
194.26 professional judgment of the pharmacist or practitioner, that the drug or supply is not  
194.27 adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing,  
194.28 has not been subject to a recall, and meets the requirements for donation. ~~The pharmacist~~  
194.29 ~~or practitioner who inspects the drugs or supplies shall sign an inspection record stating that~~  
194.30 ~~the requirements for donation have been met.~~ If a local repository receives drugs and supplies  
194.31 from the central repository, the local repository does not need to reinspect the drugs and  
194.32 supplies.

195.1 (b) The central repository and local repositories shall store donated drugs and supplies  
195.2 in a secure storage area under environmental conditions appropriate for the drug or supply  
195.3 being stored. Donated drugs and supplies may not be stored with nondonated inventory.

195.4 (c) The central repository and local repositories shall dispose of all drugs and medical  
195.5 supplies that are not suitable for donation in compliance with applicable federal and state  
195.6 statutes, regulations, and rules concerning hazardous waste.

195.7 (d) In the event that controlled substances or drugs that can only be dispensed to a patient  
195.8 registered with the drug's manufacturer are shipped or delivered to a central or local repository  
195.9 for donation, the shipment delivery must be documented by the repository and returned  
195.10 immediately to the donor or the donor's representative that provided the drugs.

195.11 (e) Each repository must develop drug and medical supply recall policies and procedures.  
195.12 If a repository receives a recall notification, the repository shall destroy all of the drug or  
195.13 medical supply in its inventory that is the subject of the recall and complete a record of  
195.14 destruction form in accordance with paragraph (f). If a drug or medical supply that is the  
195.15 subject of a Class I or Class II recall has been dispensed, the repository shall immediately  
195.16 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject  
195.17 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug  
195.18 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

195.19 (f) A record of destruction of donated drugs and supplies that are not dispensed under  
195.20 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation  
195.21 shall be maintained by the repository for at least two years. For each drug or supply destroyed,  
195.22 the record shall include the following information:

195.23 (1) the date of destruction;

195.24 (2) the name, strength, and quantity of the drug destroyed; and

195.25 (3) the name of the person or firm that destroyed the drug.

195.26 No other record of destruction is required.

195.27 Sec. 17. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 8, is amended  
195.28 to read:

195.29 Subd. 8. **Dispensing requirements.** (a) Donated prescription drugs and supplies may  
195.30 be dispensed if the drugs or supplies are prescribed by a practitioner for use by an eligible  
195.31 individual and are dispensed by a pharmacist or practitioner. A repository shall dispense  
195.32 drugs and supplies to eligible individuals in the following priority order: (1) individuals

196.1 who are uninsured; (2) individuals with no prescription drug coverage; and (3) individuals  
196.2 who are underinsured. A repository shall dispense donated drugs in compliance with  
196.3 applicable federal and state laws and regulations for dispensing drugs, including all  
196.4 requirements relating to packaging, labeling, record keeping, drug utilization review, and  
196.5 patient counseling.

196.6 (b) Before dispensing or administering a drug or supply, the pharmacist or practitioner  
196.7 shall visually inspect the drug or supply for adulteration, misbranding, tampering, and date  
196.8 of expiration. Drugs or supplies that have expired or appear upon visual inspection to be  
196.9 adulterated, misbranded, or tampered with in any way must not be dispensed or administered.

196.10 (c) Before a the first drug or supply is dispensed or administered to an individual, the  
196.11 individual must sign a an electronic or physical drug repository recipient form acknowledging  
196.12 that the individual understands ~~the information stated on the form. The board shall develop~~  
196.13 ~~the form and make it available on the board's website. The form must include the following~~  
196.14 ~~information:~~

196.15 (1) that the drug or supply being dispensed or administered has been donated and may  
196.16 have been previously dispensed;

196.17 (2) that a visual inspection has been conducted by the pharmacist or practitioner to ensure  
196.18 that the drug or supply has not expired, has not been adulterated or misbranded, and is in  
196.19 its original, unopened packaging; and

196.20 (3) that the dispensing pharmacist, the dispensing or administering practitioner, the  
196.21 central repository or local repository, the Board of Pharmacy, and any other participant of  
196.22 the medication repository program cannot guarantee the safety of the drug or medical supply  
196.23 being dispensed or administered and that the pharmacist or practitioner has determined that  
196.24 the drug or supply is safe to dispense or administer based on the accuracy of the donor's  
196.25 form submitted with the donated drug or medical supply and the visual inspection required  
196.26 to be performed by the pharmacist or practitioner before dispensing or administering.

196.27 Sec. 18. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 9, is amended  
196.28 to read:

196.29 Subd. 9. **Handling fees.** (a) The central or local repository may charge the individual  
196.30 receiving a drug or supply a handling fee of no more than 250 percent of the medical  
196.31 assistance program dispensing fee for each drug or medical supply dispensed or administered  
196.32 by that repository.

197.1 (b) A repository that dispenses or administers a drug or medical supply through the  
197.2 medication repository program shall not receive reimbursement under the medical assistance  
197.3 program or the MinnesotaCare program for that dispensed or administered drug or supply.

197.4 (c) A supply or handling fee must not be charged to an individual enrolled in the medical  
197.5 assistance or MinnesotaCare program.

197.6 Sec. 19. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 11, is amended  
197.7 to read:

197.8 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed  
197.9 for the administration of this program ~~shall be utilized by the participants of the program~~  
197.10 ~~and~~ shall be available on the board's website:

197.11 (1) intake application form described under subdivision 5;

197.12 (2) local repository participation form described under subdivision 4;

197.13 (3) local repository withdrawal form described under subdivision 4;

197.14 (4) medication repository donor form described under subdivision 6;

197.15 (5) record of destruction form described under subdivision 7; and

197.16 (6) medication repository recipient form described under subdivision 8.

197.17 Participants may use substantively similar electronic or physical forms.

197.18 (b) All records, including drug inventory, ~~inspection,~~ and disposal of donated drugs and  
197.19 medical supplies, must be maintained by a repository for a minimum of two years. Records  
197.20 required as part of this program must be maintained pursuant to all applicable practice acts.

197.21 (c) Data collected by the medication repository program from all local repositories shall  
197.22 be submitted quarterly or upon request to the central repository. Data collected may consist  
197.23 of the information, records, and forms required to be collected under this section.

197.24 (d) The central repository shall submit reports to the board as required by the contract  
197.25 or upon request of the board.

197.26 Sec. 20. Minnesota Statutes 2023 Supplement, section 151.555, subdivision 12, is amended  
197.27 to read:

197.28 Subd. 12. **Liability.** (a) The manufacturer of a drug or supply is not subject to criminal  
197.29 or civil liability for injury, death, or loss to a person or to property for causes of action  
197.30 described in clauses (1) and (2). A manufacturer is not liable for:

198.1 (1) the intentional or unintentional alteration of the drug or supply by a party not under  
198.2 the control of the manufacturer; or

198.3 (2) the failure of a party not under the control of the manufacturer to transfer or  
198.4 communicate product or consumer information or the expiration date of the donated drug  
198.5 or supply.

198.6 (b) A health care facility participating in the program, a pharmacist dispensing a drug  
198.7 or supply pursuant to the program, a practitioner dispensing or administering a drug or  
198.8 supply pursuant to the program, ~~or a donor of a drug or medical supply, or a person or entity~~  
198.9 that facilitates any of the above is immune from civil liability for an act or omission that  
198.10 causes injury to or the death of an individual to whom the drug or supply is dispensed and  
198.11 no disciplinary action by a health-related licensing board shall be taken against a ~~pharmacist~~  
198.12 ~~or practitioner~~ person or entity so long as the drug or supply is donated, accepted, distributed,  
198.13 and dispensed according to the requirements of this section. This immunity does not apply  
198.14 if the act or omission involves reckless, wanton, or intentional misconduct, or malpractice  
198.15 unrelated to the quality of the drug or medical supply.

198.16 Sec. 21. Minnesota Statutes 2022, section 256B.0625, subdivision 10, is amended to read:

198.17 Subd. 10. **Laboratory, x-ray, and opioid testing services.** (a) Medical assistance covers  
198.18 laboratory and x-ray services.

198.19 (b) Medical assistance covers screening and urinalysis tests for opioids without lifetime  
198.20 or annual limits.

198.21 (c) Medical assistance covers laboratory tests ordered and performed by a licensed  
198.22 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at  
198.23 no less than the rate for which the same services are covered when provided by any other  
198.24 licensed practitioner.

198.25 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
198.26 whichever is later. The commissioner of human services shall notify the revisor of statutes  
198.27 when federal approval is obtained.

198.28 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13f, is  
198.29 amended to read:

198.30 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and  
198.31 recommend drugs which require prior authorization. The Formulary Committee shall  
198.32 establish general criteria to be used for the prior authorization of brand-name drugs for

199.1 which generically equivalent drugs are available, but the committee is not required to review  
199.2 each brand-name drug for which a generically equivalent drug is available.

199.3 (b) Prior authorization may be required by the commissioner before certain formulary  
199.4 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior  
199.5 authorization directly to the commissioner. The commissioner may also request that the  
199.6 Formulary Committee review a drug for prior authorization. Before the commissioner may  
199.7 require prior authorization for a drug:

199.8 (1) the commissioner must provide information to the Formulary Committee on the  
199.9 impact that placing the drug on prior authorization may have on the quality of patient care  
199.10 and on program costs, information regarding whether the drug is subject to clinical abuse  
199.11 or misuse, and relevant data from the state Medicaid program if such data is available;

199.12 (2) the Formulary Committee must review the drug, taking into account medical and  
199.13 clinical data and the information provided by the commissioner; and

199.14 (3) the Formulary Committee must hold a public forum and receive public comment for  
199.15 an additional 15 days.

199.16 The commissioner must provide a 15-day notice period before implementing the prior  
199.17 authorization.

199.18 (c) Except as provided in subdivision 13j, prior authorization shall not be required or  
199.19 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness  
199.20 if:

199.21 (1) there is no generically equivalent drug available; and

199.22 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

199.23 (3) the drug is part of the recipient's current course of treatment.

199.24 This paragraph applies to any multistate preferred drug list or supplemental drug rebate  
199.25 program established or administered by the commissioner. Prior authorization shall  
199.26 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental  
199.27 illness within 60 days of when a generically equivalent drug becomes available, provided  
199.28 that the brand name drug was part of the recipient's course of treatment at the time the  
199.29 generically equivalent drug became available.

199.30 (d) Prior authorization must not be required for liquid methadone if only one version of  
199.31 liquid methadone is available. If more than one version of liquid methadone is available,

200.1 the commissioner shall ensure that at least one version of liquid methadone is available  
200.2 without prior authorization.

200.3 (e) Prior authorization may be required for an oral liquid form of a drug, except as  
200.4 described in paragraph (d). A prior authorization request under this paragraph must be  
200.5 automatically approved within 24 hours if the drug is being prescribed for a Food and Drug  
200.6 Administration-approved condition for a patient who utilizes an enteral tube for feedings  
200.7 or medication administration, even if the patient has current or prior claims for pills for that  
200.8 condition. If more than one version of the oral liquid form of a drug is available, the  
200.9 commissioner may select the version that is able to be approved for a Food and Drug  
200.10 Administration-approved condition for a patient who utilizes an enteral tube for feedings  
200.11 or medication administration. This paragraph applies to any multistate preferred drug list  
200.12 or supplemental drug rebate program established or administered by the commissioner. The  
200.13 commissioner shall design and implement a streamlined prior authorization form for patients  
200.14 who utilize an enteral tube for feedings or medication administration and are prescribed an  
200.15 oral liquid form of a drug. The commissioner may require prior authorization for brand  
200.16 name drugs whenever a generically equivalent product is available, even if the prescriber  
200.17 specifically indicates "dispense as written-brand necessary" on the prescription as required  
200.18 by section 151.21, subdivision 2.

200.19 (f) Notwithstanding this subdivision, the commissioner may automatically require prior  
200.20 authorization, for a period not to exceed 180 days, for any drug that is approved by the  
200.21 United States Food and Drug Administration on or after July 1, 2005. The 180-day period  
200.22 begins no later than the first day that a drug is available for shipment to pharmacies within  
200.23 the state. The Formulary Committee shall recommend to the commissioner general criteria  
200.24 to be used for the prior authorization of the drugs, but the committee is not required to  
200.25 review each individual drug. In order to continue prior authorizations for a drug after the  
200.26 180-day period has expired, the commissioner must follow the provisions of this subdivision.

200.27 (g) Prior authorization under this subdivision shall comply with section 62Q.184.

200.28 (h) Any step therapy protocol requirements established by the commissioner must comply  
200.29 with section 62Q.1841.

200.30 (i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not  
200.31 be required or utilized for any class of drugs that is approved by the United States Food and  
200.32 Drug Administration for the treatment or prevention of HIV and AIDS.

200.33 **EFFECTIVE DATE.** This section is effective January 1, 2026.

201.1 Sec. 23. Minnesota Statutes 2022, section 256B.0625, subdivision 39, is amended to read:

201.2 Subd. 39. **Childhood immunizations.** (a) Providers who administer pediatric vaccines  
201.3 within the scope of their licensure, and who are enrolled as a medical assistance provider,  
201.4 must enroll in the pediatric vaccine administration program established by section 13631  
201.5 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for  
201.6 administration of the vaccine to children eligible for medical assistance. Medical assistance  
201.7 does not pay for vaccines that are available at no cost from the pediatric vaccine  
201.8 administration program unless the vaccines qualify for 100 percent federal funding or are  
201.9 mandated by the Centers for Medicare and Medicaid Services to be covered outside of the  
201.10 Vaccines for Children program.

201.11 (b) Medical assistance covers vaccines initiated, ordered, or administered by a licensed  
201.12 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (6), at  
201.13 no less than the rate for which the same services are covered when provided by any other  
201.14 licensed practitioner.

201.15 **EFFECTIVE DATE.** The amendment to paragraph (a) is effective July 1, 2024.  
201.16 Paragraph (b) is effective January 1, 2025, or upon federal approval, whichever is later. The  
201.17 commissioner of human services shall notify the revisor of statutes when federal approval  
201.18 is obtained.

201.19 Sec. 24. **DIRECTION TO THE COMMISSIONER; ASSESSMENT OF LICENSED**  
201.20 **OUTPATIENT PHARMACIES; REPORT.**

201.21 The commissioner of health, in consultation with the Board of Pharmacy, must conduct  
201.22 an assessment of licensed outpatient pharmacies and vendors of audible container labels  
201.23 and prescription readers to determine: (1) the approximate number of such pharmacies  
201.24 currently providing accessible labels to individuals who cannot access large print or Braille  
201.25 labels; and (2) the approximate cost to such pharmacies to provide accessible labels to  
201.26 individuals who cannot access large print or Braille labels. By January 15, 2025, the  
201.27 commissioner must submit a report to the chairs and ranking minority members of the  
201.28 legislative committees with jurisdiction over health and human services finance and policy.  
201.29 The report must include the assessment results and recommendations for providing accessible  
201.30 labels to those who cannot access large print or Braille labels.

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

202.1 Sec. 25. RULEMAKING; BOARD OF PHARMACY.

202.2 The Board of Pharmacy must amend Minnesota Rules, part 6800.3400, to permit and  
202.3 promote the inclusion of the following on a prescription label:

202.4 (1) the complete and unabbreviated generic name of the drug; and

202.5 (2) instructions written in plain language explaining the patient-specific indications for  
202.6 the drug if the patient-specific indications are indicated on the prescription.

202.7 The Board of Pharmacy must comply with Minnesota Statutes, section 14.389, in adopting  
202.8 the amendment to the rule.

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

202.10 **ARTICLE 8**

202.11 **BEHAVIORAL HEALTH**

202.12 Section 1. Minnesota Statutes 2022, section 245.462, subdivision 6, is amended to read:

202.13 Subd. 6. **Community support services program.** "Community support services program"  
202.14 means services, other than inpatient or residential treatment services, provided or coordinated  
202.15 by an identified program and staff under the treatment supervision of a mental health  
202.16 professional designed to help adults with serious and persistent mental illness to function  
202.17 and remain in the community. A community support services program includes:

202.18 (1) client outreach,

202.19 (2) medication monitoring,

202.20 (3) assistance in independent living skills,

202.21 (4) development of employability and work-related opportunities,

202.22 (5) crisis assistance,

202.23 (6) psychosocial rehabilitation,

202.24 (7) help in applying for government benefits, and

202.25 (8) housing support services.

202.26 The community support services program must be coordinated with the case management  
202.27 services specified in section 245.4711. A program that meets the accreditation standards  
202.28 for Clubhouse International model programs meets the requirements of this subdivision.

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

203.2 Subd. 2. **Eligible providers.** In order to be eligible for a grant under this section, a mental  
203.3 health provider must:

203.4 (1) provide at least 25 percent of the provider's yearly patient encounters to state public  
203.5 program enrollees or patients receiving sliding fee schedule discounts through a formal  
203.6 sliding fee schedule meeting the standards established by the United States Department of  
203.7 Health and Human Services under Code of Federal Regulations, title 42, section 51c.303;  
203.8 ~~or~~

203.9 (2) primarily serve underrepresented communities as defined in section 148E.010,  
203.10 subdivision 20; or

203.11 (3) provide services to people in a city or township that is not within the seven-county  
203.12 metropolitan area as defined in section 473.121, subdivision 2, and is not the city of Duluth,  
203.13 Mankato, Moorhead, Rochester, or St. Cloud.

203.14 Sec. 3. Minnesota Statutes 2023 Supplement, section 245.4889, subdivision 1, is amended  
203.15 to read:

203.16 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to  
203.17 make grants from available appropriations to assist:

203.18 (1) counties;

203.19 (2) Indian tribes;

203.20 (3) children's collaboratives under section 124D.23 or 245.493; or

203.21 (4) mental health service providers.

203.22 (b) The following services are eligible for grants under this section:

203.23 (1) services to children with emotional disturbances as defined in section 245.4871,  
203.24 subdivision 15, and their families;

203.25 (2) transition services under section 245.4875, subdivision 8, for young adults under  
203.26 age 21 and their families;

203.27 (3) respite care services for children with emotional disturbances or severe emotional  
203.28 disturbances who are at risk of ~~out-of-home placement or residential treatment or~~  
203.29 hospitalization, who are already in out-of-home placement in family foster settings as defined  
203.30 in chapter 245A and at risk of change in out-of-home placement or placement in a residential  
203.31 facility or other higher level of care, who have utilized crisis services or emergency room

204.1 services, or who have experienced a loss of in-home staffing support. Allowable activities  
204.2 and expenses for respite care services are defined under subdivision 4. A child is not required  
204.3 to have case management services to receive respite care services. Counties must work to  
204.4 provide access to regularly scheduled respite care;

204.5 (4) children's mental health crisis services;

204.6 (5) child-, youth-, and family-specific mobile response and stabilization services models;

204.7 (6) mental health services for people from cultural and ethnic minorities, including  
204.8 supervision of clinical trainees who are Black, indigenous, or people of color;

204.9 (7) children's mental health screening and follow-up diagnostic assessment and treatment;

204.10 (8) services to promote and develop the capacity of providers to use evidence-based  
204.11 practices in providing children's mental health services;

204.12 (9) school-linked mental health services under section 245.4901;

204.13 (10) building evidence-based mental health intervention capacity for children birth to  
204.14 age five;

204.15 (11) suicide prevention and counseling services that use text messaging statewide;

204.16 (12) mental health first aid training;

204.17 (13) training for parents, collaborative partners, and mental health providers on the  
204.18 impact of adverse childhood experiences and trauma and development of an interactive  
204.19 website to share information and strategies to promote resilience and prevent trauma;

204.20 (14) transition age services to develop or expand mental health treatment and supports  
204.21 for adolescents and young adults 26 years of age or younger;

204.22 (15) early childhood mental health consultation;

204.23 (16) evidence-based interventions for youth at risk of developing or experiencing a first  
204.24 episode of psychosis, and a public awareness campaign on the signs and symptoms of  
204.25 psychosis;

204.26 (17) psychiatric consultation for primary care practitioners; and

204.27 (18) providers to begin operations and meet program requirements when establishing a  
204.28 new children's mental health program. These may be start-up grants.

204.29 (c) Services under paragraph (b) must be designed to help each child to function and  
204.30 remain with the child's family in the community and delivered consistent with the child's

205.1 treatment plan. Transition services to eligible young adults under this paragraph must be  
205.2 designed to foster independent living in the community.

205.3 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party  
205.4 reimbursement sources, if applicable.

205.5 (e) The commissioner may establish and design a pilot program to expand the mobile  
205.6 response and stabilization services model for children, youth, and families. The commissioner  
205.7 may use grant funding to consult with a qualified expert entity to assist in the formulation  
205.8 of measurable outcomes and explore and position the state to submit a Medicaid state plan  
205.9 amendment to scale the model statewide.

205.10 Sec. 4. Minnesota Statutes 2023 Supplement, section 245.735, subdivision 3, is amended  
205.11 to read:

205.12 Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall  
205.13 establish state certification and recertification processes for certified community behavioral  
205.14 health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified  
205.15 under this section to be eligible for reimbursement under medical assistance, without service  
205.16 area limits based on geographic area or region. The commissioner shall consult with CCBHC  
205.17 stakeholders before establishing and implementing changes in the certification or  
205.18 recertification process and requirements. Any changes to the certification or recertification  
205.19 process or requirements must be consistent with the most recently issued Certified  
205.20 Community Behavioral Health Clinic Certification Criteria published by the Substance  
205.21 Abuse and Mental Health Services Administration. The commissioner must allow a transition  
205.22 period for CCBHCs to meet the revised criteria ~~prior to July 1, 2024~~ on or before January  
205.23 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the  
205.24 terms of the demonstration to comply with federal requirements.

205.25 (b) As part of the state CCBHC certification and recertification processes, the  
205.26 commissioner shall provide to entities applying for certification or requesting recertification  
205.27 the standard requirements of the community needs assessment and the staffing plan that are  
205.28 consistent with the most recently issued Certified Community Behavioral Health Clinic  
205.29 Certification Criteria published by the Substance Abuse and Mental Health Services  
205.30 Administration.

205.31 (c) The commissioner shall schedule a certification review that includes a site visit within  
205.32 90 calendar days of receipt of an application for certification or recertification.

205.33 (d) Entities that choose to be CCBHCs must:

206.1 (1) complete a community needs assessment and complete a staffing plan that is  
206.2 responsive to the needs identified in the community needs assessment and update both the  
206.3 community needs assessment and the staffing plan no less frequently than every 36 months;

206.4 (2) comply with state licensing requirements and other requirements issued by the  
206.5 commissioner;

206.6 (3) employ or contract with a medical director. A medical director must be a physician  
206.7 licensed under chapter 147 and either certified by the American Board of Psychiatry and  
206.8 Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or  
206.9 eligible for board certification in psychiatry. A registered nurse who is licensed under  
206.10 sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family  
206.11 psychiatric and mental health nursing by a national nurse certification organization may  
206.12 serve as the medical director when a CCBHC is unable to employ or contract a qualified  
206.13 physician;

206.14 (4) employ or contract for clinic staff who have backgrounds in diverse disciplines,  
206.15 including licensed mental health professionals and licensed alcohol and drug counselors,  
206.16 and staff who are culturally and linguistically trained to meet the needs of the population  
206.17 the clinic serves;

206.18 (5) ensure that clinic services are available and accessible to individuals and families of  
206.19 all ages and genders with access on evenings and weekends and that crisis management  
206.20 services are available 24 hours per day;

206.21 (6) establish fees for clinic services for individuals who are not enrolled in medical  
206.22 assistance using a sliding fee scale that ensures that services to patients are not denied or  
206.23 limited due to an individual's inability to pay for services;

206.24 (7) comply with quality assurance reporting requirements and other reporting  
206.25 requirements included in the most recently issued Certified Community Behavioral Health  
206.26 Clinic Certification Criteria published by the Substance Abuse and Mental Health Services  
206.27 Administration;

206.28 (8) provide crisis mental health and substance use services, withdrawal management  
206.29 services, emergency crisis intervention services, and stabilization services through existing  
206.30 mobile crisis services; screening, assessment, and diagnosis services, including risk  
206.31 assessments and level of care determinations; person- and family-centered treatment planning;  
206.32 outpatient mental health and substance use services; targeted case management; psychiatric  
206.33 rehabilitation services; peer support and counselor services and family support services;  
206.34 and intensive community-based mental health services, including mental health services

207.1 for members of the armed forces and veterans. CCBHCs must directly provide the majority  
207.2 of these services to enrollees, but may coordinate some services with another entity through  
207.3 a collaboration or agreement, pursuant to subdivision 3a;

207.4 (9) provide coordination of care across settings and providers to ensure seamless  
207.5 transitions for individuals being served across the full spectrum of health services, including  
207.6 acute, chronic, and behavioral needs;

207.7 (10) be certified as a mental health clinic under section 245I.20;

207.8 (11) comply with standards established by the commissioner relating to CCBHC  
207.9 screenings, assessments, and evaluations that are consistent with this section;

207.10 (12) be licensed to provide substance use disorder treatment under chapter 245G;

207.11 (13) be certified to provide children's therapeutic services and supports under section  
207.12 256B.0943;

207.13 (14) be certified to provide adult rehabilitative mental health services under section  
207.14 256B.0623;

207.15 (15) be enrolled to provide mental health crisis response services under section  
207.16 256B.0624;

207.17 (16) be enrolled to provide mental health targeted case management under section  
207.18 256B.0625, subdivision 20;

207.19 (17) provide services that comply with the evidence-based practices described in  
207.20 subdivision 3d;

207.21 (18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07,  
207.22 subdivision 2, clause (8), as applicable when peer services are provided; and

207.23 (19) inform all clients upon initiation of care of the full array of services available under  
207.24 the CCBHC model.

207.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
207.26 of human services shall notify the revisor of statutes when federal approval is obtained.

207.27 Sec. 5. Minnesota Statutes 2022, section 245I.02, subdivision 17, is amended to read:

207.28 Subd. 17. **Functional assessment.** "Functional assessment" means the assessment of a  
207.29 client's current level of functioning relative to functioning that is appropriate for someone  
207.30 the client's age. ~~For a client five years of age or younger, a functional assessment is the~~  
207.31 ~~Early Childhood Service Intensity Instrument (ESCI). For a client six to 17 years of age,~~

208.1 ~~a functional assessment is the Child and Adolescent Service Intensity Instrument (CASH).~~  
208.2 ~~For a client 18 years of age or older, a functional assessment is the functional assessment~~  
208.3 ~~described in section 245I.10, subdivision 9.~~

208.4 Sec. 6. Minnesota Statutes 2022, section 245I.02, subdivision 19, is amended to read:

208.5 Subd. 19. **Level of care assessment.** "Level of care assessment" means the level of care  
208.6 decision support tool appropriate to the client's age. ~~For a client five years of age or younger,~~  
208.7 ~~a level of care assessment is the Early Childhood Service Intensity Instrument (ESCI).~~ ~~For~~  
208.8 ~~a client six to 17 years of age, a level of care assessment is the Child and Adolescent Service~~  
208.9 ~~Intensity Instrument (CASH).~~ ~~For a client 18 years of age or older, a level of care assessment~~  
208.10 ~~is the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)~~  
208.11 ~~or another tool authorized by the commissioner.~~

208.12 Sec. 7. Minnesota Statutes 2022, section 245I.04, subdivision 6, is amended to read:

208.13 Subd. 6. **Clinical trainee qualifications.** (a) A clinical trainee is a staff person who: (1)  
208.14 is enrolled in an accredited graduate program of study to prepare the staff person for  
208.15 independent licensure as a mental health professional and who is participating in a practicum  
208.16 or internship with the license holder through the individual's graduate program; ~~or~~ (2) has  
208.17 completed an accredited graduate program of study to prepare the staff person for independent  
208.18 licensure as a mental health professional and who is in compliance with the requirements  
208.19 of the applicable health-related licensing board, including requirements for supervised  
208.20 practice; or (3) has completed an accredited graduate program of study to prepare the staff  
208.21 person for independent licensure as a mental health professional, has completed a practicum  
208.22 or internship and has not yet taken or received the results from the required test or is waiting  
208.23 for the final licensure decision.

208.24 (b) A clinical trainee is responsible for notifying and applying to a health-related licensing  
208.25 board to ensure that the trainee meets the requirements of the health-related licensing board.  
208.26 As permitted by a health-related licensing board, treatment supervision under this chapter  
208.27 may be integrated into a plan to meet the supervisory requirements of the health-related  
208.28 licensing board but does not supersede those requirements.

208.29 Sec. 8. Minnesota Statutes 2022, section 245I.10, subdivision 9, is amended to read:

208.30 Subd. 9. **Functional assessment; required elements.** (a) When a license holder is  
208.31 completing a functional assessment for an adult client, the license holder must:

209.1 (1) complete a functional assessment of the client after completing the client's diagnostic  
209.2 assessment;

209.3 (2) use a collaborative process that allows the client and the client's family and other  
209.4 natural supports, the client's referral sources, and the client's providers to provide information  
209.5 about how the client's symptoms of mental illness impact the client's functioning;

209.6 (3) if applicable, document the reasons that the license holder did not contact the client's  
209.7 family and other natural supports;

209.8 (4) assess and document how the client's symptoms of mental illness impact the client's  
209.9 functioning in the following areas:

209.10 (i) the client's mental health symptoms;

209.11 (ii) the client's mental health service needs;

209.12 (iii) the client's substance use;

209.13 (iv) the client's vocational and educational functioning;

209.14 (v) the client's social functioning, including the use of leisure time;

209.15 (vi) the client's interpersonal functioning, including relationships with the client's family  
209.16 and other natural supports;

209.17 (vii) the client's ability to provide self-care and live independently;

209.18 (viii) the client's medical and dental health;

209.19 (ix) the client's financial assistance needs; and

209.20 (x) the client's housing and transportation needs;

209.21 ~~(5) include a narrative summarizing the client's strengths, resources, and all areas of~~  
209.22 ~~functional impairment;~~

209.23 ~~(6)~~ (5) complete the client's functional assessment before the client's initial individual  
209.24 treatment plan unless a service specifies otherwise; and

209.25 ~~(7)~~ (6) update the client's functional assessment with the client's current functioning  
209.26 whenever there is a significant change in the client's functioning or at least every ~~180~~ 365  
209.27 days, unless a service specifies otherwise.

209.28 (b) A license holder may use any available, validated measurement tool, including but  
209.29 not limited to the Daily Living Activities-20, when completing the required elements of a  
209.30 functional assessment under this subdivision.

210.1 Sec. 9. Minnesota Statutes 2022, section 245I.11, subdivision 1, is amended to read:

210.2 Subdivision 1. **Generally.** (a) If a license holder is licensed as a residential program,  
210.3 stores or administers client medications, or observes clients self-administer medications,  
210.4 the license holder must ensure that a staff person who is a registered nurse or licensed  
210.5 prescriber is responsible for overseeing storage and administration of client medications  
210.6 and observing as a client self-administers medications, including training according to  
210.7 section 245I.05, subdivision 6, and documenting the occurrence according to section 245I.08,  
210.8 subdivision 5.

210.9 (b) For purposes of this section, "observed self-administration" means the preparation  
210.10 and administration of a medication by a client to themselves under the direct supervision  
210.11 of a registered nurse or a staff member to whom a registered nurse delegates supervision  
210.12 duty. Observed self-administration does not include a client's use of a medication that they  
210.13 keep in their own possession while participating in a program.

210.14 Sec. 10. Minnesota Statutes 2022, section 245I.11, is amended by adding a subdivision  
210.15 to read:

210.16 Subd. 6. **Medication administration in children's day treatment settings.** (a) For a  
210.17 program providing children's day treatment services under section 256B.0943, the license  
210.18 holder must maintain policies and procedures that state whether the program will store  
210.19 medication and administer or allow observed self-administration.

210.20 (b) For a program providing children's day treatment services under section 256B.0943  
210.21 that does not store medications but allows clients to use a medication that they keep in their  
210.22 own possession while participating in a program, the license holder must maintain  
210.23 documentation from a licensed prescriber regarding the safety of medications held by clients,  
210.24 including:

210.25 (1) an evaluation that the client is capable of holding and administering the medication  
210.26 safely;

210.27 (2) an evaluation of whether the medication is prone to diversion, misuse, or self-injury;  
210.28 and

210.29 (3) any conditions under which the license holder should no longer allow the client to  
210.30 maintain the medication in their own possession.

211.1 Sec. 11. Minnesota Statutes 2022, section 245I.20, subdivision 4, is amended to read:

211.2 Subd. 4. **Minimum staffing standards.** (a) A certification holder's treatment team must  
211.3 consist of at least four mental health professionals. At least two of the mental health  
211.4 professionals must be employed by or under contract with the mental health clinic for a  
211.5 minimum of 35 hours per week each. ~~Each of the two mental health professionals must~~  
211.6 ~~specialize in a different mental health discipline.~~

211.7 (b) The treatment team must include:

211.8 (1) a physician qualified as a mental health professional according to section 245I.04,  
211.9 subdivision 2, clause (4), or a nurse qualified as a mental health professional according to  
211.10 section 245I.04, subdivision 2, clause (1); and

211.11 (2) a psychologist qualified as a mental health professional according to section 245I.04,  
211.12 subdivision 2, clause (3).

211.13 (c) The staff persons fulfilling the requirement in paragraph (b) must provide clinical  
211.14 services at least:

211.15 (1) eight hours every two weeks if the mental health clinic has over 25.0 full-time  
211.16 equivalent treatment team members;

211.17 (2) eight hours each month if the mental health clinic has 15.1 to 25.0 full-time equivalent  
211.18 treatment team members;

211.19 (3) four hours each month if the mental health clinic has 5.1 to 15.0 full-time equivalent  
211.20 treatment team members; or

211.21 (4) two hours each month if the mental health clinic has 2.0 to 5.0 full-time equivalent  
211.22 treatment team members or only provides in-home services to clients.

211.23 (d) The certification holder must maintain a record that demonstrates compliance with  
211.24 this subdivision.

211.25 Sec. 12. Minnesota Statutes 2022, section 245I.23, subdivision 14, is amended to read:

211.26 Subd. 14. **Weekly team meetings.** (a) The license holder must hold weekly team meetings  
211.27 and ancillary meetings according to this subdivision.

211.28 (b) A mental health professional or certified rehabilitation specialist must hold at least  
211.29 one team meeting each calendar week ~~and~~. The mental health professional or certified  
211.30 rehabilitation specialist must lead and be physically present at the team meeting, except as  
211.31 permitted under paragraph (e). All treatment team members, including treatment team

212.1 members who work on a part-time or intermittent basis, must participate in a minimum of  
212.2 one team meeting during each calendar week when the treatment team member is working  
212.3 for the license holder. The license holder must document all weekly team meetings, including  
212.4 the names of meeting attendees, and indicate whether the meeting was conducted remotely  
212.5 under paragraph (e).

212.6 (c) If a treatment team member cannot participate in a weekly team meeting, the treatment  
212.7 team member must participate in an ancillary meeting. A mental health professional, certified  
212.8 rehabilitation specialist, clinical trainee, or mental health practitioner who participated in  
212.9 the most recent weekly team meeting may lead the ancillary meeting. During the ancillary  
212.10 meeting, the treatment team member leading the ancillary meeting must review the  
212.11 information that was shared at the most recent weekly team meeting, including revisions  
212.12 to client treatment plans and other information that the treatment supervisors exchanged  
212.13 with treatment team members. The license holder must document all ancillary meetings,  
212.14 including the names of meeting attendees.

212.15 (d) If a treatment team member working only one shift during a week cannot participate  
212.16 in a weekly team meeting or participate in an ancillary meeting, the treatment team member  
212.17 must read the minutes of the weekly team meeting required to be documented in paragraph  
212.18 (b). The treatment team member must sign to acknowledge receipt of this information, and  
212.19 document pertinent information or questions. The mental health professional or certified  
212.20 rehabilitation specialist must review any documented questions or pertinent information  
212.21 before the next weekly team meeting.

212.22 (e) A license holder may permit a mental health professional or certified rehabilitation  
212.23 specialist to lead the weekly meeting remotely due to medical or weather conditions. If the  
212.24 conditions that do not permit physical presence persist for longer than one week, the license  
212.25 holder must request a variance to conduct additional meetings remotely.

212.26 Sec. 13. Minnesota Statutes 2023 Supplement, section 254B.04, subdivision 1a, is amended  
212.27 to read:

212.28 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal  
212.29 Regulations, title 25, part 20, who meet the income standards of section 256B.056,  
212.30 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health  
212.31 fund services. State money appropriated for this paragraph must be placed in a separate  
212.32 account established for this purpose.

212.33 (b) Persons with dependent children who are determined to be in need of substance use  
212.34 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in

213.1 need of chemical dependency treatment pursuant to a case plan under section 260C.201,  
213.2 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment  
213.3 services. Treatment services must be appropriate for the individual or family, which may  
213.4 include long-term care treatment or treatment in a facility that allows the dependent children  
213.5 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if  
213.6 applicable.

213.7 (c) Notwithstanding paragraph (a), ~~persons~~ any person enrolled in medical assistance  
213.8 ~~are~~ or MinnesotaCare is eligible for room and board services under section 254B.05,  
213.9 subdivision 5, paragraph (b), clause ~~(12)~~ (9).

213.10 (d) A client is eligible to have substance use disorder treatment paid for with funds from  
213.11 the behavioral health fund when the client:

213.12 (1) is eligible for MFIP as determined under chapter 256J;

213.13 (2) is eligible for medical assistance as determined under Minnesota Rules, parts  
213.14 9505.0010 to 9505.0150;

213.15 (3) is eligible for general assistance, general assistance medical care, or work readiness  
213.16 as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

213.17 (4) has income that is within current household size and income guidelines for entitled  
213.18 persons, as defined in this subdivision and subdivision 7.

213.19 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have  
213.20 a third-party payment source are eligible for the behavioral health fund if the third-party  
213.21 payment source pays less than 100 percent of the cost of treatment services for eligible  
213.22 clients.

213.23 (f) A client is ineligible to have substance use disorder treatment services paid for with  
213.24 behavioral health fund money if the client:

213.25 (1) has an income that exceeds current household size and income guidelines for entitled  
213.26 persons as defined in this subdivision and subdivision 7; or

213.27 (2) has an available third-party payment source that will pay the total cost of the client's  
213.28 treatment.

213.29 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode  
213.30 is eligible for continued treatment service that is paid for by the behavioral health fund until  
213.31 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan  
213.32 if the client:

214.1 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance  
214.2 medical care; or

214.3 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local  
214.4 agency under section 254B.04.

214.5 (h) When a county commits a client under chapter 253B to a regional treatment center  
214.6 for substance use disorder services and the client is ineligible for the behavioral health fund,  
214.7 the county is responsible for the payment to the regional treatment center according to  
214.8 section 254B.05, subdivision 4.

214.9 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when  
214.10 provided through intensive residential treatment services and residential crisis services under  
214.11 section 256B.0622.

214.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

214.13 Sec. 14. **[256B.0617] MENTAL HEALTH SERVICES PROVIDER**

214.14 **CERTIFICATION.**

214.15 (a) The commissioner of human services shall establish an initial provider entity  
214.16 application and certification and recertification processes to determine whether a provider  
214.17 entity has administrative and clinical infrastructures that meet the certification requirements.  
214.18 This process applies to providers of the following services:

214.19 (1) children's intensive behavioral health services under section 256B.0946; and

214.20 (2) intensive nonresidential rehabilitative mental health services under section 256B.0947.

214.21 (b) The commissioner shall recertify a provider entity every three years using the  
214.22 individual provider's certification anniversary or the calendar year end. The commissioner  
214.23 may approve a recertification extension in the interest of sustaining services when a certain  
214.24 date for recertification is identified.

214.25 (c) The commissioner shall establish a process for decertification of a provider entity  
214.26 and shall require corrective action, medical assistance repayment, or decertification of a  
214.27 provider entity that no longer meets the requirements in this section or that fails to meet the  
214.28 clinical quality standards or administrative standards provided by the commissioner in the  
214.29 application and certification process.

214.30 (d) The commissioner must provide the following to provider entities for the certification,  
214.31 recertification, and decertification processes:

214.32 (1) a structured listing of required provider certification criteria;

215.1 (2) a formal written letter with a determination of certification, recertification, or  
215.2 decertification signed by the commissioner or the appropriate division director; and

215.3 (3) a formal written communication outlining the process for necessary corrective action  
215.4 and follow-up by the commissioner signed by the commissioner or their designee, if  
215.5 applicable. In the case of corrective action, the commissioner may schedule interim  
215.6 recertification site reviews to confirm certification or decertification.

215.7 **EFFECTIVE DATE.** This section is effective July 1, 2024, and the commissioner of  
215.8 human services must implement all requirements of this section by September 1, 2024.

215.9 Sec. 15. Minnesota Statutes 2022, section 256B.0622, subdivision 2a, is amended to read:

215.10 Subd. 2a. **Eligibility for assertive community treatment.** (a) An eligible client for  
215.11 assertive community treatment is an individual who meets the following criteria as assessed  
215.12 by an ACT team:

215.13 (1) is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the  
215.14 commissioner;

215.15 (2) has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive  
215.16 disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals  
215.17 with other psychiatric illnesses may qualify for assertive community treatment if they have  
215.18 a serious mental illness and meet the criteria outlined in clauses (3) and (4), but no more  
215.19 than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals  
215.20 with a primary diagnosis of a substance use disorder, intellectual developmental disabilities,  
215.21 borderline personality disorder, antisocial personality disorder, traumatic brain injury, or  
215.22 an autism spectrum disorder are not eligible for assertive community treatment;

215.23 (3) has significant functional impairment as demonstrated by at least one of the following  
215.24 conditions:

215.25 (i) significant difficulty consistently performing the range of routine tasks required for  
215.26 basic adult functioning in the community or persistent difficulty performing daily living  
215.27 tasks without significant support or assistance;

215.28 (ii) significant difficulty maintaining employment at a self-sustaining level or significant  
215.29 difficulty consistently carrying out the head-of-household responsibilities; or

215.30 (iii) significant difficulty maintaining a safe living situation;

215.31 (4) has a need for continuous high-intensity services as evidenced by at least two of the  
215.32 following:

- 216.1 (i) two or more psychiatric hospitalizations or residential crisis stabilization services in  
216.2 the previous 12 months;
- 216.3 (ii) frequent utilization of mental health crisis services in the previous six months;
- 216.4 (iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;
- 216.5 (iv) intractable, persistent, or prolonged severe psychiatric symptoms;
- 216.6 (v) coexisting mental health and substance use disorders lasting at least six months;
- 216.7 (vi) recent history of involvement with the criminal justice system or demonstrated risk  
216.8 of future involvement;
- 216.9 (vii) significant difficulty meeting basic survival needs;
- 216.10 (viii) residing in substandard housing, experiencing homelessness, or facing imminent  
216.11 risk of homelessness;
- 216.12 (ix) significant impairment with social and interpersonal functioning such that basic  
216.13 needs are in jeopardy;
- 216.14 (x) coexisting mental health and physical health disorders lasting at least six months;
- 216.15 (xi) residing in an inpatient or supervised community residence but clinically assessed  
216.16 to be able to live in a more independent living situation if intensive services are provided;
- 216.17 (xii) requiring a residential placement if more intensive services are not available; or
- 216.18 (xiii) difficulty effectively using traditional office-based outpatient services;
- 216.19 (5) there are no indications that other available community-based services would be  
216.20 equally or more effective as evidenced by consistent and extensive efforts to treat the  
216.21 individual; and
- 216.22 (6) in the written opinion of a licensed mental health professional, has the need for mental  
216.23 health services that cannot be met with other available community-based services, or is  
216.24 likely to experience a mental health crisis or require a more restrictive setting if assertive  
216.25 community treatment is not provided.
- 216.26 (b) An individual meets the criteria for assertive community treatment under this section  
216.27 if they have participated within the last year or are currently participating in a first episode  
216.28 of psychosis program if the individual:
- 216.29 (1) meets the eligibility requirements outlined in paragraph (a), clauses (1), (2), (5), and  
216.30 (6); and

217.1 (2) needs the level of intensity provided by an ACT team, in the opinion of the individual's  
217.2 first episode of psychosis program, in order to prevent crisis services use, hospitalization,  
217.3 homelessness, and involvement with the criminal justice system.

217.4 Sec. 16. Minnesota Statutes 2022, section 256B.0622, subdivision 3a, is amended to read:

217.5 Subd. 3a. **Provider certification and contract requirements for assertive community**  
217.6 **treatment.** (a) The assertive community treatment provider must:

217.7 ~~(1) have a contract with the host county to provide assertive community treatment~~  
217.8 ~~services; and~~

217.9 ~~(2)~~ have each ACT team be certified by the state following the certification process and  
217.10 procedures developed by the commissioner. The certification process determines whether  
217.11 the ACT team meets the standards for assertive community treatment under this section,  
217.12 the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum  
217.13 program fidelity standards as measured by a nationally recognized fidelity tool approved  
217.14 by the commissioner. Recertification must occur at least every three years.

217.15 (b) An ACT team certified under this subdivision must meet the following standards:

217.16 (1) have capacity to recruit, hire, manage, and train required ACT team members;

217.17 (2) have adequate administrative ability to ensure availability of services;

217.18 (3) ensure flexibility in service delivery to respond to the changing and intermittent care  
217.19 needs of a client as identified by the client and the individual treatment plan;

217.20 (4) keep all necessary records required by law;

217.21 (5) be an enrolled Medicaid provider; and

217.22 (6) establish and maintain a quality assurance plan to determine specific service outcomes  
217.23 and the client's satisfaction with services.

217.24 (c) The commissioner may intervene at any time and decertify an ACT team with cause.  
217.25 The commissioner shall establish a process for decertification of an ACT team and shall  
217.26 require corrective action, medical assistance repayment, or decertification of an ACT team  
217.27 that no longer meets the requirements in this section or that fails to meet the clinical quality  
217.28 standards or administrative standards provided by the commissioner in the application and  
217.29 certification process. The decertification is subject to appeal to the state.

218.1 Sec. 17. Minnesota Statutes 2022, section 256B.0622, subdivision 7a, is amended to read:

218.2 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

218.3 The required treatment staff qualifications and roles for an ACT team are:

218.4 (1) the team leader:

218.5 (i) shall be a mental health professional. Individuals who are not licensed but who are  
218.6 eligible for licensure and are otherwise qualified may also fulfill this role ~~but must obtain~~  
218.7 ~~full licensure within 24 months of assuming the role of team leader;~~

218.8 (ii) must be an active member of the ACT team and provide some direct services to  
218.9 clients;

218.10 (iii) must be a single full-time staff member, dedicated to the ACT team, who is  
218.11 responsible for overseeing the administrative operations of the team, ~~providing treatment~~  
218.12 ~~supervision of services in conjunction with the psychiatrist or psychiatric care provider,~~ and  
218.13 supervising team members to ensure delivery of best and ethical practices; and

218.14 (iv) must be available to ~~provide~~ ensure that overall treatment supervision to the ACT  
218.15 team is available after regular business hours and on weekends and holidays. ~~The team~~  
218.16 ~~leader may delegate this duty to another~~ and is provided by a qualified member of the ACT  
218.17 team;

218.18 (2) the psychiatric care provider:

218.19 (i) must be a mental health professional permitted to prescribe psychiatric medications  
218.20 as part of the mental health professional's scope of practice. The psychiatric care provider  
218.21 must have demonstrated clinical experience working with individuals with serious and  
218.22 persistent mental illness;

218.23 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for  
218.24 screening and admitting clients; monitoring clients' treatment and team member service  
218.25 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,  
218.26 and health-related conditions; actively collaborating with nurses; and helping provide  
218.27 treatment supervision to the team;

218.28 (iii) shall fulfill the following functions for assertive community treatment clients:  
218.29 provide assessment and treatment of clients' symptoms and response to medications, including  
218.30 side effects; provide brief therapy to clients; provide diagnostic and medication education  
218.31 to clients, with medication decisions based on shared decision making; monitor clients'  
218.32 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and  
218.33 community visits;

219.1 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized  
219.2 for mental health treatment and shall communicate directly with the client's inpatient  
219.3 psychiatric care providers to ensure continuity of care;

219.4 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per  
219.5 50 clients. Part-time psychiatric care providers shall have designated hours to work on the  
219.6 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,  
219.7 supervisory, and administrative responsibilities. No more than two psychiatric care providers  
219.8 may share this role; and

219.9 (vi) shall provide psychiatric backup to the program after regular business hours and on  
219.10 weekends and holidays. The psychiatric care provider may delegate this duty to another  
219.11 qualified psychiatric provider;

219.12 (3) the nursing staff:

219.13 (i) shall consist of one to three registered nurses or advanced practice registered nurses,  
219.14 of whom at least one has a minimum of one-year experience working with adults with  
219.15 serious mental illness and a working knowledge of psychiatric medications. No more than  
219.16 two individuals can share a full-time equivalent position;

219.17 (ii) are responsible for managing medication, administering and documenting medication  
219.18 treatment, and managing a secure medication room; and

219.19 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications  
219.20 as prescribed; screen and monitor clients' mental and physical health conditions and  
219.21 medication side effects; engage in health promotion, prevention, and education activities;  
219.22 communicate and coordinate services with other medical providers; facilitate the development  
219.23 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring  
219.24 psychiatric and physical health symptoms and medication side effects;

219.25 (4) the co-occurring disorder specialist:

219.26 (i) shall be a full-time equivalent co-occurring disorder specialist who has received  
219.27 specific training on co-occurring disorders that is consistent with national evidence-based  
219.28 practices. The training must include practical knowledge of common substances and how  
219.29 they affect mental illnesses, the ability to assess substance use disorders and the client's  
219.30 stage of treatment, motivational interviewing, and skills necessary to provide counseling to  
219.31 clients at all different stages of change and treatment. The co-occurring disorder specialist  
219.32 may also be an individual who is a licensed alcohol and drug counselor as described in  
219.33 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,

220.1 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring  
220.2 disorder specialists may occupy this role; and

220.3 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.

220.4 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT  
220.5 team members on co-occurring disorders;

220.6 (5) the vocational specialist:

220.7 (i) shall be a full-time vocational specialist who has at least one-year experience providing  
220.8 employment services or advanced education that involved field training in vocational services  
220.9 to individuals with mental illness. An individual who does not meet these qualifications  
220.10 may also serve as the vocational specialist upon completing a training plan approved by the  
220.11 commissioner;

220.12 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational  
220.13 specialist serves as a consultant and educator to fellow ACT team members on these services;

220.14 and

220.15 (iii) must not refer individuals to receive any type of vocational services or linkage by  
220.16 providers outside of the ACT team;

220.17 (6) the mental health certified peer specialist:

220.18 (i) shall be a full-time equivalent. No more than two individuals can share this position.  
220.19 The mental health certified peer specialist is a fully integrated team member who provides  
220.20 highly individualized services in the community and promotes the self-determination and  
220.21 shared decision-making abilities of clients. This requirement may be waived due to workforce  
220.22 shortages upon approval of the commissioner;

220.23 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,  
220.24 self-advocacy, and self-direction, promote wellness management strategies, and assist clients  
220.25 in developing advance directives; and

220.26 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage  
220.27 wellness and resilience, provide consultation to team members, promote a culture where  
220.28 the clients' points of view and preferences are recognized, understood, respected, and  
220.29 integrated into treatment, and serve in a manner equivalent to other team members;

220.30 (7) the program administrative assistant shall be a full-time office-based program  
220.31 administrative assistant position assigned to solely work with the ACT team, providing a  
220.32 range of supports to the team, clients, and families; and

221.1 (8) additional staff:

221.2 (i) shall be based on team size. Additional treatment team staff may include mental  
221.3 health professionals; clinical trainees; certified rehabilitation specialists; mental health  
221.4 practitioners; or mental health rehabilitation workers. These individuals shall have the  
221.5 knowledge, skills, and abilities required by the population served to carry out rehabilitation  
221.6 and support functions; and

221.7 (ii) shall be selected based on specific program needs or the population served.

221.8 (b) Each ACT team must clearly document schedules for all ACT team members.

221.9 (c) Each ACT team member must serve as a primary team member for clients assigned  
221.10 by the team leader and are responsible for facilitating the individual treatment plan process  
221.11 for those clients. The primary team member for a client is the responsible team member  
221.12 knowledgeable about the client's life and circumstances and writes the individual treatment  
221.13 plan. The primary team member provides individual supportive therapy or counseling, and  
221.14 provides primary support and education to the client's family and support system.

221.15 (d) Members of the ACT team must have strong clinical skills, professional qualifications,  
221.16 experience, and competency to provide a full breadth of rehabilitation services. Each staff  
221.17 member shall be proficient in their respective discipline and be able to work collaboratively  
221.18 as a member of a multidisciplinary team to deliver the majority of the treatment,  
221.19 rehabilitation, and support services clients require to fully benefit from receiving assertive  
221.20 community treatment.

221.21 (e) Each ACT team member must fulfill training requirements established by the  
221.22 commissioner.

221.23 Sec. 18. Minnesota Statutes 2023 Supplement, section 256B.0622, subdivision 7b, is  
221.24 amended to read:

221.25 Subd. 7b. **Assertive community treatment program size and opportunities scores.** (a)  
221.26 Each ACT team ~~shall maintain an annual average caseload that does not exceed 100 clients.~~  
221.27 ~~Staff to client ratios shall be based on team size as follows:~~ must demonstrate that the team  
221.28 attained a passing score according to the most recently issued Tool for Measurement of  
221.29 Assertive Community Treatment (TMACT).

221.30 ~~(1) a small ACT team must:~~

221.31 ~~(i) employ at least six but no more than seven full-time treatment team staff, excluding~~  
221.32 ~~the program assistant and the psychiatric care provider;~~

- 222.1 ~~(ii) serve an annual average maximum of no more than 50 clients;~~
- 222.2 ~~(iii) ensure at least one full-time equivalent position for every eight clients served;~~
- 222.3 ~~(iv) schedule ACT team staff on weekdays and on-call duty to provide crisis services~~
- 222.4 ~~and deliver services after hours when staff are not working;~~
- 222.5 ~~(v) provide crisis services during business hours if the small ACT team does not have~~
- 222.6 ~~sufficient staff numbers to operate an after-hours on-call system. During all other hours,~~
- 222.7 ~~the ACT team may arrange for coverage for crisis assessment and intervention services~~
- 222.8 ~~through a reliable crisis-intervention provider as long as there is a mechanism by which the~~
- 222.9 ~~ACT team communicates routinely with the crisis-intervention provider and the on-call~~
- 222.10 ~~ACT team staff are available to see clients face-to-face when necessary or if requested by~~
- 222.11 ~~the crisis-intervention services provider;~~
- 222.12 ~~(vi) adjust schedules and provide staff to carry out the needed service activities in the~~
- 222.13 ~~evenings or on weekend days or holidays, when necessary;~~
- 222.14 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~
- 222.15 ~~provider is not regularly scheduled to work. If availability of the ACT team's psychiatric~~
- 222.16 ~~care provider during all hours is not feasible, alternative psychiatric prescriber backup must~~
- 222.17 ~~be arranged and a mechanism of timely communication and coordination established in~~
- 222.18 ~~writing; and~~
- 222.19 ~~(viii) be composed of, at minimum, one full-time team leader, at least 16 hours each~~
- 222.20 ~~week per 50 clients of psychiatric provider time, or equivalent if fewer clients, one full-time~~
- 222.21 ~~equivalent nursing, one full-time co-occurring disorder specialist, one full-time equivalent~~
- 222.22 ~~mental health certified peer specialist, one full-time vocational specialist, one full-time~~
- 222.23 ~~program assistant, and at least one additional full-time ACT team member who has mental~~
- 222.24 ~~health professional, certified rehabilitation specialist, clinical trainee, or mental health~~
- 222.25 ~~practitioner status; and~~
- 222.26 ~~(2) a midsize ACT team shall:~~
- 222.27 ~~(i) be composed of, at minimum, one full-time team leader, at least 16 hours of psychiatry~~
- 222.28 ~~time for 51 clients, with an additional two hours for every six clients added to the team, 1.5~~
- 222.29 ~~to two full-time equivalent nursing staff, one full-time co-occurring disorder specialist, one~~
- 222.30 ~~full-time equivalent mental health certified peer specialist, one full-time vocational specialist,~~
- 222.31 ~~one full-time program assistant, and at least 1.5 to two additional full-time equivalent ACT~~
- 222.32 ~~members, with at least one dedicated full-time staff member with mental health professional~~

- 223.1 ~~status. Remaining team members may have mental health professional, certified rehabilitation~~  
223.2 ~~specialist, clinical trainee, or mental health practitioner status;~~
- 223.3 ~~(ii) employ seven or more treatment team full-time equivalents, excluding the program~~  
223.4 ~~assistant and the psychiatric care provider;~~
- 223.5 ~~(iii) serve an annual average maximum caseload of 51 to 74 clients;~~
- 223.6 ~~(iv) ensure at least one full-time equivalent position for every nine clients served;~~
- 223.7 ~~(v) schedule ACT team staff for a minimum of ten-hour shift coverage on weekdays~~  
223.8 ~~and six to eight-hour shift coverage on weekends and holidays. In addition to these minimum~~  
223.9 ~~specifications, staff are regularly scheduled to provide the necessary services on a~~  
223.10 ~~client-by-client basis in the evenings and on weekends and holidays;~~
- 223.11 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~  
223.12 ~~when staff are not working;~~
- 223.13 ~~(vii) have the authority to arrange for coverage for crisis assessment and intervention~~  
223.14 ~~services through a reliable crisis intervention provider as long as there is a mechanism by~~  
223.15 ~~which the ACT team communicates routinely with the crisis intervention provider and the~~  
223.16 ~~on-call ACT team staff are available to see clients face-to-face when necessary or if requested~~  
223.17 ~~by the crisis intervention services provider; and~~
- 223.18 ~~(viii) arrange for and provide psychiatric backup during all hours the psychiatric care~~  
223.19 ~~provider is not regularly scheduled to work. If availability of the psychiatric care provider~~  
223.20 ~~during all hours is not feasible, alternative psychiatric prescriber backup must be arranged~~  
223.21 ~~and a mechanism of timely communication and coordination established in writing;~~
- 223.22 ~~(3) a large ACT team must:~~
- 223.23 ~~(i) be composed of, at minimum, one full-time team leader, at least 32 hours each week~~  
223.24 ~~per 100 clients, or equivalent of psychiatry time, three full-time equivalent nursing staff,~~  
223.25 ~~one full-time co-occurring disorder specialist, one full-time equivalent mental health certified~~  
223.26 ~~peer specialist, one full-time vocational specialist, one full-time program assistant, and at~~  
223.27 ~~least two additional full-time equivalent ACT team members, with at least one dedicated~~  
223.28 ~~full-time staff member with mental health professional status. Remaining team members~~  
223.29 ~~may have mental health professional or mental health practitioner status;~~
- 223.30 ~~(ii) employ nine or more treatment team full-time equivalents, excluding the program~~  
223.31 ~~assistant and psychiatric care provider;~~
- 223.32 ~~(iii) serve an annual average maximum caseload of 75 to 100 clients;~~

- 224.1 ~~(iv) ensure at least one full-time equivalent position for every nine individuals served;~~  
224.2 ~~(v) schedule staff to work two eight-hour shifts, with a minimum of two staff on the~~  
224.3 ~~second shift providing services at least 12 hours per day weekdays. For weekends and~~  
224.4 ~~holidays, the team must operate and schedule ACT team staff to work one eight-hour shift,~~  
224.5 ~~with a minimum of two staff each weekend day and every holiday;~~  
224.6 ~~(vi) schedule ACT team staff on-call duty to provide crisis services and deliver services~~  
224.7 ~~when staff are not working; and~~  
224.8 ~~(vii) arrange for and provide psychiatric backup during all hours the psychiatric care~~  
224.9 ~~provider is not regularly scheduled to work. If availability of the ACT team psychiatric care~~  
224.10 ~~provider during all hours is not feasible, alternative psychiatric backup must be arranged~~  
224.11 ~~and a mechanism of timely communication and coordination established in writing.~~  
224.12 ~~(b) An ACT team of any size may have a staff-to-client ratio that is lower than the~~  
224.13 ~~requirements described in paragraph (a) upon approval by the commissioner, but may not~~  
224.14 ~~exceed a one-to-ten staff-to-client ratio.~~

224.15 Sec. 19. Minnesota Statutes 2022, section 256B.0622, subdivision 7d, is amended to read:

224.16 Subd. 7d. **Assertive community treatment assessment and individual treatment**  
224.17 **plan.** (a) An initial assessment shall be completed the day of the client's admission to  
224.18 assertive community treatment by the ACT team leader or the psychiatric care provider,  
224.19 with participation by designated ACT team members and the client. The initial assessment  
224.20 must include obtaining or completing a standard diagnostic assessment according to section  
224.21 245I.10, subdivision 6, and completing a 30-day individual treatment plan. The team leader,  
224.22 psychiatric care provider, or other mental health professional designated by the team leader  
224.23 or psychiatric care provider, must update the client's diagnostic assessment ~~at least annually~~  
224.24 as required under section 245I.10, subdivision 2, paragraphs (f) and (g).

224.25 (b) A functional assessment must be completed according to section 245I.10, subdivision  
224.26 9. Each part of the functional assessment areas shall be completed by each respective team  
224.27 specialist or an ACT team member with skill and knowledge in the area being assessed.

224.28 (c) Between 30 and 45 days after the client's admission to assertive community treatment,  
224.29 the entire ACT team must hold a comprehensive case conference, where all team members,  
224.30 including the psychiatric provider, present information discovered from the completed  
224.31 assessments and provide treatment recommendations. The conference must serve as the  
224.32 basis for the first individual treatment plan, which must be written by the primary team  
224.33 member.

225.1 (d) The client's psychiatric care provider, primary team member, and individual treatment  
225.2 team members shall assume responsibility for preparing the written narrative of the results  
225.3 from the psychiatric and social functioning history timeline and the comprehensive  
225.4 assessment.

225.5 (e) The primary team member and individual treatment team members shall be assigned  
225.6 by the team leader in collaboration with the psychiatric care provider by the time of the first  
225.7 treatment planning meeting or 30 days after admission, whichever occurs first.

225.8 (f) Individual treatment plans must be developed through the following treatment planning  
225.9 process:

225.10 (1) The individual treatment plan shall be developed in collaboration with the client and  
225.11 the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT  
225.12 team shall evaluate, together with each client, the client's needs, strengths, and preferences  
225.13 and develop the individual treatment plan collaboratively. The ACT team shall make every  
225.14 effort to ensure that the client and the client's family and natural supports, with the client's  
225.15 consent, are in attendance at the treatment planning meeting, are involved in ongoing  
225.16 meetings related to treatment, and have the necessary supports to fully participate. The  
225.17 client's participation in the development of the individual treatment plan shall be documented.

225.18 (2) The client and the ACT team shall work together to formulate and prioritize the  
225.19 issues, set goals, research approaches and interventions, and establish the plan. The plan is  
225.20 individually tailored so that the treatment, rehabilitation, and support approaches and  
225.21 interventions achieve optimum symptom reduction, help fulfill the personal needs and  
225.22 aspirations of the client, take into account the cultural beliefs and realities of the individual,  
225.23 and improve all the aspects of psychosocial functioning that are important to the client. The  
225.24 process supports strengths, rehabilitation, and recovery.

225.25 (3) Each client's individual treatment plan shall identify service needs, strengths and  
225.26 capacities, and barriers, and set specific and measurable short- and long-term goals for each  
225.27 service need. The individual treatment plan must clearly specify the approaches and  
225.28 interventions necessary for the client to achieve the individual goals, when the interventions  
225.29 shall happen, and identify which ACT team member shall carry out the approaches and  
225.30 interventions.

225.31 (4) The primary team member and the individual treatment team, together with the client  
225.32 and the client's family and natural supports with the client's consent, are responsible for  
225.33 reviewing and rewriting the treatment goals and individual treatment plan whenever there  
225.34 is a major decision point in the client's course of treatment or at least every six months.

226.1 (5) The primary team member shall prepare a summary that thoroughly describes in  
226.2 writing the client's and the individual treatment team's evaluation of the client's progress  
226.3 and goal attainment, the effectiveness of the interventions, and the satisfaction with services  
226.4 since the last individual treatment plan. The client's most recent diagnostic assessment must  
226.5 be included with the treatment plan summary.

226.6 (6) The individual treatment plan and review must be approved or acknowledged by the  
226.7 client, the primary team member, the team leader, the psychiatric care provider, and all  
226.8 individual treatment team members. A copy of the approved individual treatment plan must  
226.9 be made available to the client.

226.10 Sec. 20. Minnesota Statutes 2022, section 256B.0623, subdivision 5, is amended to read:

226.11 Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services  
226.12 must be provided by qualified individual provider staff of a certified provider entity.

226.13 Individual provider staff must be qualified as:

226.14 (1) a mental health professional who is qualified according to section 245I.04, subdivision  
226.15 2;

226.16 (2) a certified rehabilitation specialist who is qualified according to section 245I.04,  
226.17 subdivision 8;

226.18 (3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

226.19 (4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

226.20 (5) a mental health certified peer specialist who is qualified according to section 245I.04,  
226.21 subdivision 10; ~~or~~

226.22 (6) a mental health rehabilitation worker who is qualified according to section 245I.04,  
226.23 subdivision 14; or

226.24 (7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

226.25 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
226.26 of human services must notify the revisor of statutes when federal approval is obtained.

226.27 Sec. 21. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 5m, is  
226.28 amended to read:

226.29 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical  
226.30 assistance covers services provided by a not-for-profit certified community behavioral health  
226.31 clinic (CCBHC) that meets the requirements of section 245.735, subdivision 3.

227.1 (b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an  
227.2 eligible service is delivered using the CCBHC daily bundled rate system for medical  
227.3 assistance payments as described in paragraph (c). The commissioner shall include a quality  
227.4 incentive payment in the CCBHC daily bundled rate system as described in paragraph (e).  
227.5 There is no county share for medical assistance services when reimbursed through the  
227.6 CCBHC daily bundled rate system.

227.7 (c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC  
227.8 payments under medical assistance meets the following requirements:

227.9 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each  
227.10 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable  
227.11 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the  
227.12 payment rate, total annual visits include visits covered by medical assistance and visits not  
227.13 covered by medical assistance. Allowable costs include but are not limited to the salaries  
227.14 and benefits of medical assistance providers; the cost of CCBHC services provided under  
227.15 section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as  
227.16 insurance or supplies needed to provide CCBHC services;

227.17 (2) payment shall be limited to one payment per day per medical assistance enrollee  
227.18 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement  
227.19 if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph  
227.20 (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or  
227.21 licensed agency employed by or under contract with a CCBHC;

227.22 (3) initial CCBHC daily bundled rates for newly certified CCBHCs under section 245.735,  
227.23 subdivision 3, shall be established by the commissioner using a provider-specific rate based  
227.24 on the newly certified CCBHC's audited historical cost report data adjusted for the expected  
227.25 cost of delivering CCBHC services. Estimates are subject to review by the commissioner  
227.26 and must include the expected cost of providing the full scope of CCBHC services and the  
227.27 expected number of visits for the rate period;

227.28 (4) the commissioner shall rebase CCBHC rates once every two years following the last  
227.29 rebasing and no less than 12 months following an initial rate or a rate change due to a change  
227.30 in the scope of services. For CCBHCs certified after September 31, 2020, and before January  
227.31 1, 2021, the commissioner shall rebase rates according to this clause for services provided  
227.32 on or after January 1, 2024;

227.33 (5) the commissioner shall provide for a 60-day appeals process after notice of the results  
227.34 of the rebasing;

228.1 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal  
228.2 Medicaid rate is not eligible for the CCBHC rate methodology;

228.3 (7) payments for CCBHC services to individuals enrolled in managed care shall be  
228.4 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall  
228.5 complete the phase-out of CCBHC wrap payments within 60 days of the implementation  
228.6 of the CCBHC daily bundled rate system in the Medicaid Management Information System  
228.7 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments  
228.8 due made payable to CCBHCs no later than 18 months thereafter;

228.9 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each  
228.10 provider-specific rate by the Medicare Economic Index for primary care services. This  
228.11 update shall occur each year in between rebasing periods determined by the commissioner  
228.12 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state  
228.13 annually using the CCBHC cost report established by the commissioner; and

228.14 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of  
228.15 services when such changes are expected to result in an adjustment to the CCBHC payment  
228.16 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information  
228.17 regarding the changes in the scope of services, including the estimated cost of providing  
228.18 the new or modified services and any projected increase or decrease in the number of visits  
228.19 resulting from the change. Estimated costs are subject to review by the commissioner. Rate  
228.20 adjustments for changes in scope shall occur no more than once per year in between rebasing  
228.21 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

228.22 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC  
228.23 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of  
228.24 this requirement on the rate of access to the services delivered by CCBHC providers. If, for  
228.25 any contract year, federal approval is not received for this paragraph, the commissioner  
228.26 must adjust the capitation rates paid to managed care plans and county-based purchasing  
228.27 plans for that contract year to reflect the removal of this provision. Contracts between  
228.28 managed care plans and county-based purchasing plans and providers to whom this paragraph  
228.29 applies must allow recovery of payments from those providers if capitation rates are adjusted  
228.30 in accordance with this paragraph. Payment recoveries must not exceed the amount equal  
228.31 to any increase in rates that results from this provision. This paragraph expires if federal  
228.32 approval is not received for this paragraph at any time.

228.33 (e) The commissioner shall implement a quality incentive payment program for CCBHCs  
228.34 that meets the following requirements:

229.1 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric  
229.2 thresholds for performance metrics established by the commissioner, in addition to payments  
229.3 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in  
229.4 paragraph (c);

229.5 (2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement  
229.6 year to be eligible for incentive payments;

229.7 (3) each CCBHC shall receive written notice of the criteria that must be met in order to  
229.8 receive quality incentive payments at least 90 days prior to the measurement year; and

229.9 (4) a CCBHC must provide the commissioner with data needed to determine incentive  
229.10 payment eligibility within six months following the measurement year. The commissioner  
229.11 shall notify CCBHC providers of their performance on the required measures and the  
229.12 incentive payment amount within 12 months following the measurement year.

229.13 (f) All claims to managed care plans for CCBHC services as provided under this section  
229.14 shall be submitted directly to, and paid by, the commissioner on the dates specified no later  
229.15 than January 1 of the following calendar year, if:

229.16 (1) one or more managed care plans does not comply with the federal requirement for  
229.17 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,  
229.18 section 447.45(b), and the managed care plan does not resolve the payment issue within 30  
229.19 days of noncompliance; and

229.20 (2) the total amount of clean claims not paid in accordance with federal requirements  
229.21 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims  
229.22 eligible for payment by managed care plans.

229.23 If the conditions in this paragraph are met between January 1 and June 30 of a calendar  
229.24 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of  
229.25 the following year. If the conditions in this paragraph are met between July 1 and December  
229.26 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning  
229.27 on July 1 of the following year.

229.28 (g) Peer services provided by a CCBHC certified under section 245.735 are a covered  
229.29 service under medical assistance when a licensed mental health professional or alcohol and  
229.30 drug counselor determines that peer services are medically necessary. Eligibility under this  
229.31 subdivision for peer services provided by a CCBHC supersede eligibility standards under  
229.32 sections 256B.0615, 256B.0616, and 245G.07, subdivision 2, clause (8).

230.1 Sec. 22. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 3, is  
230.2 amended to read:

230.3 Subd. 3. **Adult day treatment services.** (a) Medical assistance covers adult day treatment  
230.4 (ADT) services that are provided under contract with the county board. Adult day treatment  
230.5 payment is subject to the conditions in paragraphs (b) to (e). The provider must make  
230.6 reasonable and good faith efforts to report individual client outcomes to the commissioner  
230.7 using instruments, protocols, and forms approved by the commissioner.

230.8 (b) Adult day treatment is an intensive psychotherapeutic treatment to reduce or relieve  
230.9 the effects of mental illness on a client to enable the client to benefit from a lower level of  
230.10 care and to live and function more independently in the community. Adult day treatment  
230.11 services must be provided to a client to stabilize the client's mental health and to improve  
230.12 the client's independent living and socialization skills. Adult day treatment must consist of  
230.13 at least one hour of group psychotherapy and must include group time focused on  
230.14 rehabilitative interventions or other therapeutic services that a multidisciplinary team provides  
230.15 to each client. Adult day treatment services are not a part of inpatient or residential treatment  
230.16 services. The following providers may apply to become adult day treatment providers:

230.17 (1) a hospital ~~accredited by the Joint Commission on Accreditation of Health~~  
230.18 ~~Organizations~~ with Centers for Medicare and Medicaid Services approved hospital  
230.19 accreditation and licensed under sections 144.50 to 144.55;

230.20 (2) a community mental health center under section 256B.0625, subdivision 5; or

230.21 (3) an entity that is under contract with the county board to operate a program that meets  
230.22 the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170  
230.23 to 9505.0475.

230.24 (c) An adult day treatment services provider must:

230.25 (1) ensure that the commissioner has approved of the organization as an adult day  
230.26 treatment provider organization;

230.27 (2) ensure that a multidisciplinary team provides ADT services to a group of clients. A  
230.28 mental health professional must supervise each multidisciplinary staff person who provides  
230.29 ADT services;

230.30 (3) make ADT services available to the client at least two days a week for at least three  
230.31 consecutive hours per day. ADT services may be longer than three hours per day, but medical  
230.32 assistance may not reimburse a provider for more than 15 hours per week;

231.1 (4) provide ADT services to each client that includes group psychotherapy by a mental  
231.2 health professional or clinical trainee and daily rehabilitative interventions by a mental  
231.3 health professional, clinical trainee, or mental health practitioner; and

231.4 (5) include ADT services in the client's individual treatment plan, when appropriate.

231.5 The adult day treatment provider must:

231.6 (i) complete a functional assessment of each client under section 245I.10, subdivision  
231.7 9;

231.8 (ii) notwithstanding section 245I.10, subdivision 8, review the client's progress and  
231.9 update the individual treatment plan at least every 90 days until the client is discharged  
231.10 from the program; and

231.11 (iii) include a discharge plan for the client in the client's individual treatment plan.

231.12 (d) To be eligible for adult day treatment, a client must:

231.13 (1) be 18 years of age or older;

231.14 (2) not reside in a nursing facility, hospital, institute of mental disease, or state-operated  
231.15 treatment center unless the client has an active discharge plan that indicates a move to an  
231.16 independent living setting within 180 days;

231.17 (3) have the capacity to engage in rehabilitative programming, skills activities, and  
231.18 psychotherapy in the structured, therapeutic setting of an adult day treatment program and  
231.19 demonstrate measurable improvements in functioning resulting from participation in the  
231.20 adult day treatment program;

231.21 (4) have a level of care assessment under section 245I.02, subdivision 19, recommending  
231.22 that the client participate in services with the level of intensity and duration of an adult day  
231.23 treatment program; and

231.24 (5) have the recommendation of a mental health professional for adult day treatment  
231.25 services. The mental health professional must find that adult day treatment services are  
231.26 medically necessary for the client.

231.27 (e) Medical assistance does not cover the following services as adult day treatment  
231.28 services:

231.29 (1) services that are primarily recreational or that are provided in a setting that is not  
231.30 under medical supervision, including sports activities, exercise groups, craft hours, leisure  
231.31 time, social hours, meal or snack time, trips to community activities, and tours;

232.1 (2) social or educational services that do not have or cannot reasonably be expected to  
232.2 have a therapeutic outcome related to the client's mental illness;

232.3 (3) consultations with other providers or service agency staff persons about the care or  
232.4 progress of a client;

232.5 (4) prevention or education programs that are provided to the community;

232.6 (5) day treatment for clients with a primary diagnosis of a substance use disorder;

232.7 (6) day treatment provided in the client's home;

232.8 (7) psychotherapy for more than two hours per day; and

232.9 (8) participation in meal preparation and eating that is not part of a clinical treatment  
232.10 plan to address the client's eating disorder.

232.11 Sec. 23. Minnesota Statutes 2023 Supplement, section 256B.0671, subdivision 5, is  
232.12 amended to read:

232.13 Subd. 5. **Child and family psychoeducation services.** (a) Medical assistance covers  
232.14 child and family psychoeducation services provided to a child up to under age 21 with and  
232.15 the child's family members, when determined to be medically necessary due to a diagnosed  
232.16 mental health condition when or diagnosed mental illness identified in the child's individual  
232.17 treatment plan and provided by a mental health professional who is qualified under section  
232.18 245I.04, subdivision 2, and practicing within the scope of practice under section 245I.04,  
232.19 subdivision 3; a mental health practitioner who is qualified under section 245I.04, subdivision  
232.20 4, and practicing within the scope of practice under section 245I.04, subdivision 5; or a  
232.21 clinical trainee who has determined it medically necessary to involve family members in  
232.22 the child's care is qualified under section 245I.04, subdivision 6, and practicing within the  
232.23 scope of practice under section 245I.04, subdivision 7.

232.24 (b) "Child and family psychoeducation services" means information or demonstration  
232.25 provided to an individual or family as part of an individual, family, multifamily group, or  
232.26 peer group session to explain, educate, and support the child and family in understanding  
232.27 a child's symptoms of mental illness, the impact on the child's development, and needed  
232.28 components of treatment and skill development so that the individual, family, or group can  
232.29 help the child to prevent relapse, prevent the acquisition of comorbid disorders, and achieve  
232.30 optimal mental health and long-term resilience.

232.31 (c) Child and family psychoeducation services include individual, family, or group skills  
232.32 development or training to:

233.1 (1) support the development of psychosocial skills that are medically necessary to  
233.2 rehabilitate the child to an age-appropriate developmental trajectory when the child's  
233.3 development was disrupted by a mental health condition or diagnosed mental illness; or

233.4 (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace  
233.5 skills deficits or maladaptive skills acquired over the course of the child's mental health  
233.6 condition or mental illness.

233.7 (d) Skills development or training delivered to a child or the child's family under this  
233.8 subdivision must be targeted to the specific deficits related to the child's mental health  
233.9 condition or mental illness and must be prescribed in the child's individual treatment plan.  
233.10 Group skills training may be provided to multiple recipients who, because of the nature of  
233.11 their emotional, behavioral, or social functional ability, may benefit from interaction in a  
233.12 group setting.

233.13 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
233.14 whichever is later. The commissioner of human services shall notify the revisor of statutes  
233.15 when federal approval is obtained.

233.16 Sec. 24. Minnesota Statutes 2022, section 256B.0943, subdivision 3, is amended to read:

233.17 **Subd. 3. Determination of client eligibility.** (a) A client's eligibility to receive children's  
233.18 therapeutic services and supports under this section shall be determined based on a standard  
233.19 diagnostic assessment by a mental health professional or a clinical trainee that is performed  
233.20 within one year before the initial start of service and updated as required under section  
233.21 245I.10, subdivision 2. The standard diagnostic assessment must:

233.22 (1) determine whether a child under age 18 has a diagnosis of emotional disturbance or,  
233.23 if the person is between the ages of 18 and 21, whether the person has a mental illness;

233.24 (2) document children's therapeutic services and supports as medically necessary to  
233.25 address an identified disability, functional impairment, and the individual client's needs and  
233.26 goals; and

233.27 (3) be used in the development of the individual treatment plan.

233.28 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to  
233.29 five days of day treatment under this section based on a hospital's medical history and  
233.30 presentation examination of the client.

233.31 (c) Children's therapeutic services and supports include development and rehabilitative  
233.32 services that support a child's developmental treatment needs.

234.1 Sec. 25. Minnesota Statutes 2022, section 256B.0943, subdivision 12, is amended to read:

234.2 Subd. 12. **Excluded services.** The following services are not eligible for medical  
234.3 assistance payment as children's therapeutic services and supports:

234.4 (1) service components of children's therapeutic services and supports simultaneously  
234.5 provided by more than one provider entity unless prior authorization is obtained;

234.6 (2) treatment by multiple providers within the same agency at the same clock time,  
234.7 unless one service is delivered to the child and the other service is delivered to the child's  
234.8 family or treatment team without the child present;

234.9 (3) children's therapeutic services and supports provided in violation of medical assistance  
234.10 policy in Minnesota Rules, part 9505.0220;

234.11 (4) mental health behavioral aide services provided by a personal care assistant who is  
234.12 not qualified as a mental health behavioral aide and employed by a certified children's  
234.13 therapeutic services and supports provider entity;

234.14 (5) service components of CTSS that are the responsibility of a residential or program  
234.15 license holder, including foster care providers under the terms of a service agreement or  
234.16 administrative rules governing licensure; and

234.17 (6) adjunctive activities that may be offered by a provider entity but are not otherwise  
234.18 covered by medical assistance, including:

234.19 (i) a service that is primarily recreation oriented or that is provided in a setting that is  
234.20 not medically supervised. This includes sports activities, exercise groups, activities such as  
234.21 craft hours, leisure time, social hours, meal or snack time, trips to community activities,  
234.22 and tours;

234.23 (ii) a social or educational service that does not have or cannot reasonably be expected  
234.24 to have a therapeutic outcome related to the client's emotional disturbance;

234.25 (iii) prevention or education programs provided to the community; and

234.26 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

234.27 Sec. 26. Minnesota Statutes 2022, section 256B.0947, subdivision 5, is amended to read:

234.28 Subd. 5. **Standards for intensive nonresidential rehabilitative providers.** (a) Services  
234.29 must meet the standards in this section and chapter 245I as required in section 245I.011,  
234.30 subdivision 5.

235.1 (b) The treatment team must have specialized training in providing services to the specific  
235.2 age group of youth that the team serves. An individual treatment team must serve youth  
235.3 who are: (1) at least eight years of age or older and under 16 years of age, or (2) at least 14  
235.4 years of age or older and under 21 years of age.

235.5 (c) The treatment team for intensive nonresidential rehabilitative mental health services  
235.6 comprises both permanently employed core team members and client-specific team members  
235.7 as follows:

235.8 (1) Based on professional qualifications and client needs, clinically qualified core team  
235.9 members are assigned on a rotating basis as the client's lead worker to coordinate a client's  
235.10 care. The core team must comprise at least four full-time equivalent direct care staff and  
235.11 must minimally include:

235.12 (i) a mental health professional who serves as team leader to provide administrative  
235.13 direction and treatment supervision to the team;

235.14 (ii) an advanced-practice registered nurse with certification in psychiatric or mental  
235.15 health care or a board-certified child and adolescent psychiatrist, either of which must be  
235.16 credentialed to prescribe medications;

235.17 ~~(iii) a licensed alcohol and drug counselor who is also trained in mental health~~  
235.18 ~~interventions; and~~

235.19 ~~(iv)~~ (iii) a mental health certified peer specialist who is qualified according to section  
235.20 245I.04, subdivision 10, and is also a former children's mental health consumer; and

235.21 (iv) a co-occurring disorder specialist who meets the requirements under section  
235.22 256B.0622, subdivision 7a, paragraph (a), clause (4), who will provide or facilitate the  
235.23 provision of co-occurring disorder treatment to clients.

235.24 (2) The core team may also include any of the following:

235.25 (i) additional mental health professionals;

235.26 (ii) a vocational specialist;

235.27 (iii) an educational specialist with knowledge and experience working with youth  
235.28 regarding special education requirements and goals, special education plans, and coordination  
235.29 of educational activities with health care activities;

235.30 (iv) a child and adolescent psychiatrist who may be retained on a consultant basis;

235.31 (v) a clinical trainee qualified according to section 245I.04, subdivision 6;

- 236.1 (vi) a mental health practitioner qualified according to section 245I.04, subdivision 4;
- 236.2 (vii) a case management service provider, as defined in section 245.4871, subdivision  
236.3 4;
- 236.4 (viii) a housing access specialist; and
- 236.5 (ix) a family peer specialist as defined in subdivision 2, paragraph (j).
- 236.6 (3) A treatment team may include, in addition to those in clause (1) or (2), ad hoc  
236.7 members not employed by the team who consult on a specific client and who must accept  
236.8 overall clinical direction from the treatment team for the duration of the client's placement  
236.9 with the treatment team and must be paid by the provider agency at the rate for a typical  
236.10 session by that provider with that client or at a rate negotiated with the client-specific  
236.11 member. Client-specific treatment team members may include:
- 236.12 (i) the mental health professional treating the client prior to placement with the treatment  
236.13 team;
- 236.14 (ii) the client's current substance use counselor, if applicable;
- 236.15 (iii) a lead member of the client's individualized education program team or school-based  
236.16 mental health provider, if applicable;
- 236.17 (iv) a representative from the client's health care home or primary care clinic, as needed  
236.18 to ensure integration of medical and behavioral health care;
- 236.19 (v) the client's probation officer or other juvenile justice representative, if applicable;  
236.20 and
- 236.21 (vi) the client's current vocational or employment counselor, if applicable.
- 236.22 (d) The treatment supervisor shall be an active member of the treatment team and shall  
236.23 function as a practicing clinician at least on a part-time basis. The treatment team shall meet  
236.24 with the treatment supervisor at least weekly to discuss recipients' progress and make rapid  
236.25 adjustments to meet recipients' needs. The team meeting must include client-specific case  
236.26 reviews and general treatment discussions among team members. Client-specific case  
236.27 reviews and planning must be documented in the individual client's treatment record.
- 236.28 (e) The staffing ratio must not exceed ten clients to one full-time equivalent treatment  
236.29 team position.
- 236.30 (f) The treatment team shall serve no more than 80 clients at any one time. Should local  
236.31 demand exceed the team's capacity, an additional team must be established rather than  
236.32 exceed this limit.

237.1 (g) Nonclinical staff shall have prompt access in person or by telephone to a mental  
237.2 health practitioner, clinical trainee, or mental health professional. The provider shall have  
237.3 the capacity to promptly and appropriately respond to emergent needs and make any  
237.4 necessary staffing adjustments to ensure the health and safety of clients.

237.5 (h) The intensive nonresidential rehabilitative mental health services provider shall  
237.6 participate in evaluation of the assertive community treatment for youth (Youth ACT) model  
237.7 as conducted by the commissioner, including the collection and reporting of data and the  
237.8 reporting of performance measures as specified by contract with the commissioner.

237.9 (i) A regional treatment team may serve multiple counties.

237.10 Sec. 27. Minnesota Statutes 2022, section 256B.76, subdivision 6, is amended to read:

237.11 Subd. 6. **Medicare relative value units.** (a) Effective for services rendered on or after  
237.12 January 1, 2007, the commissioner shall make payments for physician and professional  
237.13 services based on the Medicare relative value units (~~RVU's~~) (RVUs). This change shall be  
237.14 budget neutral and the cost of implementing ~~RVU's~~ RVUs will be incorporated in the  
237.15 established conversion factor.

237.16 (b) Effective for services rendered on or after January 1, 2025, rates for mental health  
237.17 services reimbursed under the resource-based relative value scale (RBRVS) must be equal  
237.18 to 83 percent of the Medicare Physician Fee Schedule.

237.19 (c) Effective for services rendered on or after January 1, 2025, the commissioner shall  
237.20 increase capitation payments made to managed care plans and county-based purchasing  
237.21 plans to reflect the rate increases provided under this subdivision. Managed care plans and  
237.22 county-based purchasing plans must use the capitation rate increase provided under this  
237.23 paragraph to increase payment rates to the providers corresponding to the rate increases.  
237.24 The commissioner must monitor the effect of this rate increase on enrollee access to services  
237.25 under this subdivision. If for any contract year federal approval is not received for this  
237.26 paragraph, the commissioner must adjust the capitation rates paid to managed care plans  
237.27 and county-based purchasing plans for that contract year to reflect the removal of this  
237.28 paragraph. Contracts between managed care plans and county-based purchasing plans and  
237.29 providers to whom this paragraph applies must allow recovery of payments from those  
237.30 providers if capitation rates are adjusted in accordance with this paragraph. Payment  
237.31 recoveries must not exceed the amount equal to any increase in rates that results from this  
237.32 paragraph.

238.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
238.2 whichever is later. The commissioner of human services shall notify the revisor of statutes  
238.3 when federal approval is obtained.

238.4 Sec. 28. Laws 2023, chapter 70, article 1, section 35, is amended to read:

238.5 Sec. 35. Minnesota Statutes 2022, section 256B.761, is amended to read:

238.6 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

238.7 (a) Effective for services rendered on or after July 1, 2001, payment for medication  
238.8 management provided to psychiatric patients, outpatient mental health services, day treatment  
238.9 services, home-based mental health services, and family community support services shall  
238.10 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of  
238.11 1999 charges.

238.12 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health  
238.13 services provided by an entity that operates: (1) a Medicare-certified comprehensive  
238.14 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,  
238.15 with at least 33 percent of the clients receiving rehabilitation services in the most recent  
238.16 calendar year who are medical assistance recipients, will be increased by 38 percent, when  
238.17 those services are provided within the comprehensive outpatient rehabilitation facility and  
238.18 provided to residents of nursing facilities owned by the entity.

238.19 (c) In addition to rate increases otherwise provided, the commissioner may restructure  
238.20 coverage policy and rates to improve access to adult rehabilitative mental health services  
238.21 under section 256B.0623 and related mental health support services under section 256B.021,  
238.22 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected  
238.23 state share of increased costs due to this paragraph is transferred from adult mental health  
238.24 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent  
238.25 base adjustment for subsequent fiscal years. Payments made to managed care plans and  
238.26 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect  
238.27 the rate changes described in this paragraph.

238.28 (d) Any ratables effective before July 1, 2015, do not apply to early intensive  
238.29 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

238.30 (e) Effective for services rendered on or after January 1, 2024, payment rates for  
238.31 behavioral health services included in the rate analysis required by Laws 2021, First Special  
238.32 Session chapter 7, article 17, section 18, except for adult day treatment services under section

239.1 256B.0671, subdivision 3; early intensive developmental and behavioral intervention services  
239.2 under section 256B.0949; and substance use disorder services under chapter 254B, must be  
239.3 increased by three percent from the rates in effect on December 31, 2023. Effective for  
239.4 services rendered on or after January 1, 2025, payment rates for behavioral health services  
239.5 included in the rate analysis required by Laws 2021, First Special Session chapter 7, article  
239.6 17, section 18, ~~except for adult day treatment services under section 256B.0671, subdivision~~  
239.7 ~~3~~; early intensive developmental behavioral intervention services under section 256B.0949;  
239.8 and substance use disorder services under chapter 254B, must be annually adjusted according  
239.9 to the change from the midpoint of the previous rate year to the midpoint of the rate year  
239.10 for which the rate is being determined using the Centers for Medicare and Medicaid Services  
239.11 Medicare Economic Index as forecasted in the fourth quarter of the calendar year before  
239.12 the rate year. For payments made in accordance with this paragraph, if and to the extent  
239.13 that the commissioner identifies that the state has received federal financial participation  
239.14 for behavioral health services in excess of the amount allowed under United States Code,  
239.15 title 42, section 447.321, the state shall repay the excess amount to the Centers for Medicare  
239.16 and Medicaid Services with state money and maintain the full payment rate under this  
239.17 paragraph. This paragraph does not apply to federally qualified health centers, rural health  
239.18 centers, Indian health services, certified community behavioral health clinics, cost-based  
239.19 rates, and rates that are negotiated with the county. This paragraph expires upon legislative  
239.20 implementation of the new rate methodology resulting from the rate analysis required by  
239.21 Laws 2021, First Special Session chapter 7, article 17, section 18.

239.22 (f) Effective January 1, 2024, the commissioner shall increase capitation payments made  
239.23 to managed care plans and county-based purchasing plans to reflect the behavioral health  
239.24 service rate increase provided in paragraph (e). Managed care and county-based purchasing  
239.25 plans must use the capitation rate increase provided under this paragraph to increase payment  
239.26 rates to behavioral health services providers. The commissioner must monitor the effect of  
239.27 this rate increase on enrollee access to behavioral health services. If for any contract year  
239.28 federal approval is not received for this paragraph, the commissioner must adjust the  
239.29 capitation rates paid to managed care plans and county-based purchasing plans for that  
239.30 contract year to reflect the removal of this provision. Contracts between managed care plans  
239.31 and county-based purchasing plans and providers to whom this paragraph applies must  
239.32 allow recovery of payments from those providers if capitation rates are adjusted in accordance  
239.33 with this paragraph. Payment recoveries must not exceed the amount equal to any increase  
239.34 in rates that results from this provision.

240.1 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,  
240.2 whichever is later. The commissioner of human services shall notify the revisor of statutes  
240.3 when federal approval is obtained.

240.4 Sec. 29. **FIRST EPISODE PSYCHOSIS COORDINATED SPECIALITY CARE**  
240.5 **MEDICAL ASSISTANCE BENEFIT.**

240.6 (a) The commissioner of human services must develop a First Episode Psychosis  
240.7 Coordinated Specialty Care (FEP-CSC) medical assistance benefit.

240.8 (b) The benefit must cover medically necessary treatment. Services must include:

240.9 (1) assertive outreach and engagement strategies encouraging individuals' involvement;

240.10 (2) person-centered care, delivered in the home and community, extending beyond  
240.11 typical hours of operation, such as evenings and weekends;

240.12 (3) crisis planning and intervention;

240.13 (4) team leadership from a mental health professional who provides ongoing consultation  
240.14 to the team members, coordinates admission screening, and leads the weekly team meetings  
240.15 to facilitate case review and entry to the program;

240.16 (5) employment and education services that enable individuals to function in workplace  
240.17 and educational settings that support individual preferences;

240.18 (6) family education and support that builds on an individual's identified family and  
240.19 natural support systems;

240.20 (7) individual and group psychotherapy that include but are not limited to cognitive  
240.21 behavioral therapies;

240.22 (8) care coordination services in clinic, community, and home settings to assist individuals  
240.23 with practical problem solving, such as securing transportation, addressing housing and  
240.24 other basic needs, managing money, obtaining medical care, and coordinating care with  
240.25 other providers; and

240.26 (9) pharmacotherapy, medication management, and primary care coordination provided  
240.27 by a mental health professional who is permitted to prescribe psychiatric medications.

240.28 (c) An eligible recipient is an individual who:

240.29 (1) is between the ages of 15 and 40;

240.30 (2) is experiencing early signs of psychosis with the duration of onset being less than  
240.31 two years; and

241.1 (3) has been on antipsychotic medications for less than a total of 12 months.

241.2 (d) By December 1, 2026, the commissioner must submit a report to the chairs and  
241.3 ranking minority members of the legislative committees with jurisdiction over human  
241.4 services policy and finance. The report must include:

241.5 (1) an overview of the recommended benefit;

241.6 (2) eligibility requirements;

241.7 (3) program standards;

241.8 (4) a reimbursement methodology that covers team-based bundled costs;

241.9 (5) performance evaluation criteria for programs; and

241.10 (6) draft legislation with the statutory changes necessary to implement the benefit.

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

241.12 **Sec. 30. MEDICAL ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL**  
241.13 **HEALTH CRISIS STABILIZATION.**

241.14 (a) The commissioner of human services must consult with providers, advocates, Tribal  
241.15 Nations, counties, people with lived experience as or with a child in a mental health crisis,  
241.16 and other interested community members to develop a covered benefit under medical  
241.17 assistance to provide residential mental health crisis stabilization for children. The benefit  
241.18 must:

241.19 (1) consist of evidence-based promising practices, or culturally responsive treatment  
241.20 services for children under the age of 21 experiencing a mental health crisis;

241.21 (2) embody an integrative care model that supports individuals experiencing a mental  
241.22 health crisis who may also be experiencing co-occurring conditions;

241.23 (3) qualify for federal financial participation; and

241.24 (4) include services that support children and families, including but not limited to:

241.25 (i) an assessment of the child's immediate needs and factors that led to the mental health  
241.26 crisis;

241.27 (ii) individualized care to address immediate needs and restore the child to a precrisis  
241.28 level of functioning;

241.29 (iii) 24-hour on-site staff and assistance;

241.30 (iv) supportive counseling and clinical services;

242.1 (v) skills training and positive support services, as identified in the child's individual  
242.2 crisis stabilization plan;

242.3 (vi) referrals to other service providers in the community as needed and to support the  
242.4 child's transition from residential crisis stabilization services;

242.5 (vii) development of an individualized and culturally responsive crisis response action  
242.6 plan; and

242.7 (viii) assistance to access and store medication.

242.8 (b) When developing the new benefit, the commissioner must make recommendations  
242.9 for providers to be reimbursed for room and board.

242.10 (c) The commissioner must consult with or contract with rate-setting experts to develop  
242.11 a prospective data-based rate methodology for the children's residential mental health crisis  
242.12 stabilization benefit.

242.13 (d) No later than October 1, 2025, the commissioner must submit to the chairs and  
242.14 ranking minority members of the legislative committees with jurisdiction over human  
242.15 services policy and finance a report detailing the children's residential mental health crisis  
242.16 stabilization benefit and must include:

242.17 (1) eligibility criteria, clinical and service requirements, provider standards, licensing  
242.18 requirements, and reimbursement rates;

242.19 (2) the process for community engagement, community input, and crisis models studied  
242.20 in other states;

242.21 (3) a deadline for the commissioner to submit a state plan amendment to the Centers for  
242.22 Medicare and Medicaid Services; and

242.23 (4) draft legislation with the statutory changes necessary to implement the benefit.

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

242.25 **Sec. 31. MEDICAL ASSISTANCE CLUBHOUSE BENEFIT ANALYSIS.**

242.26 The commissioner of human services must conduct an analysis to identify existing or  
242.27 pending Medicaid Clubhouse benefits in other states, federal authorities used, populations  
242.28 served, service and reimbursement design, and accreditation standards. By December 1,  
242.29 2025, the commissioner must submit a report to the chairs and ranking minority members  
242.30 of the legislative committees with jurisdiction over health and human services finance and

243.1 policy. The report must include a comparative analysis of Medicaid Clubhouse programs  
243.2 and recommendations for designing a medical assistance benefit in Minnesota.

243.3 **Sec. 32. DIRECTION TO COMMISSIONER OF HUMAN SERVICES; MENTAL**  
243.4 **HEALTH PROCEDURE CODES.**

243.5 The commissioner of human services must develop recommendations, in consultation  
243.6 with external partners and medical coding and compliance experts, on simplifying mental  
243.7 health procedure codes and the feasibility of converting mental health procedure codes to  
243.8 the current procedural terminology (CPT) code structure. By October 1, 2025, the  
243.9 commissioner must submit a report to the chairs and ranking minority members of the  
243.10 legislative committees with jurisdiction over mental health on the recommendations and  
243.11 methodology to simplify and restructure mental health procedure codes with corresponding  
243.12 resource-based relative value scale (RBRVS) values.

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

243.14 **Sec. 33. MENTAL HEALTH SERVICES FORMULA-BASED ALLOCATION.**

243.15 The commissioner of human services shall consult with the commissioner of management  
243.16 and budget, counties, Tribes, mental health providers, and advocacy organizations to develop  
243.17 recommendations for moving from the children's and adult mental health grant funding  
243.18 structure to a formula-based allocation structure for mental health services. The  
243.19 recommendations must consider formula-based allocations for grants for respite care,  
243.20 school-linked behavioral health, mobile crisis teams, and first episode of psychosis programs.

243.21 **Sec. 34. REVISOR INSTRUCTION.**

243.22 The revisor of statutes, in consultation with the Office of Senate Counsel, Research and  
243.23 Fiscal Analysis; the House Research Department; and the commissioner of human services  
243.24 shall prepare legislation for the 2025 legislative session to recodify Minnesota Statutes,  
243.25 section 256B.0622, to move provisions related to assertive community treatment and intensive  
243.26 residential treatment services into separate sections of statute. The revisor shall correct any  
243.27 cross-references made necessary by this recodification.

244.1 **ARTICLE 9**

244.2 **DEPARTMENT OF HUMAN SERVICES POLICY**

244.3 Section 1. Minnesota Statutes 2023 Supplement, section 245A.03, subdivision 2, as  
244.4 amended by Laws 2024, chapter 85, section 52, and Laws 2024, chapter 80, article 2, section  
244.5 35, is amended to read:

244.6 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

244.7 (1) residential or nonresidential programs that are provided to a person by an individual  
244.8 who is related;

244.9 (2) nonresidential programs that are provided by an unrelated individual to persons from  
244.10 a single related family;

244.11 (3) residential or nonresidential programs that are provided to adults who do not misuse  
244.12 substances or have a substance use disorder, a mental illness, a developmental disability, a  
244.13 functional impairment, or a physical disability;

244.14 (4) sheltered workshops or work activity programs that are certified by the commissioner  
244.15 of employment and economic development;

244.16 (5) programs operated by a public school for children 33 months or older;

244.17 (6) nonresidential programs primarily for children that provide care or supervision for  
244.18 periods of less than three hours a day while the child's parent or legal guardian is in the  
244.19 same building as the nonresidential program or present within another building that is  
244.20 directly contiguous to the building in which the nonresidential program is located;

244.21 (7) nursing homes or hospitals licensed by the commissioner of health except as specified  
244.22 under section 245A.02;

244.23 (8) board and lodge facilities licensed by the commissioner of health that do not provide  
244.24 children's residential services under Minnesota Rules, chapter 2960, mental health or  
244.25 substance use disorder treatment;

244.26 (9) programs licensed by the commissioner of corrections;

244.27 (10) recreation programs for children or adults that are operated or approved by a park  
244.28 and recreation board whose primary purpose is to provide social and recreational activities;

244.29 (11) noncertified boarding care homes unless they provide services for five or more  
244.30 persons whose primary diagnosis is mental illness or a developmental disability;

- 245.1 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art  
245.2 programs, and nonresidential programs for children provided for a cumulative total of less  
245.3 than 30 days in any 12-month period;
- 245.4 (13) residential programs for persons with mental illness, that are located in hospitals;
- 245.5 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter  
245.6 4630;
- 245.7 (15) mental health outpatient services for adults with mental illness or children with  
245.8 emotional disturbance;
- 245.9 (16) residential programs serving school-age children whose sole purpose is cultural or  
245.10 educational exchange, until the commissioner adopts appropriate rules;
- 245.11 (17) community support services programs as defined in section 245.462, subdivision  
245.12 6, and family community support services as defined in section 245.4871, subdivision 17;
- 245.13 (18) ~~settings registered under chapter 144D which provide home care services licensed~~  
245.14 ~~by the commissioner of health to fewer than seven adults~~ assisted living facilities licensed  
245.15 by the commissioner of health under chapter 144G;
- 245.16 (19) substance use disorder treatment activities of licensed professionals in private  
245.17 practice as defined in section 245G.01, subdivision 17;
- 245.18 (20) consumer-directed community support service funded under the Medicaid waiver  
245.19 for persons with developmental disabilities when the individual who provided the service  
245.20 is:
- 245.21 (i) the same individual who is the direct payee of these specific waiver funds or paid by  
245.22 a fiscal agent, fiscal intermediary, or employer of record; and
- 245.23 (ii) not otherwise under the control of a residential or nonresidential program that is  
245.24 required to be licensed under this chapter when providing the service;
- 245.25 (21) a county that is an eligible vendor under section 254B.05 to provide care coordination  
245.26 and comprehensive assessment services;
- 245.27 (22) a recovery community organization that is an eligible vendor under section 254B.05  
245.28 to provide peer recovery support services; or
- 245.29 (23) programs licensed by the commissioner of children, youth, and families in chapter  
245.30 142B.

246.1 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a  
246.2 building in which a nonresidential program is located if it shares a common wall with the  
246.3 building in which the nonresidential program is located or is attached to that building by  
246.4 skyway, tunnel, atrium, or common roof.

246.5 ~~(b)~~ (c) Except for the home and community-based services identified in section 245D.03,  
246.6 subdivision 1, nothing in this chapter shall be construed to require licensure for any services  
246.7 provided and funded according to an approved federal waiver plan where licensure is  
246.8 specifically identified as not being a condition for the services and funding.

246.9 Sec. 3. Minnesota Statutes 2022, section 245A.04, is amended by adding a subdivision to  
246.10 read:

246.11 Subd. 7b. Notification to commissioner of changes in key staff positions; children's  
246.12 residential facilities and detoxification programs. (a) A license holder must notify the  
246.13 commissioner within five business days of a change or vacancy in a key staff position under  
246.14 paragraph (b) or (c). The license holder must notify the commissioner of the staffing change  
246.15 on a form approved by the commissioner and include the name of the staff person now  
246.16 assigned to the key staff position and the staff person's qualifications for the position. The  
246.17 license holder must notify the program licensor of a vacancy to discuss how the duties of  
246.18 the key staff position will be fulfilled during the vacancy.

246.19 (b) The key staff position for a children's residential facility licensed according to  
246.20 Minnesota Rules, parts 2960.0130 to 2960.0220, is a program director; and

246.21 (c) The key staff positions for a detoxification program licensed according to Minnesota  
246.22 Rules, parts 9530.6510 to 9530.6590, are:

246.23 (1) a program director as required by Minnesota Rules, part 9530.6560, subpart 1;

246.24 (2) a registered nurse as required by Minnesota Rules, part 9530.6560, subpart 4; and

246.25 (3) a medical director as required by Minnesota Rules, part 9530.6560, subpart 5.

246.26 **EFFECTIVE DATE.** This section is effective January 1, 2025.

246.27 Sec. 2. Minnesota Statutes 2022, section 245A.043, subdivision 2, is amended to read:

246.28 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change  
246.29 in ownership, the commissioner shall require submission of a new license application. This  
246.30 subdivision does not apply to a licensed program or service located in a home where the  
246.31 license holder resides. A change in ownership occurs when:

247.1 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent  
247.2 of the property, stock, or assets;

247.3 (2) the license holder merges with another organization;

247.4 (3) the license holder consolidates with two or more organizations, resulting in the  
247.5 creation of a new organization;

247.6 (4) there is a change to the federal tax identification number associated with the license  
247.7 holder; or

247.8 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for  
247.9 the original ~~application~~ license have changed.

247.10 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses (1) and or (5), no change  
247.11 in ownership has occurred and a new license application is not required if at least one  
247.12 controlling individual has been listed ~~listed~~ affiliated as a controlling individual for the license  
247.13 for at least the previous 12 months immediately preceding the change.

247.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

247.15 Sec. 3. Minnesota Statutes 2023 Supplement, section 245A.043, subdivision 3, is amended  
247.16 to read:

247.17 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is  
247.18 proposed and the party intends to assume operation without an interruption in service longer  
247.19 than 60 days after acquiring the program or service, the license holder must provide the  
247.20 commissioner with written notice of the proposed change on a form provided by the  
247.21 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.  
247.22 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that  
247.23 intends to operate the service or program.

247.24 (b) The party must submit a license application under this chapter on the form and in  
247.25 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in  
247.26 ownership is anticipated to be complete; and must include documentation to support the  
247.27 upcoming change. The party must comply with background study requirements under chapter  
247.28 245C and shall pay the application fee required under section 245A.10.

247.29 (c) A party that intends to assume operation without an interruption in service longer  
247.30 than 60 days after acquiring the program or service is exempt from the requirements of  
247.31 sections 245G.03, subdivision 2, paragraph (b), and 254B.03, subdivision 2, paragraphs (c)  
247.32 and (d).

248.1        ~~(e)~~ (d) The commissioner may streamline application procedures when the party is an  
 248.2 existing license holder under this chapter and is acquiring a program licensed under this  
 248.3 chapter or service in the same service class as one or more licensed programs or services  
 248.4 the party operates and those licenses are in substantial compliance. For purposes of this  
 248.5 subdivision, "substantial compliance" means within the previous 12 months the commissioner  
 248.6 did not (1) issue a sanction under section 245A.07 against a license held by the party, or  
 248.7 (2) make a license held by the party conditional according to section 245A.06.

248.8        ~~(d) Except when a temporary change in ownership license is issued pursuant to~~  
 248.9 ~~subdivision 4~~ (e) While the standard change of ownership process is pending, the existing  
 248.10 license holder ~~is solely~~ remains responsible for operating the program according to applicable  
 248.11 laws and rules until a license under this chapter is issued to the party.

248.12        ~~(e)~~ (f) If a licensing inspection of the program or service was conducted within the  
 248.13 previous 12 months and the existing license holder's license record demonstrates substantial  
 248.14 compliance with the applicable licensing requirements, the commissioner may waive the  
 248.15 party's inspection required by section 245A.04, subdivision 4. The party must submit to the  
 248.16 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire  
 248.17 marshal deemed that an inspection was not warranted, and (2) proof that the premises was  
 248.18 inspected for compliance with the building code or that no inspection was deemed warranted.

248.19        ~~(f)~~ (g) If the party is seeking a license for a program or service that has an outstanding  
 248.20 action under section 245A.06 or 245A.07, the party must submit a ~~letter~~ written plan as part  
 248.21 of the application process identifying how the party has or will come into full compliance  
 248.22 with the licensing requirements.

248.23        ~~(g)~~ (h) The commissioner shall evaluate the party's application according to section  
 248.24 245A.04, subdivision 6. If the commissioner determines that the party has remedied or  
 248.25 demonstrates the ability to remedy the outstanding actions under section 245A.06 or 245A.07  
 248.26 and has determined that the program otherwise complies with all applicable laws and rules,  
 248.27 the commissioner shall issue a license or conditional license under this chapter. A conditional  
 248.28 license issued under this section is final and not subject to reconsideration under section  
 248.29 245A.06, subdivision 4. The conditional license remains in effect until the commissioner  
 248.30 determines that the grounds for the action are corrected or no longer exist.

248.31        ~~(h)~~ (i) The commissioner may deny an application as provided in section 245A.05. An  
 248.32 applicant whose application was denied by the commissioner may appeal the denial according  
 248.33 to section 245A.05.

249.1 (j) This subdivision does not apply to a licensed program or service located in a home  
249.2 where the license holder resides.

249.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

249.4 Sec. 4. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision  
249.5 to read:

249.6 **Subd. 3a. Emergency change in ownership process.** (a) In the event of a death of a  
249.7 license holder or sole controlling individual or a court order or other event that results in  
249.8 the license holder being inaccessible or unable to operate the program or service, a party  
249.9 may submit a request to the commissioner to allow the party to assume operation of the  
249.10 program or service under an emergency change in ownership process to ensure persons  
249.11 continue to receive services while the commissioner evaluates the party's license application.

249.12 (b) To request the emergency change of ownership process, the party must immediately:

249.13 (1) notify the commissioner of the event resulting in the inability of the license holder  
249.14 to operate the program and of the party's intent to assume operations; and

249.15 (2) provide the commissioner with documentation that demonstrates the party has a legal  
249.16 or legitimate ownership interest in the program or service if applicable and is able to operate  
249.17 the program or service.

249.18 (c) If the commissioner approves the party to continue operating the program or service  
249.19 under an emergency change in ownership process, the party must:

249.20 (1) request to be added as a controlling individual or license holder to the existing license;

249.21 (2) notify persons receiving services of the emergency change in ownership in a manner  
249.22 approved by the commissioner;

249.23 (3) submit an application for a new license within 30 days of approval;

249.24 (4) comply with the background study requirements under chapter 245C; and

249.25 (5) pay the application fee required under section 245A.10.

249.26 (d) While the emergency change of ownership process is pending, a party approved  
249.27 under this subdivision is responsible for operating the program under the existing license  
249.28 according to applicable laws and rules until a new license under this chapter is issued.

249.29 (e) The provisions in subdivision 3, paragraphs (c), (d), and (f) to (i) apply to this  
249.30 subdivision.

250.1 (f) Once a party is issued a new license or has decided not to seek a new license, the  
250.2 commissioner must close the existing license.

250.3 (g) This subdivision applies to any program or service licensed under this chapter.

250.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

250.5 Sec. 5. Minnesota Statutes 2022, section 245A.043, subdivision 4, is amended to read:

250.6 Subd. 4. **Temporary change in ownership transitional license.** ~~(a) After receiving the~~  
250.7 ~~party's application pursuant to subdivision 3, upon the written request of the existing license~~  
250.8 ~~holder and the party, the commissioner may issue a temporary change in ownership license~~  
250.9 ~~to the party while the commissioner evaluates the party's application. Until a decision is~~  
250.10 ~~made to grant or deny a license under this chapter, the existing license holder and the party~~  
250.11 ~~shall both be responsible for operating the program or service according to applicable laws~~  
250.12 ~~and rules, and the sale or transfer of the existing license holder's ownership interest in the~~  
250.13 ~~licensed program or service does not terminate the existing license.~~

250.14 ~~(b) The commissioner may issue a temporary change in ownership license when a license~~  
250.15 ~~holder's death, divorce, or other event affects the ownership of the program and an applicant~~  
250.16 ~~seeks to assume operation of the program or service to ensure continuity of the program or~~  
250.17 ~~service while a license application is evaluated.~~

250.18 ~~(c) This subdivision applies to any program or service licensed under this chapter.~~

250.19 If a party's application under subdivision 2 is for a satellite license for a community  
250.20 residential setting under section 245D.23 or day services facility under 245D.27 and if the  
250.21 party already holds an active license to provide services under chapter 245D, the  
250.22 commissioner may issue a temporary transitional license to the party for the community  
250.23 residential setting or day services facility while the commissioner evaluates the party's  
250.24 application. Until a decision is made to grant or deny a community residential setting or  
250.25 day services facility satellite license, the party must be solely responsible for operating the  
250.26 program according to applicable laws and rules, and the existing license must be closed.  
250.27 The temporary transitional license expires after 12 months from the date it was issued or  
250.28 upon issuance of the community residential setting or day services facility satellite license,  
250.29 whichever occurs first.

250.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

251.1 Sec. 6. Minnesota Statutes 2022, section 245A.043, is amended by adding a subdivision  
251.2 to read:

251.3 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder  
251.4 has not fully complied with this section, the commissioner may impose a licensing sanction  
251.5 under section 245A.05, 245A.06, or 245A.07.

251.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

251.7 Sec. 7. Minnesota Statutes 2023 Supplement, section 245A.07, subdivision 1, as amended  
251.8 by Laws 2024, chapter 80, article 2, section 44, is amended to read:

251.9 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional  
251.10 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,  
251.11 or secure an injunction against the continuing operation of the program of a license holder  
251.12 who does not comply with applicable law or rule.

251.13 When applying sanctions authorized under this section, the commissioner shall consider  
251.14 the nature, chronicity, or severity of the violation of law or rule and the effect of the violation  
251.15 on the health, safety, or rights of persons served by the program.

251.16 (b) If a license holder appeals the suspension or revocation of a license and the license  
251.17 holder continues to operate the program pending a final order on the appeal, the commissioner  
251.18 shall issue the license holder a temporary provisional license. The commissioner may include  
251.19 terms the license holder must follow pending a final order on the appeal. Unless otherwise  
251.20 specified by the commissioner, variances in effect on the date of the license sanction under  
251.21 appeal continue under the temporary provisional license. If a license holder fails to comply  
251.22 with applicable law or rule while operating under a temporary provisional license, the  
251.23 commissioner may impose additional sanctions under this section and section 245A.06, and  
251.24 may terminate any prior variance. If a temporary provisional license is set to expire, a new  
251.25 temporary provisional license shall be issued to the license holder upon payment of any fee  
251.26 required under section 245A.10. The temporary provisional license shall expire on the date  
251.27 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional  
251.28 license shall be issued for the remainder of the current license period.

251.29 (c) If a license holder is under investigation and the license issued under this chapter is  
251.30 due to expire before completion of the investigation, the program shall be issued a new  
251.31 license upon completion of the reapplication requirements and payment of any applicable  
251.32 license fee. Upon completion of the investigation, a licensing sanction may be imposed  
251.33 against the new license under this section, section 245A.06, or 245A.08.

252.1 (d) Failure to reapply or closure of a license issued under this chapter by the license  
252.2 holder prior to the completion of any investigation shall not preclude the commissioner  
252.3 from issuing a licensing sanction under this section or section 245A.06 at the conclusion  
252.4 of the investigation.

252.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

252.6 Sec. 8. Minnesota Statutes 2022, section 245A.07, subdivision 6, is amended to read:

252.7 Subd. 6. **Appeal of multiple sanctions.** (a) When the license holder appeals more than  
252.8 one licensing action or sanction that were simultaneously issued by the commissioner, the  
252.9 license holder shall specify the actions or sanctions that are being appealed.

252.10 (b) If there are different timelines prescribed in statutes for the licensing actions or  
252.11 sanctions being appealed, the license holder must submit the appeal within the longest of  
252.12 those timelines specified in statutes.

252.13 (c) The appeal must be made in writing by certified mail ~~or~~, by personal service, or  
252.14 through the provider licensing and reporting hub. If mailed, the appeal must be postmarked  
252.15 and sent to the commissioner within the prescribed timeline with the first day beginning  
252.16 the day after the license holder receives the certified letter. If a request is made by personal  
252.17 service, it must be received by the commissioner within the prescribed timeline with the  
252.18 first day beginning the day after the license holder receives the certified letter. If the appeal  
252.19 is made through the provider licensing and reporting hub, it must be received by the  
252.20 commissioner within the prescribed timeline with the first day beginning the day after the  
252.21 commissioner issued the order through the hub.

252.22 (d) When there are different timelines prescribed in statutes for the appeal of licensing  
252.23 actions or sanctions simultaneously issued by the commissioner, the commissioner shall  
252.24 specify in the notice to the license holder the timeline for appeal as specified under paragraph  
252.25 (b).

252.26 Sec. 9. Minnesota Statutes 2023 Supplement, section 245A.11, subdivision 7, is amended  
252.27 to read:

252.28 Subd. 7. **Adult foster care and community residential setting; variance for alternate**  
252.29 **overnight supervision.** (a) The commissioner may grant a variance under section 245A.04,  
252.30 subdivision 9, to statute or rule parts requiring a caregiver to be present in an adult foster  
252.31 care home or a community residential setting during normal sleeping hours to allow for  
252.32 alternative methods of overnight supervision. The commissioner may grant the variance if

253.1 the local county licensing agency recommends the variance and the county recommendation  
253.2 includes documentation verifying that:

253.3 (1) the county has approved the license holder's plan for alternative methods of providing  
253.4 overnight supervision and determined the plan protects the residents' health, safety, and  
253.5 rights;

253.6 (2) the license holder has obtained written and signed informed consent from each  
253.7 resident or each resident's legal representative documenting the resident's or legal  
253.8 representative's agreement with the alternative method of overnight supervision; and

253.9 (3) the alternative method of providing overnight supervision, which may include the  
253.10 use of technology, is specified for each resident in the resident's: (i) individualized plan of  
253.11 care; (ii) ~~individual service~~ support plan under section 256B.092, subdivision 1b, if required;  
253.12 or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105,  
253.13 subpart 19, if required.

253.14 (b) To be eligible for a variance under paragraph (a), the adult foster care or community  
253.15 residential setting license holder must not have had a conditional license issued under section  
253.16 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24  
253.17 months based on failure to provide adequate supervision, health care services, or resident  
253.18 safety in the adult foster care home or a community residential setting.

253.19 (c) A license holder requesting a variance under this subdivision to utilize technology  
253.20 as a component of a plan for alternative overnight supervision may request the commissioner's  
253.21 review in the absence of a county recommendation. Upon receipt of such a request from a  
253.22 license holder, the commissioner shall review the variance request with the county.

253.23 ~~(d) The variance requirements under this subdivision for alternative overnight supervision~~  
253.24 ~~do not apply to community residential settings licensed under chapter 245D.~~

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

253.26 Sec. 10. Minnesota Statutes 2023 Supplement, section 245A.16, subdivision 1, as amended  
253.27 by Laws 2024, chapter 80, article 2, section 65, is amended to read:

253.28 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been  
253.29 designated by the commissioner to perform licensing functions and activities under section  
253.30 245A.04; to recommend denial of applicants under section 245A.05; to issue correction  
253.31 orders, to issue variances, and recommend a conditional license under section 245A.06; or  
253.32 to recommend suspending or revoking a license or issuing a fine under section 245A.07,  
253.33 shall comply with rules and directives of the commissioner governing those functions and

254.1 with this section. The following variances are excluded from the delegation of variance  
254.2 authority and may be issued only by the commissioner:

254.3 (1) dual licensure of family child foster care and family adult foster care, dual licensure  
254.4 of child foster residence setting and community residential setting, and dual licensure of  
254.5 family adult foster care and family child care;

254.6 (2) adult foster care or community residential setting maximum capacity;

254.7 (3) adult foster care or community residential setting minimum age requirement;

254.8 (4) child foster care maximum age requirement;

254.9 (5) variances regarding disqualified individuals;

254.10 (6) the required presence of a caregiver in the adult foster care residence during normal  
254.11 sleeping hours;

254.12 (7) variances to requirements relating to chemical use problems of a license holder or a  
254.13 household member of a license holder; and

254.14 (8) variances to section 142B.46 for the use of a cradleboard for a cultural  
254.15 accommodation.

254.16 (b) For family adult day services programs, the commissioner may authorize licensing  
254.17 reviews every two years after a licensee has had at least one annual review.

254.18 (c) A license issued under this section may be issued for up to two years.

254.19 (d) During implementation of chapter 245D, the commissioner shall consider:

254.20 (1) the role of counties in quality assurance;

254.21 (2) the duties of county licensing staff; and

254.22 (3) the possible use of joint powers agreements, according to section 471.59, with counties  
254.23 through which some licensing duties under chapter 245D may be delegated by the  
254.24 commissioner to the counties.

254.25 Any consideration related to this paragraph must meet all of the requirements of the corrective  
254.26 action plan ordered by the federal Centers for Medicare and Medicaid Services.

254.27 (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or  
254.28 successor provisions; and section 245D.061 or successor provisions, for family child foster  
254.29 care programs providing out-of-home respite, as identified in section 245D.03, subdivision  
254.30 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

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

255.2 Sec. 11. Minnesota Statutes 2023 Supplement, section 245A.211, subdivision 4, is amended  
255.3 to read:

255.4 Subd. 4. **Contraindicated physical restraints.** A license or certification holder must  
255.5 not implement a restraint on a person receiving services in a program in a way that is  
255.6 contraindicated for any of the person's known medical or psychological conditions. Prior  
255.7 to using restraints on a person, ~~the license or certification holder must assess and document~~  
255.8 ~~a determination of any~~ with a known medical or psychological conditions that restraints are  
255.9 contraindicated for, the license or certification holder must document the contraindication  
255.10 and the type of restraints that will not be used on the person based on this determination.

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

255.12 Sec. 12. Minnesota Statutes 2023 Supplement, section 245A.242, subdivision 2, is amended  
255.13 to read:

255.14 Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply  
255.15 of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency  
255.16 treatment of opioid overdose and must have a written standing order protocol by a physician  
255.17 who is licensed under chapter 147, advanced practice registered nurse who is licensed under  
255.18 chapter 148, or physician assistant who is licensed under chapter 147A, that permits the  
255.19 license holder to maintain a supply of opiate antagonists on site. A license holder must  
255.20 require staff to undergo training in the specific mode of administration used at the program,  
255.21 which may include intranasal administration, intramuscular injection, or both.

255.22 (b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960  
255.23 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

255.24 (1) emergency opiate antagonist medications are not required to be stored in a locked  
255.25 area and staff and adult clients may carry this medication on them and store it in an unlocked  
255.26 location;

255.27 (2) staff persons who only administer emergency opiate antagonist medications only  
255.28 require the training required by paragraph (a), which any knowledgeable trainer may provide.  
255.29 The trainer is not required to be a registered nurse or part of an accredited educational  
255.30 institution; and

255.31 (3) nonresidential substance use disorder treatment programs that do not administer  
255.32 client medications beyond emergency opiate antagonist medications are not required to

256.1 have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and  
256.2 must instead describe the program's procedures for administering opiate antagonist  
256.3 medications in the license holder's description of health care services under section 245G.08,  
256.4 subdivision 1.

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

256.6 Sec. 13. Minnesota Statutes 2023 Supplement, section 245C.02, subdivision 13e, is  
256.7 amended to read:

256.8 Subd. 13e. **NETStudy 2.0.** (a) "NETStudy 2.0" means the commissioner's system that  
256.9 replaces both NETStudy and the department's internal background study processing system.  
256.10 NETStudy 2.0 is designed to enhance protection of children and vulnerable adults by  
256.11 improving the accuracy of background studies through fingerprint-based criminal record  
256.12 checks and expanding the background studies to include a review of information from the  
256.13 Minnesota Court Information System and the national crime information database. NETStudy  
256.14 2.0 is also designed to increase efficiencies in and the speed of the hiring process by:

256.15 (1) providing access to and updates from public web-based data related to employment  
256.16 eligibility;

256.17 (2) decreasing the need for repeat studies through electronic updates of background  
256.18 study subjects' criminal records;

256.19 (3) supporting identity verification using subjects' Social Security numbers and  
256.20 photographs;

256.21 (4) using electronic employer notifications;

256.22 (5) issuing immediate verification of subjects' eligibility to provide services as more  
256.23 studies are completed under the NETStudy 2.0 system; and

256.24 (6) providing electronic access to certain notices for entities and background study  
256.25 subjects.

256.26 (b) Information obtained by entities from public web-based data through NETStudy 2.0  
256.27 under paragraph (a), clause (1), or any other source that is not direct correspondence from  
256.28 the commissioner is not a notice of disqualification from the commissioner under this  
256.29 chapter.

257.1 Sec. 14. [245C.041] EMERGENCY WAIVER TO TEMPORARILY MODIFY  
257.2 BACKGROUND STUDY REQUIREMENTS.

257.3 (a) In the event of an emergency identified by the commissioner, the commissioner may  
257.4 temporarily waive or modify provisions in this chapter, except that the commissioner shall  
257.5 not waive or modify:

257.6 (1) disqualification standards in section 245C.14 or 245C.15; or

257.7 (2) any provision regarding the scope of individuals required to be subject to a background  
257.8 study conducted under this chapter.

257.9 (b) For the purposes of this section, an emergency may include, but is not limited to a  
257.10 public health emergency, environmental emergency, natural disaster, or other unplanned  
257.11 event that the commissioner has determined prevents the requirements in this chapter from  
257.12 being met. This authority shall not exceed the amount of time needed to respond to the  
257.13 emergency and reinstate the requirements of this chapter. The commissioner has the authority  
257.14 to establish the process and time frame for returning to full compliance with this chapter.  
257.15 The commissioner shall determine the length of time an emergency study is valid.

257.16 (c) At the conclusion of the emergency, entities must submit a new, compliant background  
257.17 study application and fee for each individual who was the subject of background study  
257.18 affected by the powers created in this section, referred to as an "emergency study" to have  
257.19 a new study that fully complies with this chapter within a time frame and notice period  
257.20 established by the commissioner.

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

257.22 Sec. 15. Minnesota Statutes 2022, section 245C.05, subdivision 5, is amended to read:

257.23 Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph ~~(b)~~ (c), for  
257.24 background studies conducted by the commissioner for child foster care, children's residential  
257.25 facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the  
257.26 subject of the background study, who is 18 years of age or older, shall provide the  
257.27 commissioner with a set of classifiable fingerprints obtained from an authorized agency for  
257.28 a national criminal history record check.

257.29 (b) Notwithstanding paragraph (c), for background studies conducted by the commissioner  
257.30 for Head Start programs, the subject of the background study shall provide the commissioner  
257.31 with a set of classifiable fingerprints obtained from an authorized agency for a national  
257.32 criminal history record check.

258.1 ~~(b)~~ (c) For background studies initiated on or after the implementation of NETStudy  
258.2 2.0, except as provided under subdivision 5a, every subject of a background study must  
258.3 provide the commissioner with a set of the background study subject's classifiable fingerprints  
258.4 and photograph. The photograph and fingerprints must be recorded at the same time by the  
258.5 authorized fingerprint collection vendor or vendors and sent to the commissioner through  
258.6 the commissioner's secure data system described in section 245C.32, subdivision 1a,  
258.7 paragraph (b).

258.8 ~~(e)~~ (d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal  
258.9 Apprehension and, when specifically required by law, submitted to the Federal Bureau of  
258.10 Investigation for a national criminal history record check.

258.11 ~~(d)~~ (e) The fingerprints must not be retained by the Department of Public Safety, Bureau  
258.12 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will  
258.13 not retain background study subjects' fingerprints.

258.14 ~~(e)~~ (f) The authorized fingerprint collection vendor or vendors shall, for purposes of  
258.15 verifying the identity of the background study subject, be able to view the identifying  
258.16 information entered into NETStudy 2.0 by the entity that initiated the background study,  
258.17 but shall not retain the subject's fingerprints, photograph, or information from NETStudy  
258.18 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the  
258.19 name and date and time the subject's fingerprints were recorded and sent, only as necessary  
258.20 for auditing and billing activities.

258.21 ~~(f)~~ (g) For any background study conducted under this chapter, the subject shall provide  
258.22 the commissioner with a set of classifiable fingerprints when the commissioner has reasonable  
258.23 cause to require a national criminal history record check as defined in section 245C.02,  
258.24 subdivision 15a.

258.25 Sec. 16. Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 1, is amended  
258.26 to read:

258.27 Subdivision 1. **Background studies conducted by Department of Human Services.** (a)  
258.28 For a background study conducted by the Department of Human Services, the commissioner  
258.29 shall review:

258.30 (1) information related to names of substantiated perpetrators of maltreatment of  
258.31 vulnerable adults that has been received by the commissioner as required under section  
258.32 626.557, subdivision 9c, paragraph (j);

259.1 (2) the commissioner's records relating to the maltreatment of minors in licensed  
259.2 programs, and from findings of maltreatment of minors as indicated through the social  
259.3 service information system;

259.4 (3) information from juvenile courts as required ~~in subdivision 4 for individuals listed~~  
259.5 ~~in section 245C.03, subdivision 1, paragraph (a),~~ for studies under this chapter when there  
259.6 is reasonable cause;

259.7 (4) information from the Bureau of Criminal Apprehension, including information  
259.8 regarding a background study subject's registration in Minnesota as a predatory offender  
259.9 under section 243.166;

259.10 (5) except as provided in clause (6), information received as a result of submission of  
259.11 fingerprints for a national criminal history record check, as defined in section 245C.02,  
259.12 subdivision 13c, when the commissioner has reasonable cause for a national criminal history  
259.13 record check as defined under section 245C.02, subdivision 15a, or as required under section  
259.14 144.057, subdivision 1, clause (2);

259.15 (6) for a background study related to a child foster family setting application for licensure,  
259.16 foster residence settings, children's residential facilities, a transfer of permanent legal and  
259.17 physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a  
259.18 background study required for family child care, certified license-exempt child care, child  
259.19 care centers, and legal nonlicensed child care authorized under chapter 119B, the  
259.20 commissioner shall also review:

259.21 (i) information from the child abuse and neglect registry for any state in which the  
259.22 background study subject has resided for the past five years;

259.23 (ii) when the background study subject is 18 years of age or older, or a minor under  
259.24 section 245C.05, subdivision 5a, paragraph (c), information received following submission  
259.25 of fingerprints for a national criminal history record check; and

259.26 (iii) when the background study subject is 18 years of age or older or a minor under  
259.27 section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified  
259.28 license-exempt child care, licensed child care centers, and legal nonlicensed child care  
259.29 authorized under chapter 119B, information obtained using non-fingerprint-based data  
259.30 including information from the criminal and sex offender registries for any state in which  
259.31 the background study subject resided for the past five years and information from the national  
259.32 crime information database and the national sex offender registry;

260.1 (7) for a background study required for family child care, certified license-exempt child  
260.2 care centers, licensed child care centers, and legal nonlicensed child care authorized under  
260.3 chapter 119B, the background study shall also include, to the extent practicable, a name  
260.4 and date-of-birth search of the National Sex Offender Public website; and

260.5 (8) for a background study required for treatment programs for sexual psychopathic  
260.6 personalities or sexually dangerous persons, the background study shall only include a  
260.7 review of the information required under paragraph (a), clauses (1) to (4).

260.8 (b) Except as otherwise provided in this paragraph, notwithstanding expungement by a  
260.9 court, the commissioner may consider information obtained under paragraph (a), clauses  
260.10 (3) and (4), unless:

260.11 (1) the commissioner received notice of the petition for expungement and the court order  
260.12 for expungement is directed specifically to the commissioner; or

260.13 (2) the commissioner received notice of the expungement order issued pursuant to section  
260.14 609A.017, 609A.025, or 609A.035, and the order for expungement is directed specifically  
260.15 to the commissioner.

260.16 The commissioner may not consider information obtained under paragraph (a), clauses (3)  
260.17 and (4), or from any other source that identifies a violation of chapter 152 without  
260.18 determining if the offense involved the possession of marijuana or tetrahydrocannabinol  
260.19 and, if so, whether the person received a grant of expungement or order of expungement,  
260.20 or the person was resentenced to a lesser offense. If the person received a grant of  
260.21 expungement or order of expungement, the commissioner may not consider information  
260.22 related to that violation but may consider any other relevant information arising out of the  
260.23 same incident.

260.24 (c) The commissioner shall also review criminal case information received according  
260.25 to section 245C.04, subdivision 4a, from the Minnesota court information system that relates  
260.26 to individuals who have already been studied under this chapter and who remain affiliated  
260.27 with the agency that initiated the background study.

260.28 (d) When the commissioner has reasonable cause to believe that the identity of a  
260.29 background study subject is uncertain, the commissioner may require the subject to provide  
260.30 a set of classifiable fingerprints for purposes of completing a fingerprint-based record check  
260.31 with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph  
260.32 shall not be saved by the commissioner after they have been used to verify the identity of  
260.33 the background study subject against the particular criminal record in question.

261.1 (e) The commissioner may inform the entity that initiated a background study under  
261.2 NETStudy 2.0 of the status of processing of the subject's fingerprints.

261.3 Sec. 17. Minnesota Statutes 2022, section 245C.10, subdivision 18, is amended to read:

261.4 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**  
261.5 **of health.** The applicant or license holder is responsible for paying to the Department of  
261.6 Human Services all fees associated with the preparation of the fingerprints, the criminal  
261.7 records check consent form, and, through a fee of no more than \$44 per study, the criminal  
261.8 background check.

261.9 Sec. 18. Minnesota Statutes 2022, section 245C.14, subdivision 1, is amended to read:

261.10 Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall  
261.11 disqualify an individual who is the subject of a background study from any position allowing  
261.12 direct contact with persons receiving services from the license holder or entity identified in  
261.13 section 245C.03, upon receipt of information showing, or when a background study  
261.14 completed under this chapter shows any of the following:

261.15 (1) a conviction of, admission to, or Alford plea to one or more crimes listed in section  
261.16 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor,  
261.17 or misdemeanor level crime;

261.18 (2) a preponderance of the evidence indicates the individual has committed an act or  
261.19 acts that meet the definition of any of the crimes listed in section 245C.15, regardless of  
261.20 whether the preponderance of the evidence is for a felony, gross misdemeanor, or  
261.21 misdemeanor level crime; ~~or~~

261.22 (3) an investigation results in an administrative determination listed under section  
261.23 245C.15, subdivision 4, paragraph (b); or

261.24 (4) the individual's parental rights have been terminated under section 260C.301,  
261.25 subdivision 1, paragraph (b), or section 260C.301, subdivision 3.

261.26 (b) No individual who is disqualified following a background study under section  
261.27 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with  
261.28 persons served by a program or entity identified in section 245C.03, unless the commissioner  
261.29 has provided written notice under section 245C.17 stating that:

261.30 (1) the individual may remain in direct contact during the period in which the individual  
261.31 may request reconsideration as provided in section 245C.21, subdivision 2;

262.1 (2) the commissioner has set aside the individual's disqualification for that program or  
262.2 entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

262.3 (3) the license holder has been granted a variance for the disqualified individual under  
262.4 section 245C.30.

262.5 (c) Notwithstanding paragraph (a), for the purposes of a background study affiliated  
262.6 with a licensed family foster setting, the commissioner shall disqualify an individual who  
262.7 is the subject of a background study from any position allowing direct contact with persons  
262.8 receiving services from the license holder or entity identified in section 245C.03, upon  
262.9 receipt of information showing or when a background study completed under this chapter  
262.10 shows reason for disqualification under section 245C.15, subdivision 4a.

262.11 Sec. 19. Minnesota Statutes 2022, section 245C.14, is amended by adding a subdivision  
262.12 to read:

262.13 Subd. 5. **Basis for disqualification.** Information obtained by entities from public  
262.14 web-based data through NETStudy 2.0 or any other source that is not direct correspondence  
262.15 from the commissioner is not a notice of disqualification from the commissioner under this  
262.16 chapter.

262.17 Sec. 20. Minnesota Statutes 2023 Supplement, section 245C.15, subdivision 2, is amended  
262.18 to read:

262.19 Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14  
262.20 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any,  
262.21 for the offense; and (2) the individual has committed a felony-level violation of any of the  
262.22 following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance  
262.23 crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime  
262.24 in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in  
262.25 the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the  
262.26 fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud);  
262.27 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14  
262.28 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112,  
262.29 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223  
262.30 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault  
262.31 in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal  
262.32 abuse of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235  
262.33 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.247, subdivision

263.1 4 (carjacking in the third degree); 609.255 (false imprisonment); 609.2664 (manslaughter  
 263.2 of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the  
 263.3 second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault  
 263.4 of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the  
 263.5 commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical  
 263.6 assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated  
 263.7 first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession  
 263.8 of shoplifting gear); 609.522 (organized retail theft); 609.525 (bringing stolen goods into  
 263.9 Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance  
 263.10 of dishonored checks); 609.562 (arson in the second degree); 609.563 (arson in the third  
 263.11 degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance  
 263.12 fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a  
 263.13 forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons);  
 263.14 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot);  
 263.15 609.713 (terroristic threats); 609.746 (interference with privacy); 609.82 (fraud in obtaining  
 263.16 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving  
 263.17 a minor; repeat offenses under 617.241 (obscene materials and performances; distribution  
 263.18 and exhibition prohibited; penalty); or 624.713 (certain persons not to possess firearms).

263.19 (b) An individual is disqualified under section 245C.14 if less than 15 years has passed  
 263.20 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the  
 263.21 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

263.22 (c) An individual is disqualified under section 245C.14 if less than 15 years has passed  
 263.23 since the termination of the individual's parental rights under section 260C.301, subdivision  
 263.24 1, paragraph (b), or subdivision 3.

263.25 (d) An individual is disqualified under section 245C.14 if less than 15 years has passed  
 263.26 since the discharge of the sentence imposed for an offense in any other state or country, the  
 263.27 elements of which are substantially similar to the elements of the offenses listed in paragraph  
 263.28 (a) or since the termination of parental rights in any other state or country, the elements of  
 263.29 which are substantially similar to the elements listed in paragraph (c).

263.30 (e) If the individual studied commits one of the offenses listed in paragraph (a), but the  
 263.31 sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is  
 263.32 disqualified but the disqualification look-back period for the offense is the period applicable  
 263.33 to the gross misdemeanor or misdemeanor disposition.

264.1 (f) When a disqualification is based on a judicial determination other than a conviction,  
 264.2 the disqualification period begins from the date of the court order. When a disqualification  
 264.3 is based on an admission, the disqualification period begins from the date of an admission  
 264.4 in court. When a disqualification is based on an Alford Plea, the disqualification period  
 264.5 begins from the date the Alford Plea is entered in court. When a disqualification is based  
 264.6 on a preponderance of evidence of a disqualifying act, the disqualification date begins from  
 264.7 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for  
 264.8 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

264.9 Sec. 21. Minnesota Statutes 2022, section 245C.15, subdivision 3, is amended to read:

264.10 Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section  
 264.11 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed,  
 264.12 if any, for the offense; and (2) the individual has committed a gross misdemeanor-level  
 264.13 violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance);  
 264.14 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or  
 264.15 delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or  
 264.16 services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud);  
 264.17 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222  
 264.18 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth  
 264.19 degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault  
 264.20 in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243  
 264.21 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of  
 264.22 residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal  
 264.23 neglect of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);  
 264.24 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275  
 264.25 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in  
 264.26 prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378  
 264.27 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft);  
 264.28 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527  
 264.29 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);  
 264.30 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631  
 264.31 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72,  
 264.32 subdivision 3 (disorderly conduct against a vulnerable adult); ~~repeat offenses under 609.746~~  
 264.33 (~~interference with privacy~~); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining  
 264.34 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving  
 264.35 a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature,

265.1 distribution); 617.293 (harmful materials; dissemination and display to minors prohibited);  
265.2 or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under  
265.3 section 518B.01, subdivision 14.

265.4 (b) An individual is disqualified under section 245C.14 if less than ten years has passed  
265.5 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the  
265.6 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

265.7 (c) An individual is disqualified under section 245C.14 if less than ten years has passed  
265.8 since the discharge of the sentence imposed for an offense in any other state or country, the  
265.9 elements of which are substantially similar to the elements of any of the offenses listed in  
265.10 paragraph (a).

265.11 (d) If the individual studied commits one of the offenses listed in paragraph (a), but the  
265.12 sentence or level of offense is a misdemeanor disposition, the individual is disqualified but  
265.13 the disqualification lookback period for the offense is the period applicable to misdemeanors.

265.14 (e) When a disqualification is based on a judicial determination other than a conviction,  
265.15 the disqualification period begins from the date of the court order. When a disqualification  
265.16 is based on an admission, the disqualification period begins from the date of an admission  
265.17 in court. When a disqualification is based on an Alford Plea, the disqualification period  
265.18 begins from the date the Alford Plea is entered in court. When a disqualification is based  
265.19 on a preponderance of evidence of a disqualifying act, the disqualification date begins from  
265.20 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for  
265.21 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

265.22 Sec. 22. Minnesota Statutes 2022, section 245C.15, subdivision 4, is amended to read:

265.23 Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section  
265.24 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed,  
265.25 if any, for the offense; and (2) the individual has committed a misdemeanor-level violation  
265.26 of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425  
265.27 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency);  
265.28 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182  
265.29 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,  
265.30 or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree);  
265.31 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231  
265.32 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic  
265.33 assault); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report  
265.34 maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree);

266.1 609.27 (coercion); violation of an order for protection under 609.3232 (protective order  
266.2 authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft);  
266.3 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527  
266.4 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);  
266.5 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746  
266.6 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter,  
266.7 telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821  
266.8 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293  
266.9 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes  
266.10 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic  
266.11 Abuse Act).

266.12 (b) An individual is disqualified under section 245C.14 if less than seven years has  
266.13 passed since a determination or disposition of the individual's:

266.14 (1) failure to make required reports under section 260E.06 or 626.557, subdivision 3,  
266.15 for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was  
266.16 substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

266.17 (2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a  
266.18 vulnerable adult under section 626.557, or serious or recurring maltreatment in any other  
266.19 state, the elements of which are substantially similar to the elements of maltreatment under  
266.20 section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that  
266.21 the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

266.22 (c) An individual is disqualified under section 245C.14 if less than seven years has  
266.23 passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of  
266.24 the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota  
266.25 Statutes.

266.26 (d) An individual is disqualified under section 245C.14 if less than seven years has  
266.27 passed since the discharge of the sentence imposed for an offense in any other state or  
266.28 country, the elements of which are substantially similar to the elements of any of the offenses  
266.29 listed in paragraphs (a) and (b).

266.30 (e) When a disqualification is based on a judicial determination other than a conviction,  
266.31 the disqualification period begins from the date of the court order. When a disqualification  
266.32 is based on an admission, the disqualification period begins from the date of an admission  
266.33 in court. When a disqualification is based on an Alford Plea, the disqualification period  
266.34 begins from the date the Alford Plea is entered in court. When a disqualification is based

267.1 on a preponderance of evidence of a disqualifying act, the disqualification date begins from  
267.2 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for  
267.3 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

267.4 (f) An individual is disqualified under section 245C.14 if less than seven years has passed  
267.5 since the individual was disqualified under section 256.98, subdivision 8.

267.6 Sec. 23. Minnesota Statutes 2023 Supplement, section 245C.15, subdivision 4a, is amended  
267.7 to read:

267.8 Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding  
267.9 subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting,  
267.10 regardless of how much time has passed, an individual is disqualified under section 245C.14  
267.11 if the individual committed an act that resulted in a felony-level conviction for sections:  
267.12 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder  
267.13 in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in  
267.14 the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first  
267.15 degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse);  
267.16 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense  
267.17 under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or  
267.18 neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325  
267.19 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245  
267.20 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree);  
267.21 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child  
267.22 in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663  
267.23 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child  
267.24 in the first degree); 609.2665 (manslaughter of an unborn child in the second degree);  
267.25 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child  
267.26 in the second degree); 609.268 (injury or death of an unborn child in the commission of a  
267.27 crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex  
267.28 trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in,  
267.29 hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct  
267.30 in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal  
267.31 sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree);  
267.32 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory  
267.33 conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual  
267.34 conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of  
267.35 a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first

268.1 degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of  
268.2 minors in sexual performance prohibited); or 617.247 (possession of pictorial representations  
268.3 of minors).

268.4 (b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated  
268.5 with a licensed family foster setting, an individual is disqualified under section 245C.14,  
268.6 regardless of how much time has passed, if the individual:

268.7 (1) committed an action under paragraph (e) that resulted in death or involved sexual  
268.8 abuse, as defined in section 260E.03, subdivision 20;

268.9 (2) committed an act that resulted in a gross misdemeanor-level conviction for section  
268.10 609.3451 (criminal sexual conduct in the fifth degree);

268.11 (3) committed an act against or involving a minor that resulted in a felony-level conviction  
268.12 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the  
268.13 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);  
268.14 or

268.15 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level  
268.16 conviction for section 617.293 (dissemination and display of harmful materials to minors).

268.17 (c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed  
268.18 family foster setting, an individual is disqualified under section 245C.14 if fewer than 20  
268.19 years have passed since the termination of the individual's parental rights under section  
268.20 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of  
268.21 parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to  
268.22 involuntarily terminate parental rights. An individual is disqualified under section 245C.14  
268.23 if fewer than 20 years have passed since the termination of the individual's parental rights  
268.24 in any other state or country, where the conditions for the individual's termination of parental  
268.25 rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph  
268.26 (b).

268.27 (d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed  
268.28 family foster setting, an individual is disqualified under section 245C.14 if fewer than five  
268.29 years have passed since a felony-level violation for sections: 152.021 (controlled substance  
268.30 crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023  
268.31 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the  
268.32 fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing  
268.33 controlled substances across state borders); 152.0262, subdivision 1, paragraph (b)  
268.34 (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision

269.1 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies  
269.2 prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia;  
269.3 prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related  
269.4 crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while  
269.5 impaired); 243.166 (violation of predatory offender registration requirements); 609.2113  
269.6 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn  
269.7 child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal  
269.8 abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal  
269.9 neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery);  
269.10 609.247, subdivision 4 (carjacking in the third degree); 609.322, subdivision 1a (solicitation,  
269.11 inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498,  
269.12 subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b  
269.13 (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563  
269.14 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66  
269.15 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749,  
269.16 subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting  
269.17 at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

269.18 (e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a  
269.19 background study affiliated with a licensed family child foster care license, an individual  
269.20 is disqualified under section 245C.14 if fewer than five years have passed since:

269.21 (1) a felony-level violation for an act not against or involving a minor that constitutes:  
269.22 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third  
269.23 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the  
269.24 fifth degree);

269.25 (2) a violation of an order for protection under section 518B.01, subdivision 14;

269.26 (3) a determination or disposition of the individual's failure to make required reports  
269.27 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition  
269.28 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment  
269.29 was recurring or serious;

269.30 (4) a determination or disposition of the individual's substantiated serious or recurring  
269.31 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or  
269.32 serious or recurring maltreatment in any other state, the elements of which are substantially  
269.33 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet  
269.34 the definition of serious maltreatment or recurring maltreatment;

270.1 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in  
270.2 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);  
270.3 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);  
270.4 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

270.5 (6) committing an act against or involving a minor that resulted in a misdemeanor-level  
270.6 violation of section 609.224, subdivision 1 (assault in the fifth degree).

270.7 (f) For purposes of this subdivision, the disqualification begins from:

270.8 (1) the date of the alleged violation, if the individual was not convicted;

270.9 (2) the date of conviction, if the individual was convicted of the violation but not  
270.10 committed to the custody of the commissioner of corrections; or

270.11 (3) the date of release from prison, if the individual was convicted of the violation and  
270.12 committed to the custody of the commissioner of corrections.

270.13 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation  
270.14 of the individual's supervised release, the disqualification begins from the date of release  
270.15 from the subsequent incarceration.

270.16 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the  
270.17 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota  
270.18 Statutes, permanently disqualifies the individual under section 245C.14. An individual is  
270.19 disqualified under section 245C.14 if fewer than five years have passed since the individual's  
270.20 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs  
270.21 (d) and (e).

270.22 (h) An individual's offense in any other state or country, where the elements of the  
270.23 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),  
270.24 permanently disqualifies the individual under section 245C.14. An individual is disqualified  
270.25 under section 245C.14 if fewer than five years have passed since an offense in any other  
270.26 state or country, the elements of which are substantially similar to the elements of any  
270.27 offense listed in paragraphs (d) and (e).

270.28 Sec. 24. Minnesota Statutes 2022, section 245C.22, subdivision 4, is amended to read:

270.29 Subd. 4. **Risk of harm; set aside.** (a) The commissioner may set aside the disqualification  
270.30 if the commissioner finds that the individual has submitted sufficient information to  
270.31 demonstrate that the individual does not pose a risk of harm to any person served by the  
270.32 applicant, license holder, or other entities as provided in this chapter.

271.1 (b) In determining whether the individual has met the burden of proof by demonstrating  
271.2 the individual does not pose a risk of harm, the commissioner shall consider:

271.3 (1) the nature, severity, and consequences of the event or events that led to the  
271.4 disqualification;

271.5 (2) whether there is more than one disqualifying event;

271.6 (3) the age and vulnerability of the victim at the time of the event;

271.7 (4) the harm suffered by the victim;

271.8 (5) vulnerability of persons served by the program;

271.9 (6) the similarity between the victim and persons served by the program;

271.10 (7) the time elapsed without a repeat of the same or similar event;

271.11 (8) documentation of successful completion by the individual studied of training or  
271.12 rehabilitation pertinent to the event; and

271.13 (9) any other information relevant to reconsideration.

271.14 (c) For an individual seeking a child foster care license who is a relative of the child,  
271.15 the commissioner shall consider the importance of maintaining the child's relationship with  
271.16 relatives as an additional significant factor in determining whether a background study  
271.17 disqualification should be set aside.

271.18 ~~(e)~~ (d) If the individual requested reconsideration on the basis that the information relied  
271.19 upon to disqualify the individual was incorrect or inaccurate and the commissioner determines  
271.20 that the information relied upon to disqualify the individual is correct, the commissioner  
271.21 must also determine if the individual poses a risk of harm to persons receiving services in  
271.22 accordance with paragraph (b).

271.23 ~~(d)~~ (e) For an individual seeking employment in the substance use disorder treatment  
271.24 field, the commissioner shall set aside the disqualification if the following criteria are met:

271.25 (1) the individual is not disqualified for a crime of violence as listed under section  
271.26 624.712, subdivision 5, except for the following crimes: crimes listed under section 152.021,  
271.27 subdivision 2 or 2a; 152.022, subdivision 2; 152.023, subdivision 2; 152.024; or 152.025;

271.28 (2) the individual is not disqualified under section 245C.15, subdivision 1;

271.29 (3) the individual is not disqualified under section 245C.15, subdivision 4, paragraph  
271.30 (b);

272.1 (4) the individual provided documentation of successful completion of treatment, at least  
272.2 one year prior to the date of the request for reconsideration, at a program licensed under  
272.3 chapter 245G, and has had no disqualifying crimes or conduct under section 245C.15 after  
272.4 the successful completion of treatment;

272.5 (5) the individual provided documentation demonstrating abstinence from controlled  
272.6 substances, as defined in section 152.01, subdivision 4, for the period of one year prior to  
272.7 the date of the request for reconsideration; and

272.8 (6) the individual is seeking employment in the substance use disorder treatment field.

272.9 Sec. 25. Minnesota Statutes 2022, section 245C.24, subdivision 2, is amended to read:

272.10 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in  
272.11 paragraphs (b) to ~~(f)~~ (g), the commissioner may not set aside the disqualification of any  
272.12 individual disqualified pursuant to this chapter, regardless of how much time has passed,  
272.13 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision  
272.14 1.

272.15 (b) For an individual in the substance use disorder or corrections field who was  
272.16 disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose  
272.17 disqualification was set aside prior to July 1, 2005, the commissioner must consider granting  
272.18 a variance pursuant to section 245C.30 for the license holder for a program dealing primarily  
272.19 with adults. A request for reconsideration evaluated under this paragraph must include a  
272.20 letter of recommendation from the license holder that was subject to the prior set-aside  
272.21 decision addressing the individual's quality of care to children or vulnerable adults and the  
272.22 circumstances of the individual's departure from that service.

272.23 (c) If an individual who requires a background study for nonemergency medical  
272.24 transportation services under section 245C.03, subdivision 12, was disqualified for a crime  
272.25 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have  
272.26 passed since the discharge of the sentence imposed, the commissioner may consider granting  
272.27 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this  
272.28 paragraph must include a letter of recommendation from the employer. This paragraph does  
272.29 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to  
272.30 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,  
272.31 clause (1); 617.246; or 617.247.

272.32 (d) When a licensed foster care provider adopts an individual who had received foster  
272.33 care services from the provider for over six months, and the adopted individual is required

273.1 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause  
273.2 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30  
273.3 to permit the adopted individual with a permanent disqualification to remain affiliated with  
273.4 the license holder under the conditions of the variance when the variance is recommended  
273.5 by the county of responsibility for each of the remaining individuals in placement in the  
273.6 home and the licensing agency for the home.

273.7 (e) For an individual 18 years of age or older affiliated with a licensed family foster  
273.8 setting, the commissioner must not set aside or grant a variance for the disqualification of  
273.9 any individual disqualified pursuant to this chapter, regardless of how much time has passed,  
273.10 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision  
273.11 4a, paragraphs (a) and (b).

273.12 (f) In connection with a family foster setting license, the commissioner may grant a  
273.13 variance to the disqualification for an individual who is under 18 years of age at the time  
273.14 the background study is submitted.

273.15 (g) In connection with foster residence settings and children's residential facilities, the  
273.16 commissioner must not set aside or grant a variance for the disqualification of any individual  
273.17 disqualified pursuant to this chapter, regardless of how much time has passed, if the individual  
273.18 was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph  
273.19 (a) or (b).

273.20 Sec. 26. Minnesota Statutes 2022, section 245C.24, subdivision 5, is amended to read:

273.21 Subd. 5. **Five-year bar to set aside or variance disqualification; children's residential**  
273.22 **facilities, foster residence settings.** The commissioner shall not set aside or grant a variance  
273.23 for the disqualification of an individual in connection with a license for a children's residential  
273.24 facility or foster residence setting who was convicted of a felony within the past five years  
273.25 for: (1) physical assault or battery; or (2) a drug-related offense.

273.26 Sec. 27. Minnesota Statutes 2022, section 245C.30, is amended by adding a subdivision  
273.27 to read:

273.28 Subd. 1b. **Child foster care variances.** For an individual seeking a child foster care  
273.29 license who is a relative of the child, the commissioner shall consider the importance of  
273.30 maintaining the child's relationship with relatives as an additional significant factor in  
273.31 determining whether the individual should be granted a variance.

274.1 Sec. 28. Minnesota Statutes 2022, section 245F.09, subdivision 2, is amended to read:

274.2 Subd. 2. **Protective procedures plan.** A license holder must have a written policy and  
274.3 procedure that establishes the protective procedures that program staff must follow when  
274.4 a patient is in imminent danger of harming self or others. The policy must be appropriate  
274.5 to the type of facility and the level of staff training. The protective procedures policy must  
274.6 include:

274.7 (1) an approval signed and dated by the program director and medical director prior to  
274.8 implementation. Any changes to the policy must also be approved, signed, and dated by the  
274.9 current program director and the medical director prior to implementation;

274.10 (2) which protective procedures the license holder will use to prevent patients from  
274.11 imminent danger of harming self or others;

274.12 (3) the emergency conditions under which the protective procedures are permitted to be  
274.13 used, if any;

274.14 (4) the patient's health conditions that limit the specific procedures that may be used and  
274.15 alternative means of ensuring safety;

274.16 (5) emergency resources the program staff must contact when a patient's behavior cannot  
274.17 be controlled by the procedures established in the policy;

274.18 (6) the training that staff must have before using any protective procedure;

274.19 (7) documentation of approved therapeutic holds;

274.20 (8) the use of law enforcement personnel as described in subdivision 4;

274.21 (9) standards governing emergency use of seclusion. Seclusion must be used only when  
274.22 less restrictive measures are ineffective or not feasible. The standards in items (i) to (vii)  
274.23 must be met when seclusion is used with a patient:

274.24 (i) seclusion must be employed solely for the purpose of preventing a patient from  
274.25 imminent danger of harming self or others;

274.26 (ii) seclusion rooms must be equipped in a manner that prevents patients from self-harm  
274.27 using projections, windows, electrical fixtures, or hard objects, and must allow the patient  
274.28 to be readily observed without being interrupted;

274.29 (iii) seclusion must be authorized by the program director, a licensed physician, a  
274.30 registered nurse, or a licensed physician assistant. If one of these individuals is not present  
274.31 in the facility, the program director or a licensed physician, registered nurse, or physician

275.1 assistant must be contacted and authorization must be obtained within 30 minutes of initiating  
275.2 seclusion, according to written policies;

275.3 (iv) patients must not be placed in seclusion for more than 12 hours at any one time;

275.4 (v) once the condition of a patient in seclusion has been determined to be safe enough  
275.5 to end continuous observation, a patient in seclusion must be observed at a minimum of  
275.6 every 15 minutes for the duration of seclusion and must always be within hearing range of  
275.7 program staff;

275.8 (vi) a process for program staff to use to remove a patient to other resources available  
275.9 to the facility if seclusion does not sufficiently assure patient safety; and

275.10 (vii) a seclusion area may be used for other purposes, such as intensive observation, if  
275.11 the room meets normal standards of care for the purpose and if the room is not locked; and

275.12 (10) physical holds may only be used when less restrictive measures are not feasible.

275.13 The standards in items (i) to (iv) must be met when physical holds are used with a patient:

275.14 (i) physical holds must be employed solely for preventing a patient from imminent  
275.15 danger of harming self or others;

275.16 (ii) physical holds must be authorized by the program director, a licensed physician, a  
275.17 registered nurse, or a physician assistant. If one of these individuals is not present in the  
275.18 facility, the program director or a licensed physician, registered nurse, or physician assistant  
275.19 must be contacted and authorization must be obtained within 30 minutes of initiating a  
275.20 physical hold, according to written policies;

275.21 (iii) the patient's health concerns must be considered in deciding whether to use physical  
275.22 holds and which holds are appropriate for the patient; and

275.23 (iv) only approved holds may be utilized. Prone and contraindicated holds are not allowed  
275.24 according to section 245A.211 and must not be authorized.

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

275.26 Sec. 29. Minnesota Statutes 2022, section 245F.14, is amended by adding a subdivision  
275.27 to read:

275.28 **Subd. 8. Notification to commissioner of changes in key staff positions.** A license  
275.29 holder must notify the commissioner within five business days of a change or vacancy in a  
275.30 key staff position. The key positions are a program director as required by subdivision 1, a  
275.31 registered nurse as required by subdivision 4, and a medical director as required by  
275.32 subdivision 5. The license holder must notify the commissioner of the staffing change on

276.1 a form approved by the commissioner and include the name of the staff person now assigned  
276.2 to the key staff position and the staff person's qualifications for the position. The license  
276.3 holder must notify the program licensor of a vacancy to discuss how the duties of the key  
276.4 staff position will be fulfilled during the vacancy.

276.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

276.6 Sec. 30. Minnesota Statutes 2022, section 245F.17, is amended to read:

276.7 **245F.17 PERSONNEL FILES.**

276.8 A license holder must maintain a separate personnel file for each staff member. At a  
276.9 minimum, the file must contain:

276.10 (1) a completed application for employment signed by the staff member that contains  
276.11 the staff member's qualifications for employment and documentation related to the applicant's  
276.12 background study data, as defined in chapter 245C;

276.13 (2) documentation of the staff member's current professional license or registration, if  
276.14 relevant;

276.15 (3) documentation of orientation and subsequent training; and

276.16 (4) ~~documentation of a statement of freedom from substance use problems; and~~

276.17 ~~(5) an annual job performance evaluation.~~

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

276.19 Sec. 31. Minnesota Statutes 2022, section 245G.07, subdivision 4, is amended to read:

276.20 Subd. 4. **Location of service provision.** ~~The license holder may provide services at any~~  
276.21 ~~of the license holder's licensed locations or at another suitable location including a school,~~  
276.22 ~~government building, medical or behavioral health facility, or social service organization,~~  
276.23 ~~upon notification and approval of the commissioner. If services are provided off site from~~  
276.24 ~~the licensed site, the reason for the provision of services remotely must be documented.~~  
276.25 ~~The license holder may provide additional services under subdivision 2, clauses (2) to (5),~~  
276.26 ~~off site if the license holder includes a policy and procedure detailing the off-site location~~  
276.27 ~~as a part of the treatment service description and the program abuse prevention plan.~~

276.28 (a) The license holder must provide all treatment services a client receives at one of the  
276.29 license holder's substance use disorder treatment licensed locations or at a location allowed  
276.30 under paragraphs (b) to (f). If the services are provided at the locations in paragraphs (b) to  
276.31 (d), the license holder must document in the client record the location services were provided.

277.1 (b) The license holder may provide nonresidential individual treatment services at a  
277.2 client's home or place of residence.

277.3 (c) If the license holder provides treatment services by telehealth, the services must be  
277.4 provided according to this paragraph:

277.5 (1) the license holder must maintain a licensed physical location in Minnesota where  
277.6 the license holder must offer all treatment services in subdivision 1, paragraph (a), clauses  
277.7 (1) to (4), physically in-person to each client;

277.8 (2) the license holder must meet all requirements for the provision of telehealth in sections  
277.9 254B.05, subdivision 5, paragraph (f), and 256B.0625, subdivision 3b. The license holder  
277.10 must document all items in section 256B.0625, subdivision 3b, paragraph (c), for each client  
277.11 receiving services by telehealth, regardless of payment type or whether the client is a medical  
277.12 assistance enrollee;

277.13 (3) the license holder may provide treatment services by telehealth to clients individually;

277.14 (4) the license holder may provide treatment services by telehealth to a group of clients  
277.15 that are each in a separate physical location;

277.16 (5) the license holder must not provide treatment services remotely by telehealth to a  
277.17 group of clients meeting together in person, unless permitted under clause (7);

277.18 (6) clients and staff may join an in-person group by telehealth if a staff member qualified  
277.19 to provide the treatment service is physically present with the group of clients meeting  
277.20 together in person; and

277.21 (7) the qualified professional providing a residential group treatment service by telehealth  
277.22 must be physically present on-site at the licensed residential location while the service is  
277.23 being provided. If weather conditions or short-term illness prohibit a qualified professional  
277.24 from traveling to the residential program and another qualified professional is not available  
277.25 to provide the service, a qualified professional may provide a residential group treatment  
277.26 service by telehealth from a location away from the licensed residential location. In such  
277.27 circumstances, the license holder must ensure that a qualified professional does not provide  
277.28 a residential group treatment service by telehealth from a location away from the licensed  
277.29 residential location for more than one day at a time, must ensure that a staff person who  
277.30 qualifies as a paraprofessional is physically present with the group of clients, and must  
277.31 document the reason for providing the remote telehealth service in the records of clients  
277.32 receiving the service. The license holder must document the dates that residential group  
277.33 treatment services were provided by telehealth from a location away from the licensed

278.1 residential location in a central log and must provide the log to the commissioner upon  
278.2 request.

278.3 (d) The license holder may provide the additional treatment services under subdivision  
278.4 2, clauses (2) to (6) and (8), away from the licensed location at a suitable location appropriate  
278.5 to the treatment service.

278.6 (e) Upon written approval from the commissioner for each satellite location, the license  
278.7 holder may provide nonresidential treatment services at satellite locations that are in a  
278.8 school, jail, or nursing home. A satellite location may only provide services to students of  
278.9 the school, inmates of the jail, or residents of the nursing home. Schools, jails, and nursing  
278.10 homes are exempt from the licensing requirements in section 245A.04, subdivision 2a, to  
278.11 document compliance with building codes, fire and safety codes, health rules, and zoning  
278.12 ordinances.

278.13 (f) The commissioner may approve other suitable locations as satellite locations for  
278.14 nonresidential treatment services. The commissioner may require satellite locations under  
278.15 this paragraph to meet all applicable licensing requirements. The license holder may not  
278.16 have more than two satellite locations per license under this paragraph.

278.17 (g) The license holder must provide the commissioner access to all files, documentation,  
278.18 staff persons, and any other information the commissioner requires at the main licensed  
278.19 location for all clients served at any location under paragraphs (b) to (f).

278.20 (h) Notwithstanding sections 245A.65, subdivision 2, and 626.557, subdivision 14, a  
278.21 program abuse prevention plan is not required for satellite or other locations under paragraphs  
278.22 (b) to (e). An individual abuse prevention plan is still required for any client that is a  
278.23 vulnerable adult as defined in section 626.5572, subdivision 21.

278.24 **EFFECTIVE DATE.** This section is effective January 1, 2025.

278.25 Sec. 32. Minnesota Statutes 2022, section 245G.08, subdivision 5, is amended to read:

278.26 **Subd. 5. Administration of medication and assistance with self-medication.** (a) A  
278.27 license holder must meet the requirements in this subdivision if a service provided includes  
278.28 the administration of medication.

278.29 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a  
278.30 licensed practitioner or a registered nurse the task of administration of medication or assisting  
278.31 with self-medication, must:

279.1 (1) successfully complete a medication administration training program for unlicensed  
279.2 personnel through an accredited Minnesota postsecondary educational institution. A staff  
279.3 member's completion of the course must be documented in writing and placed in the staff  
279.4 member's personnel file;

279.5 (2) be trained according to a formalized training program that is taught by a registered  
279.6 nurse and offered by the license holder. ~~The training must include the process for~~  
279.7 ~~administration of naloxone, if naloxone is kept on site.~~ A staff member's completion of the  
279.8 training must be documented in writing and placed in the staff member's personnel records;  
279.9 or

279.10 (3) demonstrate to a registered nurse competency to perform the delegated activity. A  
279.11 registered nurse must be employed or contracted to develop the policies and procedures for  
279.12 administration of medication or assisting with self-administration of medication, or both.

279.13 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision  
279.14 23. The registered nurse's supervision must include, at a minimum, monthly on-site  
279.15 supervision or more often if warranted by a client's health needs. The policies and procedures  
279.16 must include:

279.17 (1) a provision that a delegation of administration of medication is limited to a method  
279.18 a staff member has been trained to administer and limited to:

279.19 (i) a medication that is administered orally, topically, or as a suppository, an eye drop,  
279.20 an ear drop, an inhalant, or an intranasal; and

279.21 (ii) an intramuscular injection of ~~naloxone~~ an opiate antagonist as defined in section  
279.22 604A.04, subdivision 1, or epinephrine;

279.23 (2) a provision that each client's file must include documentation indicating whether  
279.24 staff must conduct the administration of medication or the client must self-administer  
279.25 medication, or both;

279.26 (3) a provision that a client may carry emergency medication such as nitroglycerin as  
279.27 instructed by the client's physician, advanced practice registered nurse, or physician assistant;

279.28 (4) a provision for the client to self-administer medication when a client is scheduled to  
279.29 be away from the facility;

279.30 (5) a provision that if a client self-administers medication when the client is present in  
279.31 the facility, the client must self-administer medication under the observation of a trained  
279.32 staff member;

280.1 (6) a provision that when a license holder serves a client who is a parent with a child,  
280.2 the parent may only administer medication to the child under a staff member's supervision;

280.3 (7) requirements for recording the client's use of medication, including staff signatures  
280.4 with date and time;

280.5 (8) guidelines for when to inform a nurse of problems with self-administration of  
280.6 medication, including a client's failure to administer, refusal of a medication, adverse  
280.7 reaction, or error; and

280.8 (9) procedures for acceptance, documentation, and implementation of a prescription,  
280.9 whether written, verbal, telephonic, or electronic.

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

280.11 Sec. 33. Minnesota Statutes 2022, section 245G.08, subdivision 6, is amended to read:

280.12 Subd. 6. **Control of drugs.** A license holder must have and implement written policies  
280.13 and procedures developed by a registered nurse that contain:

280.14 (1) a requirement that each drug must be stored in a locked compartment. A Schedule  
280.15 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked  
280.16 compartment, permanently affixed to the physical plant or medication cart;

280.17 (2) a system which accounts for all scheduled drugs each shift;

280.18 (3) a procedure for recording the client's use of medication, including the signature of  
280.19 the staff member who completed the administration of the medication with the time and  
280.20 date;

280.21 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

280.22 (5) a statement that only authorized personnel are permitted access to the keys to a locked  
280.23 compartment;

280.24 (6) a statement that no legend drug supply for one client shall be given to another client;  
280.25 and

280.26 (7) a procedure for monitoring the available supply of ~~naloxone~~ an opiate antagonist as  
280.27 defined in section 604A.04, subdivision 1, on site; and replenishing the naloxone supply  
280.28 when needed, and destroying naloxone according to clause (4).

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

281.1 Sec. 34. Minnesota Statutes 2022, section 245G.10, is amended by adding a subdivision  
281.2 to read:

281.3 Subd. 6. Notification to commissioner of changes in key staff positions. A license  
281.4 holder must notify the commissioner within five business days of a change or vacancy in a  
281.5 key staff position. The key positions are a treatment director as required by subdivision 1,  
281.6 an alcohol and drug counselor supervisor as required by subdivision 2, and a registered  
281.7 nurse as required by section 245G.08, subdivision 5, paragraph (c). The license holder must  
281.8 notify the commissioner of the staffing change on a form approved by the commissioner  
281.9 and include the name of the staff person now assigned to the key staff position and the staff  
281.10 person's qualifications for the position. The license holder must notify the program licensor  
281.11 of a vacancy to discuss how the duties of the key staff position will be fulfilled during the  
281.12 vacancy.

281.13 **EFFECTIVE DATE.** This section is effective January 1, 2025.

281.14 Sec. 35. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 2, is amended  
281.15 to read:

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

281.18 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being  
281.19 diverted from intended use of the medication.

281.20 (c) "Guest dose" means administration of a medication used for the treatment of opioid  
281.21 addiction to a person who is not a client of the program that is administering or dispensing  
281.22 the medication.

281.23 (d) "Medical director" means a practitioner licensed to practice medicine in the  
281.24 jurisdiction that the opioid treatment program is located who assumes responsibility for  
281.25 administering all medical services performed by the program, either by performing the  
281.26 services directly or by delegating specific responsibility to a practitioner of the opioid  
281.27 treatment program.

281.28 (e) "Medication used for the treatment of opioid use disorder" means a medication  
281.29 approved by the Food and Drug Administration for the treatment of opioid use disorder.

281.30 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

281.31 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,  
281.32 title 42, section 8.12, and includes programs licensed under this chapter.

282.1 (h) "Practitioner" means a staff member holding a current, unrestricted license to practice  
282.2 medicine issued by the Board of Medical Practice or nursing issued by the Board of Nursing  
282.3 and is currently registered with the Drug Enforcement Administration to order or dispense  
282.4 controlled substances in Schedules II to V under the Controlled Substances Act, United  
282.5 States Code, title 21, part B, section 821. ~~Practitioner includes an advanced practice registered~~  
282.6 ~~nurse and physician assistant if the staff member receives a variance by the state opioid~~  
282.7 ~~treatment authority under section 254A.03 and the federal Substance Abuse and Mental~~  
282.8 ~~Health Services Administration.~~

282.9 (i) "Unsupervised use" or "take-home" means the use of a medication for the treatment  
282.10 of opioid use disorder dispensed for use by a client outside of the program setting.

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

282.12 Sec. 36. Minnesota Statutes 2022, section 245G.22, subdivision 6, is amended to read:

282.13 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of  
282.14 medication used for the treatment of opioid use disorder to the illicit market, medication  
282.15 dispensed to a client for unsupervised use shall be subject to the requirements of this  
282.16 subdivision. Any client in an opioid treatment program may receive ~~a single unsupervised~~  
282.17 ~~use dose for a day that the clinic is closed for business, including Sundays and state and~~  
282.18 ~~federal holidays~~ their individualized take-home doses as ordered for days that the clinic is  
282.19 closed for business, on one weekend day (e.g., Sunday) and state and federal holidays, no  
282.20 matter their length of time in treatment, as allowed under Code of Federal Regulations, title  
282.21 42, part 8.12 (i)(1).

282.22 (b) For take-home doses beyond those allowed by paragraph (a), a practitioner with  
282.23 authority to prescribe must review and document the criteria in this paragraph and paragraph  
282.24 (e) the Code of Federal Regulations, title 42, part 8.12 (i)(2), when determining whether  
282.25 dispensing medication for a client's unsupervised use is safe and it is appropriate to  
282.26 implement, increase, or extend the amount of time between visits to the program. The criteria  
282.27 are:

282.28 ~~(1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,~~  
282.29 ~~and alcohol;~~

282.30 ~~(2) regularity of program attendance;~~

282.31 ~~(3) absence of serious behavioral problems at the program;~~

282.32 ~~(4) absence of known recent criminal activity such as drug dealing;~~

283.1 ~~(5) stability of the client's home environment and social relationships;~~

283.2 ~~(6) length of time in comprehensive maintenance treatment;~~

283.3 ~~(7) reasonable assurance that unsupervised use medication will be safely stored within~~  
283.4 ~~the client's home; and~~

283.5 ~~(8) whether the rehabilitative benefit the client derived from decreasing the frequency~~  
283.6 ~~of program attendance outweighs the potential risks of diversion or unsupervised use.~~

283.7 (c) The determination, including the basis of the determination must be documented by  
283.8 a practitioner in the client's medical record.

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

283.10 Sec. 37. Minnesota Statutes 2022, section 245G.22, subdivision 7, is amended to read:

283.11 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a  
283.12 ~~medical director or prescribing practitioner assesses and, determines, and documents~~ that  
283.13 a client meets the criteria in subdivision 6 ~~and may be dispensed a medication used for the~~  
283.14 ~~treatment of opioid addiction, the restrictions in this subdivision must be followed when~~  
283.15 ~~the medication to be dispensed is methadone hydrochloride. The results of the assessment~~  
283.16 ~~must be contained in the client file. The number of unsupervised use medication doses per~~  
283.17 ~~week in paragraphs (b) to (d) is in addition to the number of unsupervised use medication~~  
283.18 ~~doses a client may receive for days the clinic is closed for business as allowed by subdivision~~  
283.19 ~~6, paragraph (a) and that a patient is safely able to manage unsupervised doses of methadone,~~  
283.20 the number of take-home doses the client receives must be limited by the number allowed  
283.21 by the Code of Federal Regulations, title 42, part 8.12 (i)(3).

283.22 ~~(b) During the first 90 days of treatment, the unsupervised use medication supply must~~  
283.23 ~~be limited to a maximum of a single dose each week and the client shall ingest all other~~  
283.24 ~~doses under direct supervision.~~

283.25 ~~(c) In the second 90 days of treatment, the unsupervised use medication supply must be~~  
283.26 ~~limited to two doses per week.~~

283.27 ~~(d) In the third 90 days of treatment, the unsupervised use medication supply must not~~  
283.28 ~~exceed three doses per week.~~

283.29 ~~(e) In the remaining months of the first year, a client may be given a maximum six-day~~  
283.30 ~~unsupervised use medication supply.~~

283.31 ~~(f) After one year of continuous treatment, a client may be given a maximum two-week~~  
283.32 ~~unsupervised use medication supply.~~

284.1 ~~(g) After two years of continuous treatment, a client may be given a maximum one-month~~  
284.2 ~~unsupervised use medication supply, but must make monthly visits to the program.~~

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

284.4 Sec. 38. Minnesota Statutes 2023 Supplement, section 245G.22, subdivision 17, is amended  
284.5 to read:

284.6 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the  
284.7 policies and procedures required in this subdivision.

284.8 (b) For a program that is not open every day of the year, the license holder must maintain  
284.9 a policy and procedure that covers requirements under section 245G.22, subdivisions 6 and  
284.10 7. Unsupervised use of medication used for the treatment of opioid use disorder for days  
284.11 that the program is closed for business, ~~including but not limited to Sundays~~ on one weekend  
284.12 day and state and federal holidays, must meet the requirements under section 245G.22,  
284.13 subdivisions 6 and 7.

284.14 (c) The license holder must maintain a policy and procedure that includes specific  
284.15 measures to reduce the possibility of diversion. The policy and procedure must:

284.16 (1) specifically identify and define the responsibilities of the medical and administrative  
284.17 staff for performing diversion control measures; and

284.18 (2) include a process for contacting no less than five percent of clients who have  
284.19 unsupervised use of medication, excluding clients approved solely under subdivision 6,  
284.20 paragraph (a), to require clients to physically return to the program each month. The system  
284.21 must require clients to return to the program within a stipulated time frame and turn in all  
284.22 unused medication containers related to opioid use disorder treatment. The license holder  
284.23 must document all related contacts on a central log and the outcome of the contact for each  
284.24 client in the client's record. The medical director must be informed of each outcome that  
284.25 results in a situation in which a possible diversion issue was identified.

284.26 (d) Medication used for the treatment of opioid use disorder must be ordered,  
284.27 administered, and dispensed according to applicable state and federal regulations and the  
284.28 standards set by applicable accreditation entities. If a medication order requires assessment  
284.29 by the person administering or dispensing the medication to determine the amount to be  
284.30 administered or dispensed, the assessment must be completed by an individual whose  
284.31 professional scope of practice permits an assessment. For the purposes of enforcement of  
284.32 this paragraph, the commissioner has the authority to monitor the person administering or  
284.33 dispensing the medication for compliance with state and federal regulations and the relevant

285.1 standards of the license holder's accreditation agency and may issue licensing actions  
285.2 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's  
285.3 determination of noncompliance.

285.4 (e) A counselor in an opioid treatment program must not supervise more than 50 clients.

285.5 (f) Notwithstanding paragraph (e), from July 1, 2023, to June 30, 2024, a counselor in  
285.6 an opioid treatment program may supervise up to 60 clients. The license holder may continue  
285.7 to serve a client who was receiving services at the program on June 30, 2024, at a counselor  
285.8 to client ratio of up to one to 60 and is not required to discharge any clients in order to return  
285.9 to the counselor to client ratio of one to 50. The license holder may not, however, serve a  
285.10 new client after June 30, 2024, unless the counselor who would supervise the new client is  
285.11 supervising fewer than 50 existing clients.

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

285.13 Sec. 39. Minnesota Statutes 2023 Supplement, section 256B.064, subdivision 4, is amended  
285.14 to read:

285.15 Subd. 4. **Notice.** (a) The department shall serve the notice required under subdivision 2  
285.16 ~~by certified mail at~~ using a signature-verified confirmed delivery method to the address  
285.17 submitted to the department by the individual or entity. Service is complete upon mailing.

285.18 (b) The department shall give notice in writing to a recipient placed in the Minnesota  
285.19 restricted recipient program under section 256B.0646 and Minnesota Rules, part 9505.2200.  
285.20 The department shall send the notice by first class mail to the recipient's current address on  
285.21 file with the department. A recipient placed in the Minnesota restricted recipient program  
285.22 may contest the placement by submitting a written request for a hearing to the department  
285.23 within 90 days of the notice being mailed.

285.24 Sec. 40. Minnesota Statutes 2022, section 256B.0757, subdivision 4a, is amended to read:

285.25 Subd. 4a. **Behavioral health home services provider requirements.** A behavioral  
285.26 health home services provider must:

285.27 (1) be an enrolled Minnesota Health Care Programs provider;

285.28 (2) provide a medical assistance covered primary care or behavioral health service;

285.29 (3) utilize an electronic health record;

285.30 (4) utilize an electronic patient registry that contains data elements required by the  
285.31 commissioner;

286.1 (5) demonstrate the organization's capacity to administer screenings approved by the  
286.2 commissioner for substance use disorder or alcohol and tobacco use;

286.3 (6) demonstrate the organization's capacity to refer an individual to resources appropriate  
286.4 to the individual's screening results;

286.5 (7) have policies and procedures to track referrals to ensure that the referral met the  
286.6 individual's needs;

286.7 (8) conduct a brief needs assessment when an individual begins receiving behavioral  
286.8 health home services. The brief needs assessment must be completed with input from the  
286.9 individual and the individual's identified supports. The brief needs assessment must address  
286.10 the individual's immediate safety and transportation needs and potential barriers to  
286.11 participating in behavioral health home services;

286.12 (9) conduct a health wellness assessment within 60 days after intake that contains all  
286.13 required elements identified by the commissioner;

286.14 (10) conduct a health action plan that contains all required elements identified by the  
286.15 commissioner. The plan must be completed within 90 days after intake and must be updated  
286.16 at least once every six months, or more frequently if significant changes to an individual's  
286.17 needs or goals occur;

286.18 (11) agree to cooperate with and participate in the state's monitoring and evaluation of  
286.19 behavioral health home services; and

286.20 (12) obtain the individual's ~~written~~ consent to begin receiving behavioral health home  
286.21 services using a form approved by the commissioner.

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

286.23 Sec. 41. Minnesota Statutes 2022, section 256B.0757, subdivision 4d, is amended to read:

286.24 Subd. 4d. **Behavioral health home services delivery standards.** (a) A behavioral health  
286.25 home services provider must meet the following service delivery standards:

286.26 (1) establish and maintain processes to support the coordination of an individual's primary  
286.27 care, behavioral health, and dental care;

286.28 (2) maintain a team-based model of care, including regular coordination and  
286.29 communication between behavioral health home services team members;

- 287.1 (3) use evidence-based practices that recognize and are tailored to the medical, social,  
287.2 economic, behavioral health, functional impairment, cultural, and environmental factors  
287.3 affecting the individual's health and health care choices;
- 287.4 (4) use person-centered planning practices to ensure the individual's health action plan  
287.5 accurately reflects the individual's preferences, goals, resources, and optimal outcomes for  
287.6 the individual and the individual's identified supports;
- 287.7 (5) use the patient registry to identify individuals and population subgroups requiring  
287.8 specific levels or types of care and provide or refer the individual to needed treatment,  
287.9 intervention, or services;
- 287.10 (6) ~~utilize the Department of Human Services Partner Portal to~~ identify past and current  
287.11 treatment or services and identify potential gaps in care using a tool approved by the  
287.12 commissioner;
- 287.13 (7) deliver services consistent with the standards for frequency and face-to-face contact  
287.14 required by the commissioner;
- 287.15 (8) ensure that a diagnostic assessment is completed for each individual receiving  
287.16 behavioral health home services within six months of the start of behavioral health home  
287.17 services;
- 287.18 (9) deliver services in locations and settings that meet the needs of the individual;
- 287.19 (10) provide a central point of contact to ensure that individuals and the individual's  
287.20 identified supports can successfully navigate the array of services that impact the individual's  
287.21 health and well-being;
- 287.22 (11) have capacity to assess an individual's readiness for change and the individual's  
287.23 capacity to integrate new health care or community supports into the individual's life;
- 287.24 (12) offer or facilitate the provision of wellness and prevention education on  
287.25 evidenced-based curriculums specific to the prevention and management of common chronic  
287.26 conditions;
- 287.27 (13) help an individual set up and prepare for medical, behavioral health, social service,  
287.28 or community support appointments, including accompanying the individual to appointments  
287.29 as appropriate, and providing follow-up with the individual after these appointments;
- 287.30 (14) offer or facilitate the provision of health coaching related to chronic disease  
287.31 management and how to navigate complex systems of care to the individual, the individual's  
287.32 family, and identified supports;

288.1 (15) connect an individual, the individual's family, and identified supports to appropriate  
288.2 support services that help the individual overcome access or service barriers, increase  
288.3 self-sufficiency skills, and improve overall health;

288.4 (16) provide effective referrals and timely access to services; and

288.5 (17) establish a continuous quality improvement process for providing behavioral health  
288.6 home services.

288.7 (b) The behavioral health home services provider must also create a plan, in partnership  
288.8 with the individual and the individual's identified supports, to support the individual after  
288.9 discharge from a hospital, residential treatment program, or other setting. The plan must  
288.10 include protocols for:

288.11 (1) maintaining contact between the behavioral health home services team member, the  
288.12 individual, and the individual's identified supports during and after discharge;

288.13 (2) linking the individual to new resources as needed;

288.14 (3) reestablishing the individual's existing services and community and social supports;  
288.15 and

288.16 (4) following up with appropriate entities to transfer or obtain the individual's service  
288.17 records as necessary for continued care.

288.18 (c) If the individual is enrolled in a managed care plan, a behavioral health home services  
288.19 provider must:

288.20 (1) notify the behavioral health home services contact designated by the managed care  
288.21 plan within 30 days of when the individual begins behavioral health home services; and

288.22 (2) adhere to the managed care plan communication and coordination requirements  
288.23 described in the behavioral health home services manual.

288.24 (d) Before terminating behavioral health home services, the behavioral health home  
288.25 services provider must:

288.26 (1) provide a 60-day notice of termination of behavioral health home services to all  
288.27 individuals receiving behavioral health home services, the commissioner, and managed care  
288.28 plans, if applicable; and

288.29 (2) refer individuals receiving behavioral health home services to a new behavioral  
288.30 health home services provider.

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

289.1 Sec. 42. Minnesota Statutes 2023 Supplement, section 256D.01, subdivision 1a, is amended  
289.2 to read:

289.3 Subd. 1a. **Standards.** (a) A principal objective in providing general assistance is to  
289.4 provide for single adults, childless couples, or children as defined in section 256D.02,  
289.5 subdivision 2b, ineligible for federal programs who are unable to provide for themselves.  
289.6 The minimum standard of assistance determines the total amount of the general assistance  
289.7 grant without separate standards for shelter, utilities, or other needs.

289.8 (b) The standard of assistance for an assistance unit consisting of a recipient who is  
289.9 childless and unmarried or living apart from children and spouse and who does not live with  
289.10 a parent or parents or a legal custodian, or consisting of a childless couple, is \$350 per month  
289.11 effective October 1, 2024, and must be adjusted by a percentage equal to the change in the  
289.12 consumer price index as of January 1 every year, beginning October 1, 2025.

289.13 (c) For an assistance unit consisting of a single adult who lives with a parent or parents,  
289.14 the general assistance standard of assistance is \$350 per month effective October 1, 2023,  
289.15 2024, and must be adjusted by a percentage equal to the change in the consumer price index  
289.16 as of January 1 every year, beginning October 1, 2025. Benefits received by a responsible  
289.17 relative of the assistance unit under the Supplemental Security Income program, a workers'  
289.18 compensation program, the Minnesota supplemental aid program, or any other program  
289.19 based on the responsible relative's disability, and any benefits received by a responsible  
289.20 relative of the assistance unit under the Social Security retirement program, may not be  
289.21 counted in the determination of eligibility or benefit level for the assistance unit. Except as  
289.22 provided below, the assistance unit is ineligible for general assistance if the available  
289.23 resources or the countable income of the assistance unit and the parent or parents with whom  
289.24 the assistance unit lives are such that a family consisting of the assistance unit's parent or  
289.25 parents, the parent or parents' other family members and the assistance unit as the only or  
289.26 additional minor child would be financially ineligible for general assistance. For the purposes  
289.27 of calculating the countable income of the assistance unit's parent or parents, the calculation  
289.28 methods must follow the provisions under section 256P.06.

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

289.30 Sec. 43. Minnesota Statutes 2022, section 256I.04, subdivision 2f, is amended to read:

289.31 Subd. 2f. **Required services.** (a) In ~~licensed and registered~~ authorized settings under  
289.32 subdivision 2a, providers shall ensure that participants have at a minimum:

289.33 (1) food preparation and service for three nutritional meals a day on site;

290.1 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;  
290.2 (3) housekeeping, including cleaning and lavatory supplies or service; and  
290.3 (4) maintenance and operation of the building and grounds, including heat, water, garbage  
290.4 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair  
290.5 and maintain equipment and facilities.

290.6 (b) In addition, when providers serve participants described in subdivision 1, paragraph  
290.7 (c), the providers are required to assist the participants in applying for continuing housing  
290.8 support payments before the end of the eligibility period.

290.9 Sec. 44. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 1a, is amended  
290.10 to read:

290.11 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,  
290.12 subdivision 3, the agency may negotiate a payment not to exceed \$494.91 for other services  
290.13 necessary to provide room and board if the residence is licensed by or registered by the  
290.14 Department of Health, or licensed by the Department of Human Services to provide services  
290.15 in addition to room and board, and if the provider of services is not also concurrently  
290.16 receiving funding for services for a recipient in the residence under the following programs  
290.17 or funding sources: (1) home and community-based waiver services under chapter 256S or  
290.18 section 256B.0913, 256B.092, or 256B.49; (2) personal care assistance under section  
290.19 256B.0659; (3) community first services and supports under section 256B.85; or (4) services  
290.20 for adults with mental illness grants under section 245.73. If funding is available for other  
290.21 necessary services through a home and community-based waiver under chapter 256S, or  
290.22 section 256B.0913, 256B.092, or 256B.49; personal care assistance services under section  
290.23 256B.0659; community first services and supports under section 256B.85; or services for  
290.24 adults with mental illness grants under section 245.73, then the housing support rate is  
290.25 limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case may  
290.26 the supplementary service rate exceed \$494.91. The registration and licensure requirement  
290.27 does not apply to establishments which are exempt from state licensure because they are  
290.28 located on Indian reservations and for which the tribe has prescribed health and safety  
290.29 requirements. Service payments under this section may be prohibited under rules to prevent  
290.30 the supplanting of federal funds with state funds.

290.31 ~~(b) The commissioner is authorized to make cost-neutral transfers from the housing~~  
290.32 ~~support fund for beds under this section to other funding programs administered by the~~  
290.33 ~~department after consultation with the agency in which the affected beds are located. The~~  
290.34 ~~commissioner may also make cost-neutral transfers from the housing support fund to agencies~~

291.1 ~~for beds permanently removed from the housing support census under a plan submitted by~~  
291.2 ~~the agency and approved by the commissioner. The commissioner shall report the amount~~  
291.3 ~~of any transfers under this provision annually to the legislature.~~

291.4 ~~(e)~~ (b) Agencies must not negotiate supplementary service rates with providers of housing  
291.5 support that are licensed as board and lodging with special services and that do not encourage  
291.6 a policy of sobriety on their premises and make referrals to available community services  
291.7 for volunteer and employment opportunities for residents.

291.8 Sec. 45. Minnesota Statutes 2023 Supplement, section 256I.05, subdivision 11, is amended  
291.9 to read:

291.10 Subd. 11. ~~Transfer of emergency shelter funds~~ Cost-neutral transfers from the  
291.11 housing support fund. (a) The commissioner is authorized to make cost-neutral transfers  
291.12 from the housing support fund for beds under this section to other funding programs  
291.13 administered by the department after consultation with the agency in which the affected  
291.14 beds are located.

291.15 (b) The commissioner may also make cost-neutral transfers from the housing support  
291.16 fund to agencies for beds removed from the housing support census under a plan submitted  
291.17 by the agency and approved by the commissioner.

291.18 ~~(a)~~ (c) The commissioner shall make a cost-neutral transfer of funding from the housing  
291.19 support fund to the agency for emergency shelter beds removed from the housing support  
291.20 census under a ~~biennial~~ plan submitted by the agency and approved by the commissioner.  
291.21 Plans submitted under this paragraph must include anticipated and actual outcomes for  
291.22 persons experiencing homelessness in emergency shelters.

291.23 ~~The plan~~ (d) Plans submitted under paragraph (b) or (c) must describe: (1) anticipated  
291.24 ~~and actual outcomes for persons experiencing homelessness in emergency shelters;~~ (2)  
291.25 improved efficiencies in administration; (3) (2) requirements for individual eligibility; and  
291.26 ~~(4) (3) plans for quality assurance monitoring and quality assurance outcomes. The~~  
291.27 commissioner shall review the agency plan plans to monitor implementation and outcomes  
291.28 at least biennially, and more frequently if the commissioner deems necessary.

291.29 ~~(b)~~ (e) Funding under paragraph ~~(a)~~ (b), (c), or (d) may be used for the provision  
291.30 of room and board or supplemental services according to section 256I.03, subdivisions 14a  
291.31 and 14b. Providers must meet the requirements of section 256I.04, subdivisions 2a to 2f.  
291.32 Funding must be allocated annually, and the room and board portion of the allocation shall  
291.33 be adjusted according to the percentage change in the housing support room and board rate.

292.1 ~~The room and board portion of the allocation shall be determined at the time of transfer.~~  
292.2 The commissioner or agency may return beds to the housing support fund with 180 days'  
292.3 notice, including financial reconciliation.

292.4 Sec. 46. Minnesota Statutes 2022, section 260E.33, subdivision 2, as amended by Laws  
292.5 2024, chapter 80, article 8, section 44, is amended to read:

292.6 Subd. 2. **Request for reconsideration.** (a) Except as provided under subdivision 5, an  
292.7 individual or facility that the commissioner of human services; commissioner of children,  
292.8 youth, and families; a local welfare agency; or the commissioner of education determines  
292.9 has maltreated a child, an interested person acting on behalf of the child, regardless of the  
292.10 determination, who contests the investigating agency's final determination regarding  
292.11 maltreatment may request the investigating agency to reconsider its final determination  
292.12 regarding maltreatment. The request for reconsideration must be submitted in writing or  
292.13 submitted in the provider licensing and reporting hub to the investigating agency within 15  
292.14 calendar days after receipt of notice of the final determination regarding maltreatment or,  
292.15 if the request is made by an interested person who is not entitled to notice, within 15 days  
292.16 after receipt of the notice by the parent or guardian of the child. If mailed, the request for  
292.17 reconsideration must be postmarked and sent to the investigating agency within 15 calendar  
292.18 days of the individual's or facility's receipt of the final determination. If the request for  
292.19 reconsideration is made by personal service, it must be received by the investigating agency  
292.20 within 15 calendar days after the individual's or facility's receipt of the final determination.  
292.21 Upon implementation of the provider licensing and reporting hub, the individual or facility  
292.22 must use the hub to request reconsideration. The reconsideration must be received by the  
292.23 commissioner within 15 calendar days of the individual's receipt of the notice of  
292.24 disqualification.

292.25 (b) An individual who was determined to have maltreated a child under this chapter and  
292.26 who was disqualified on the basis of serious or recurring maltreatment under sections  
292.27 245C.14 and 245C.15 may request reconsideration of the maltreatment determination and  
292.28 the disqualification. The request for reconsideration of the maltreatment determination and  
292.29 the disqualification must be submitted within 30 calendar days of the individual's receipt  
292.30 of the notice of disqualification under sections 245C.16 and 245C.17. If mailed, the request  
292.31 for reconsideration of the maltreatment determination and the disqualification must be  
292.32 postmarked and sent to the investigating agency within 30 calendar days of the individual's  
292.33 receipt of the maltreatment determination and notice of disqualification. If the request for  
292.34 reconsideration is made by personal service, it must be received by the investigating agency  
292.35 within 30 calendar days after the individual's receipt of the notice of disqualification.

293.1 Sec. 47. Laws 2024, chapter 80, article 2, section 6, subdivision 2, is amended to read:

293.2 Subd. 2. **Change in ownership.** (a) If the commissioner determines that there is a change  
293.3 in ownership, the commissioner shall require submission of a new license application. This  
293.4 subdivision does not apply to a licensed program or service located in a home where the  
293.5 license holder resides. A change in ownership occurs when:

293.6 (1) except as provided in paragraph (b), the license holder sells or transfers 100 percent  
293.7 of the property, stock, or assets;

293.8 (2) the license holder merges with another organization;

293.9 (3) the license holder consolidates with two or more organizations, resulting in the  
293.10 creation of a new organization;

293.11 (4) there is a change to the federal tax identification number associated with the license  
293.12 holder; or

293.13 (5) except as provided in paragraph (b), all controlling individuals ~~associated with~~ for  
293.14 the original ~~application~~ license have changed.

293.15 (b) ~~Notwithstanding~~ For changes under paragraph (a), clauses (1) and (5) clause (1) or  
293.16 (5), no change in ownership has occurred and a new license application is not required if  
293.17 at least one controlling individual has been ~~listed~~ affiliated as a controlling individual for  
293.18 the license for at least the previous 12 months immediately preceding the change.

293.19 **EFFECTIVE DATE.** This section is effective January 1, 2025.

293.20 Sec. 48. Laws 2024, chapter 80, article 2, section 6, subdivision 3, is amended to read:

293.21 Subd. 3. **Standard change of ownership process.** (a) When a change in ownership is  
293.22 proposed and the party intends to assume operation without an interruption in service longer  
293.23 than 60 days after acquiring the program or service, the license holder must provide the  
293.24 commissioner with written notice of the proposed change on a form provided by the  
293.25 commissioner at least ~~60~~ 90 days before the anticipated date of the change in ownership.  
293.26 For purposes of this ~~subdivision and subdivision 4~~ section, "party" means the party that  
293.27 intends to operate the service or program.

293.28 (b) The party must submit a license application under this chapter on the form and in  
293.29 the manner prescribed by the commissioner at least ~~30~~ 90 days before the change in  
293.30 ownership is anticipated to be complete and must include documentation to support the  
293.31 upcoming change. The party must comply with background study requirements under chapter  
293.32 245C and shall pay the application fee required under section 245A.10.

294.1 (c) The commissioner may streamline application procedures when the party is an existing  
294.2 license holder under this chapter and is acquiring a program licensed under this chapter or  
294.3 service in the same service class as one or more licensed programs or services the party  
294.4 operates and those licenses are in substantial compliance. For purposes of this subdivision,  
294.5 "substantial compliance" means within the previous 12 months the commissioner did not  
294.6 (1) issue a sanction under section 245A.07 against a license held by the party, or (2) make  
294.7 a license held by the party conditional according to section 245A.06.

294.8 (d) ~~Except when a temporary change in ownership license is issued pursuant to~~  
294.9 ~~subdivision 4~~ While the standard change of ownership process is pending, the existing  
294.10 license holder ~~is solely~~ remains responsible for operating the program according to applicable  
294.11 laws and rules until a license under this chapter is issued to the party.

294.12 (e) If a licensing inspection of the program or service was conducted within the previous  
294.13 12 months and the existing license holder's license record demonstrates substantial  
294.14 compliance with the applicable licensing requirements, the commissioner may waive the  
294.15 party's inspection required by section 245A.04, subdivision 4. The party must submit to the  
294.16 commissioner (1) proof that the premises was inspected by a fire marshal or that the fire  
294.17 marshal deemed that an inspection was not warranted, and (2) proof that the premises was  
294.18 inspected for compliance with the building code or that no inspection was deemed warranted.

294.19 (f) If the party is seeking a license for a program or service that has an outstanding action  
294.20 under section 245A.06 or 245A.07, the party must submit a letter as part of the application  
294.21 process identifying how the party has or will come into full compliance with the licensing  
294.22 requirements.

294.23 (g) The commissioner shall evaluate the party's application according to section 245A.04,  
294.24 subdivision 6. If the commissioner determines that the party has remedied or demonstrates  
294.25 the ability to remedy the outstanding actions under section 245A.06 or 245A.07 and has  
294.26 determined that the program otherwise complies with all applicable laws and rules, the  
294.27 commissioner shall issue a license or conditional license under this chapter. A conditional  
294.28 license issued under this section is final and not subject to reconsideration under section  
294.29 142B.16, subdivision 4. The conditional license remains in effect until the commissioner  
294.30 determines that the grounds for the action are corrected or no longer exist.

294.31 (h) The commissioner may deny an application as provided in section 245A.05. An  
294.32 applicant whose application was denied by the commissioner may appeal the denial according  
294.33 to section 245A.05.

295.1 (i) This subdivision does not apply to a licensed program or service located in a home  
295.2 where the license holder resides.

295.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

295.4 Sec. 49. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision  
295.5 to read:

295.6 **Subd. 3a. Emergency change in ownership process.** (a) In the event of a death of a  
295.7 license holder or sole controlling individual or a court order or other event that results in  
295.8 the license holder being inaccessible or unable to operate the program or service, a party  
295.9 may submit a request to the commissioner to allow the party to assume operation of the  
295.10 program or service under an emergency change in ownership process to ensure persons  
295.11 continue to receive services while the commissioner evaluates the party's license application.

295.12 (b) To request the emergency change of ownership process, the party must immediately:

295.13 (1) notify the commissioner of the event resulting in the inability of the license holder  
295.14 to operate the program and of the party's intent to assume operations; and

295.15 (2) provide the commissioner with documentation that demonstrates the party has a legal  
295.16 or legitimate ownership interest in the program or service if applicable and is able to operate  
295.17 the program or service.

295.18 (c) If the commissioner approves the party to continue operating the program or service  
295.19 under an emergency change in ownership process, the party must:

295.20 (1) request to be added as a controlling individual or license holder to the existing license;

295.21 (2) notify persons receiving services of the emergency change in ownership in a manner  
295.22 approved by the commissioner;

295.23 (3) submit an application for a new license within 30 days of approval;

295.24 (4) comply with the background study requirements under chapter 245C; and

295.25 (5) pay the application fee required under section 142B.12.

295.26 (d) While the emergency change of ownership process is pending, a party approved  
295.27 under this subdivision is responsible for operating the program under the existing license  
295.28 according to applicable laws and rules until a new license under this chapter is issued.

295.29 (e) The provisions in subdivision 3, paragraphs (c), (g), and (h), apply to this subdivision.

295.30 (f) Once a party is issued a new license or has decided not to seek a new license, the  
295.31 commissioner must close the existing license.

296.1 (g) This subdivision applies to any program or service licensed under this chapter.

296.2 **EFFECTIVE DATE.** This section is effective January 1, 2025.

296.3 Sec. 50. Laws 2024, chapter 80, article 2, section 6, is amended by adding a subdivision  
296.4 to read:

296.5 Subd. 5. **Failure to comply.** If the commissioner finds that the applicant or license holder  
296.6 has not fully complied with this section, the commissioner may impose a licensing sanction  
296.7 under section 142B.15, 142B.16, or 142B.18.

296.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

296.9 Sec. 51. Laws 2024, chapter 80, article 2, section 10, subdivision 1, is amended to read:

296.10 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional  
296.11 under section 142B.16, the commissioner may suspend or revoke the license, impose a fine,  
296.12 or secure an injunction against the continuing operation of the program of a license holder  
296.13 who:

296.14 (1) does not comply with applicable law or rule;

296.15 (2) has nondisqualifying background study information, as described in section 245C.05,  
296.16 subdivision 4, that reflects on the license holder's ability to safely provide care to foster  
296.17 children; or

296.18 (3) has an individual living in the household where the licensed services are provided  
296.19 or is otherwise subject to a background study, and the individual has nondisqualifying  
296.20 background study information, as described in section 245C.05, subdivision 4, that reflects  
296.21 on the license holder's ability to safely provide care to foster children.

296.22 When applying sanctions authorized under this section, the commissioner shall consider  
296.23 the nature, chronicity, or severity of the violation of law or rule and the effect of the violation  
296.24 on the health, safety, or rights of persons served by the program.

296.25 (b) If a license holder appeals the suspension or revocation of a license and the license  
296.26 holder continues to operate the program pending a final order on the appeal, the commissioner  
296.27 shall issue the license holder a temporary provisional license. Unless otherwise specified  
296.28 by the commissioner, variances in effect on the date of the license sanction under appeal  
296.29 continue under the temporary provisional license. The commissioner may include terms the  
296.30 license holder must follow pending a final order on the appeal. If a license holder fails to  
296.31 comply with applicable law or rule while operating under a temporary provisional license,

297.1 the commissioner may impose additional sanctions under this section and section 142B.16  
297.2 and may terminate any prior variance. If a temporary provisional license is set to expire, a  
297.3 new temporary provisional license shall be issued to the license holder upon payment of  
297.4 any fee required under section 142B.12. The temporary provisional license shall expire on  
297.5 the date the final order is issued. If the license holder prevails on the appeal, a new  
297.6 nonprovisional license shall be issued for the remainder of the current license period.

297.7 (c) If a license holder is under investigation and the license issued under this chapter is  
297.8 due to expire before completion of the investigation, the program shall be issued a new  
297.9 license upon completion of the reapplication requirements and payment of any applicable  
297.10 license fee. Upon completion of the investigation, a licensing sanction may be imposed  
297.11 against the new license under this section or section 142B.16 or 142B.20.

297.12 (d) Failure to reapply or closure of a license issued under this chapter by the license  
297.13 holder prior to the completion of any investigation shall not preclude the commissioner  
297.14 from issuing a licensing sanction under this section or section 142B.16 at the conclusion of  
297.15 the investigation.

297.16 **EFFECTIVE DATE.** This section is effective January 1, 2025.

297.17 Sec. 52. **REVISOR INSTRUCTION.**

297.18 The revisor of statutes shall renumber Minnesota Statutes, section 256D.21, as Minnesota  
297.19 Statutes, section 261.004.

297.20 Sec. 53. **REPEALER.**

297.21 (a) Minnesota Statutes 2022, sections 256D.19, subdivisions 1 and 2; 256D.20,  
297.22 subdivisions 1, 2, 3, and 4; and 256D.23, subdivisions 1, 2, and 3, are repealed.

297.23 (b) Minnesota Statutes 2022, section 245C.125, is repealed.

297.24 (c) Minnesota Statutes 2023 Supplement, section 245C.08, subdivision 2, is repealed.

297.25 (d) Laws 2024, chapter 80, article 2, section 6, subdivision 4, is repealed.

297.26 **EFFECTIVE DATE.** Paragraph (a) is effective the day following final enactment.

ARTICLE 10

OFFICE OF EMERGENCY MEDICAL SERVICES

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Section 1. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision to read:

Subd. 16. **Director.** "Director" means the director of the Office of Emergency Medical Services.

**EFFECTIVE DATE.** This section is effective January 1, 2025.

Sec. 2. Minnesota Statutes 2022, section 144E.001, is amended by adding a subdivision to read:

Subd. 17. **Office.** "Office" means the Office of Emergency Medical Services.

**EFFECTIVE DATE.** This section is effective January 1, 2025.

Sec. 3. **[144E.011] OFFICE OF EMERGENCY MEDICAL SERVICES.**

Subdivision 1. **Establishment.** The Office of Emergency Medical Services is established with the powers and duties established in law. In administering this chapter, the office must promote the public health and welfare, protect the safety of the public, and effectively regulate and support the operation of the emergency medical services system in this state.

Subd. 2. **Director.** The governor must appoint a director for the office with the advice and consent of the senate. The director must be in the unclassified service and must serve at the pleasure of the governor. The salary of the director shall be determined according to section 15A.0815. The director shall direct the activities of the office.

Subd. 3. **Powers and duties.** The director has the following powers and duties:

(1) to administer and enforce this chapter and adopt rules as needed to implement this chapter. Rules for which notice is published in the State Register before July 1, 2026, may be adopted using the expedited rulemaking process in section 14.389;

(2) to license ambulance services in the state and regulate their operation;

(3) to establish and modify primary service areas;

(4) to designate an ambulance service as authorized to provide service in a primary service area and to remove an ambulance service's authorization to provide service in a primary service area;

(5) to register medical response units in the state and regulate their operation;

299.1 (6) to certify emergency medical technicians, advanced emergency medical technicians,  
299.2 community emergency medical technicians, paramedics, and community paramedics and  
299.3 to register emergency medical responders;

299.4 (7) to approve education programs for ambulance service personnel and emergency  
299.5 medical responders and to administer qualifications for instructors of education programs;

299.6 (8) to administer grant programs related to emergency medical services;

299.7 (9) to report to the legislature, by February 15 each year, on the work of the office and  
299.8 the advisory councils in the previous calendar year and with recommendations for any  
299.9 needed policy changes related to emergency medical services, including but not limited to  
299.10 improving access to emergency medical services, improving service delivery by ambulance  
299.11 services and medical response units, and improving the effectiveness of the state's emergency  
299.12 medical services system. The director must develop the reports and recommendations in  
299.13 consultation with the office's deputy directors and advisory councils;

299.14 (10) to investigate complaints against and hold hearings regarding ambulance services,  
299.15 ambulance service personnel, and emergency medical responders and to impose disciplinary  
299.16 action or otherwise resolve complaints; and

299.17 (11) to perform other duties related to the provision of emergency medical services in  
299.18 the state.

299.19 Subd. 4. **Employees.** The director may employ personnel in the classified service and  
299.20 unclassified personnel as necessary to carry out the duties of this chapter.

299.21 Subd. 5. **Work plan.** The director must prepare a work plan to guide the work of the  
299.22 office. The work plan must be updated biennially.

299.23 **EFFECTIVE DATE.** This section is effective January 1, 2025.

299.24 Sec. 4. **[144E.015] MEDICAL SERVICES DIVISION.**

299.25 A Medical Services Division is created in the Office of Emergency Medical Services.  
299.26 The Medical Services Division shall be under the supervision of a deputy director of medical  
299.27 services appointed by the director. The deputy director of medical services must be a  
299.28 physician licensed under chapter 147. The deputy director, under the direction of the director,  
299.29 shall enforce and coordinate the laws, rules, and policies assigned by the director, which  
299.30 may include overseeing the clinical aspects of prehospital medical care and education  
299.31 programs for emergency medical service personnel.

299.32 **EFFECTIVE DATE.** This section is effective January 1, 2025.

300.1 **Sec. 5. [144E.016] AMBULANCE SERVICES DIVISION.**

300.2 An Ambulance Services Division is created in the Office of Emergency Medical Services.  
300.3 The Ambulance Services Division shall be under the supervision of a deputy director of  
300.4 ambulance services appointed by the director. The deputy director, under the direction of  
300.5 the director, shall enforce and coordinate the laws, rules, and policies assigned by the director,  
300.6 which may include operating standards and licensing of ambulance services; registration  
300.7 and operation of medical response units; establishment and modification of primary service  
300.8 areas; authorization of ambulance services to provide service in a primary service area and  
300.9 revocation of such authorization; coordination of ambulance services within regions and  
300.10 across the state; and administration of grants.

300.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

300.12 **Sec. 6. [144E.017] EMERGENCY MEDICAL SERVICE PROVIDERS DIVISION.**

300.13 An Emergency Medical Service Providers Division is created in the Office of Emergency  
300.14 Medical Services. The Emergency Medical Service Providers Division shall be under the  
300.15 supervision of a deputy director of emergency medical service providers appointed by the  
300.16 director. The deputy director, under the direction of the director, shall enforce and coordinate  
300.17 the laws, rules, and policies assigned by the director, which may include certification and  
300.18 registration of individual emergency medical service providers; overseeing worker safety,  
300.19 worker well-being, and working conditions; implementation of education programs; and  
300.20 administration of grants.

300.21 **EFFECTIVE DATE.** This section is effective January 1, 2025.

300.22 **Sec. 7. [144E.03] EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL.**

300.23 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Advisory  
300.24 Council is established and consists of the following members:

300.25 (1) one emergency medical technician currently practicing with a licensed ambulance  
300.26 service, appointed by the Minnesota Ambulance Association;

300.27 (2) one paramedic currently practicing with a licensed ambulance service or a medical  
300.28 response unit, appointed jointly by the Minnesota Professional Fire Fighters Association  
300.29 and the Minnesota Ambulance Association;

300.30 (3) one medical director of a licensed ambulance service, appointed by the National  
300.31 Association of EMS Physicians, Minnesota Chapter;

301.1 (4) one firefighter currently serving as an emergency medical responder, appointed by  
301.2 the Minnesota State Fire Chiefs Association;

301.3 (5) one registered nurse who is certified or currently practicing as a flight nurse, appointed  
301.4 jointly by the regional emergency services boards of the designated regional emergency  
301.5 medical services systems;

301.6 (6) one hospital administrator, appointed by the Minnesota Hospital Association;

301.7 (7) one social worker, appointed by the Board of Social Work;

301.8 (8) one member of a federally recognized Tribal Nation in Minnesota, appointed by the  
301.9 Minnesota Indian Affairs Council;

301.10 (9) three public members, appointed by the governor. At least one of the public members  
301.11 must reside outside the metropolitan counties listed in section 473.121, subdivision 4;

301.12 (10) one member with experience working as an employee organization representative  
301.13 representing emergency medical service providers, appointed by an employee organization  
301.14 representing emergency medical service providers;

301.15 (11) one member representing a local government, appointed by the Coalition of Greater  
301.16 Minnesota Cities;

301.17 (12) one member representing a local government in the seven-county metropolitan area,  
301.18 appointed by the League of Minnesota Cities;

301.19 (13) two members of the house of representatives and two members of the senate,  
301.20 appointed according to subdivision 2; and

301.21 (14) the commissioner of health and commissioner of public safety or their designees  
301.22 as ex officio members.

301.23 Subd. 2. **Legislative members.** The speaker of the house and the house minority leader  
301.24 must each appoint one member of the house of representatives to serve on the advisory  
301.25 council. The senate majority leader and the senate minority leader must each appoint one  
301.26 member of the senate to serve on the advisory council. Legislative members appointed under  
301.27 this subdivision serve until successors are appointed. Legislative members may receive per  
301.28 diem compensation and reimbursement for expenses according to the rules of their respective  
301.29 bodies.

301.30 Subd. 3. **Terms, compensation, removal, vacancies, and expiration.** Compensation  
301.31 and reimbursement for expenses for members appointed under subdivision 1, clauses (1)  
301.32 to (12); removal of members; filling of vacancies of members; and, except for initial

302.1 appointments, membership terms are governed by section 15.059. Notwithstanding section  
302.2 15.059, subdivision 6, the advisory council does not expire.

302.3 Subd. 4. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair  
302.4 from among its membership and may elect other officers as the advisory council deems  
302.5 necessary.

302.6 (b) The advisory council must meet quarterly or at the call of the chair.

302.7 (c) Meetings of the advisory council are subject to chapter 13D.

302.8 Subd. 5. **Duties.** The advisory council must review and make recommendations to the  
302.9 director and the deputy director of ambulance services on the administration of this chapter;  
302.10 the regulation of ambulance services and medical response units; the operation of the  
302.11 emergency medical services system in the state; and other topics as directed by the director.

302.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

302.13 Sec. 8. **[144E.035] EMERGENCY MEDICAL SERVICES PHYSICIAN ADVISORY**  
302.14 **COUNCIL.**

302.15 Subdivision 1. **Establishment; membership.** The Emergency Medical Services Physician  
302.16 Advisory Council is established and consists of the following members:

302.17 (1) eight physicians who meet the qualifications for medical directors in section 144E.265,  
302.18 subdivision 1, with one physician appointed by each of the regional emergency services  
302.19 boards of the designated regional emergency medical services systems;

302.20 (2) one physician who meets the qualifications for medical directors in section 144E.265,  
302.21 subdivision 1, appointed by the Minnesota State Fire Chiefs Association;

302.22 (3) one physician who is board-certified in pediatrics, appointed by the Minnesota  
302.23 Emergency Medical Services for Children program; and

302.24 (4) the medical director member of the Emergency Medical Services Advisory Council  
302.25 appointed under section 144E.03, subdivision 1, clause (3).

302.26 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation  
302.27 and reimbursement for expenses, removal of members, filling of vacancies of members,  
302.28 and, except for initial appointments, membership terms are governed by section 15.059.  
302.29 Notwithstanding section 15.059, subdivision 6, the advisory council shall not expire.

302.30 Subd. 3. **Officers; meetings.** (a) The advisory council must elect a chair and vice-chair  
302.31 from among its membership and may elect other officers as it deems necessary.

303.1 (b) The advisory council must meet twice per year or upon the call of the chair.

303.2 (c) Meetings of the advisory council are subject to chapter 13D.

303.3 Subd. 4. **Duties.** The advisory council must:

303.4 (1) review and make recommendations to the director and deputy director of medical  
303.5 services on clinical aspects of prehospital medical care. In doing so, the advisory council  
303.6 must incorporate information from medical literature, advances in bedside clinical practice,  
303.7 and advisory council member experience; and

303.8 (2) serve as subject matter experts for the director and deputy director of medical services  
303.9 on evolving topics in clinical medicine, including but not limited to infectious disease,  
303.10 pharmaceutical and equipment shortages, and implementation of new therapeutics.

303.11 **EFFECTIVE DATE.** This section is effective January 1, 2025.

303.12 Sec. 9. **[144E.04] LABOR AND EMERGENCY MEDICAL SERVICE PROVIDERS**  
303.13 **ADVISORY COUNCIL.**

303.14 Subdivision 1. **Establishment; membership.** The Labor and Emergency Medical Service  
303.15 Providers Advisory Council is established and consists of the following members:

303.16 (1) one emergency medical service provider of any type from each of the designated  
303.17 regional emergency medical services systems, appointed by their respective regional  
303.18 emergency services boards;

303.19 (2) one emergency medical technician instructor, appointed by an employee organization  
303.20 representing emergency medical service providers;

303.21 (3) two members with experience working as an employee organization representative  
303.22 representing emergency medical service providers, appointed by an employee organization  
303.23 representing emergency medical service providers;

303.24 (4) one emergency medical service provider based in a fire department, appointed jointly  
303.25 by the Minnesota State Fire Chiefs Association and the Minnesota Professional Fire Fighters  
303.26 Association; and

303.27 (5) one emergency medical service provider not based in a fire department, appointed  
303.28 by the League of Minnesota Cities.

303.29 Subd. 2. **Terms, compensation, removal, vacancies, and expiration.** Compensation  
303.30 and reimbursement for expenses for members appointed under subdivision 1; removal of  
303.31 members; filling of vacancies of members; and, except for initial appointments, membership

304.1 terms are governed by section 15.059. Notwithstanding section 15.059, subdivision 6, the  
304.2 Labor and Emergency Medical Service Providers Advisory Council does not expire.

304.3 Subd. 3. **Officers; meetings.** (a) The Labor and Emergency Medical Service Providers  
304.4 Advisory Council must elect a chair and vice-chair from among its membership and may  
304.5 elect other officers as the advisory council deems necessary.

304.6 (b) The Labor and Emergency Medical Service Providers Advisory Council must meet  
304.7 quarterly or at the call of the chair.

304.8 (c) Meetings of the Labor and Emergency Medical Service Providers Advisory Council  
304.9 are subject to chapter 13D.

304.10 Subd. 4. **Duties.** The Labor and Emergency Medical Service Providers Advisory Council  
304.11 must review and make recommendations to the director and deputy director of emergency  
304.12 medical service providers on the laws, rules, and policies assigned to the Emergency Medical  
304.13 Service Providers Division and other topics as directed by the director.

304.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

304.15 Sec. 10. Minnesota Statutes 2022, section 144E.16, subdivision 5, is amended to read:

304.16 **Subd. 5. Local government's powers.** (a) Local units of government may, with the  
304.17 approval of the ~~board~~ director, establish standards for ambulance services which impose  
304.18 additional requirements upon such services. Local units of government intending to impose  
304.19 additional requirements shall consider whether any benefit accruing to the public health  
304.20 would outweigh the costs associated with the additional requirements.

304.21 (b) Local units of government that desire to impose additional requirements shall, prior  
304.22 to adoption of relevant ordinances, rules, or regulations, furnish the ~~board~~ director with a  
304.23 copy of the proposed ordinances, rules, or regulations, along with information that  
304.24 affirmatively substantiates that the proposed ordinances, rules, or regulations:

304.25 (1) will in no way conflict with the relevant rules of the ~~board~~ office;

304.26 (2) will establish additional requirements tending to protect the public health;

304.27 (3) will not diminish public access to ambulance services of acceptable quality; and

304.28 (4) will not interfere with the orderly development of regional systems of emergency  
304.29 medical care.

304.30 (c) The ~~board~~ director shall base any decision to approve or disapprove local standards  
304.31 upon whether or not the local unit of government in question has affirmatively substantiated

305.1 that the proposed ordinances, rules, or regulations meet the criteria specified in paragraph  
305.2 (b).

305.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

305.4 Sec. 11. Minnesota Statutes 2022, section 144E.19, subdivision 3, is amended to read:

305.5 Subd. 3. **Temporary suspension.** (a) In addition to any other remedy provided by law,  
305.6 the ~~board~~ director may temporarily suspend the license of a licensee after conducting a  
305.7 preliminary inquiry to determine whether the ~~board~~ director believes that the licensee has  
305.8 violated a statute or rule that the ~~board~~ director is empowered to enforce and determining  
305.9 that the continued provision of service by the licensee would create an imminent risk to  
305.10 public health or harm to others.

305.11 (b) A temporary suspension order prohibiting a licensee from providing ambulance  
305.12 service shall give notice of the right to a preliminary hearing according to paragraph (d)  
305.13 and shall state the reasons for the entry of the temporary suspension order.

305.14 (c) Service of a temporary suspension order is effective when the order is served on the  
305.15 licensee personally or by certified mail, which is complete upon receipt, refusal, or return  
305.16 for nondelivery to the most recent address provided to the ~~board~~ director for the licensee.

305.17 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director  
305.18 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~  
305.19 that shall begin within 60 days after issuance of the temporary suspension order or within  
305.20 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from  
305.21 a licensee, whichever is sooner. The hearing shall be on the sole issue of whether there is  
305.22 a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under  
305.23 this paragraph is not subject to chapter 14.

305.24 (e) Evidence presented by the ~~board~~ director or licensee may be in the form of an affidavit.  
305.25 The licensee or the licensee's designee may appear for oral argument.

305.26 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,  
305.27 if the suspension is continued, notify the licensee of the right to a contested case hearing  
305.28 under chapter 14.

305.29 (g) If a licensee requests a contested case hearing within 30 days after receiving notice  
305.30 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to  
305.31 chapter 14. The administrative law judge shall issue a report and recommendation within  
305.32 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue  
305.33 a final order within 30 days after receipt of the administrative law judge's report.

306.1 **EFFECTIVE DATE.** This section is effective January 1, 2025.

306.2 Sec. 12. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

306.3 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny, suspend,  
306.4 revoke, place conditions on, or refuse to renew the registration of an individual who the  
306.5 ~~board~~ director determines:

306.6 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an  
306.7 agreement for corrective action, or an order that the ~~board~~ director issued or is otherwise  
306.8 empowered to enforce;

306.9 (2) misrepresents or falsifies information on an application form for registration;

306.10 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor  
306.11 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any  
306.12 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or  
306.13 alcohol;

306.14 (4) is actually or potentially unable to provide emergency medical services with  
306.15 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,  
306.16 or any other material, or as a result of any mental or physical condition;

306.17 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,  
306.18 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,  
306.19 welfare, or safety of the public;

306.20 (6) maltreats or abandons a patient;

306.21 (7) violates any state or federal controlled substance law;

306.22 (8) engages in unprofessional conduct or any other conduct which has the potential for  
306.23 causing harm to the public, including any departure from or failure to conform to the  
306.24 minimum standards of acceptable and prevailing practice without actual injury having to  
306.25 be established;

306.26 (9) provides emergency medical services under lapsed or nonrenewed credentials;

306.27 (10) is subject to a denial, corrective, disciplinary, or other similar action in another  
306.28 jurisdiction or by another regulatory authority;

306.29 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted  
306.30 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
306.31 to a patient; ~~or~~

307.1 (12) makes a false statement or knowingly provides false information to the ~~board~~  
307.2 director, or fails to cooperate with an investigation of the ~~board~~ director as required by  
307.3 section 144E.30; or

307.4 (13) fails to engage with the health professionals services program or diversion program  
307.5 required under section 144E.287 after being referred to the program, violates the terms of  
307.6 the program participation agreement, or leaves the program except upon fulfilling the terms  
307.7 for successful completion of the program as set forth in the participation agreement.

307.8 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an  
307.9 individual of the right to a contested case hearing under chapter 14. If an individual requests  
307.10 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate  
307.11 a contested case hearing according to chapter 14.

307.12 (c) The administrative law judge shall issue a report and recommendation within 30  
307.13 days after closing the contested case hearing record. The ~~board~~ director shall issue a final  
307.14 order within 30 days after receipt of the administrative law judge's report.

307.15 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions  
307.16 on, or refuse renewal of an individual's registration for disciplinary action, the individual  
307.17 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

307.18 **EFFECTIVE DATE.** This section is effective January 1, 2025.

307.19 Sec. 13. Minnesota Statutes 2022, section 144E.28, subdivision 5, is amended to read:

307.20 Subd. 5. **Denial, suspension, revocation.** (a) The ~~board~~ director may deny certification  
307.21 or take any action authorized in subdivision 4 against an individual who the ~~board~~ director  
307.22 determines:

307.23 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, or  
307.24 an order that the ~~board~~ director issued or is otherwise authorized or empowered to enforce,  
307.25 or agreement for corrective action;

307.26 (2) misrepresents or falsifies information on an application form for certification;

307.27 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor  
307.28 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any  
307.29 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or  
307.30 alcohol;

308.1 (4) is actually or potentially unable to provide emergency medical services with  
308.2 reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals,  
308.3 or any other material, or as a result of any mental or physical condition;

308.4 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,  
308.5 defraud, or harm the public or demonstrating a willful or careless disregard for the health,  
308.6 welfare, or safety of the public;

308.7 (6) maltreats or abandons a patient;

308.8 (7) violates any state or federal controlled substance law;

308.9 (8) engages in unprofessional conduct or any other conduct which has the potential for  
308.10 causing harm to the public, including any departure from or failure to conform to the  
308.11 minimum standards of acceptable and prevailing practice without actual injury having to  
308.12 be established;

308.13 (9) provides emergency medical services under lapsed or nonrenewed credentials;

308.14 (10) is subject to a denial, corrective, disciplinary, or other similar action in another  
308.15 jurisdiction or by another regulatory authority;

308.16 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted  
308.17 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
308.18 to a patient; ~~or~~

308.19 (12) makes a false statement or knowingly provides false information to the ~~board~~ director  
308.20 or fails to cooperate with an investigation of the ~~board~~ director as required by section  
308.21 144E.30; or

308.22 (13) fails to engage with the health professionals services program or diversion program  
308.23 required under section 144E.287 after being referred to the program, violates the terms of  
308.24 the program participation agreement, or leaves the program except upon fulfilling the terms  
308.25 for successful completion of the program as set forth in the participation agreement.

308.26 (b) Before taking action under paragraph (a), the ~~board~~ director shall give notice to an  
308.27 individual of the right to a contested case hearing under chapter 14. If an individual requests  
308.28 a contested case hearing within 30 days after receiving notice, the ~~board~~ director shall initiate  
308.29 a contested case hearing according to chapter 14 and no disciplinary action shall be taken  
308.30 at that time.

309.1 (c) The administrative law judge shall issue a report and recommendation within 30  
309.2 days after closing the contested case hearing record. The ~~board~~ director shall issue a final  
309.3 order within 30 days after receipt of the administrative law judge's report.

309.4 (d) After six months from the ~~board's~~ director's decision to deny, revoke, place conditions  
309.5 on, or refuse renewal of an individual's certification for disciplinary action, the individual  
309.6 shall have the opportunity to apply to the ~~board~~ director for reinstatement.

309.7 **EFFECTIVE DATE.** This section is effective January 1, 2025.

309.8 Sec. 14. Minnesota Statutes 2022, section 144E.28, subdivision 6, is amended to read:

309.9 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,  
309.10 the ~~board~~ director may temporarily suspend the certification of an individual after conducting  
309.11 a preliminary inquiry to determine whether the ~~board~~ director believes that the individual  
309.12 has violated a statute or rule that the ~~board~~ director is empowered to enforce and determining  
309.13 that the continued provision of service by the individual would create an imminent risk to  
309.14 public health or harm to others.

309.15 (b) A temporary suspension order prohibiting an individual from providing emergency  
309.16 medical care shall give notice of the right to a preliminary hearing according to paragraph  
309.17 (d) and shall state the reasons for the entry of the temporary suspension order.

309.18 (c) Service of a temporary suspension order is effective when the order is served on the  
309.19 individual personally or by certified mail, which is complete upon receipt, refusal, or return  
309.20 for nondelivery to the most recent address provided to the ~~board~~ director for the individual.

309.21 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director  
309.22 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~  
309.23 that shall begin within 60 days after issuance of the temporary suspension order or within  
309.24 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from  
309.25 the individual, whichever is sooner. The hearing shall be on the sole issue of whether there  
309.26 is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under  
309.27 this paragraph is not subject to chapter 14.

309.28 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an  
309.29 affidavit. The individual or individual's designee may appear for oral argument.

309.30 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,  
309.31 if the suspension is continued, notify the individual of the right to a contested case hearing  
309.32 under chapter 14.

310.1 (g) If an individual requests a contested case hearing within 30 days of receiving notice  
310.2 under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according to  
310.3 chapter 14. The administrative law judge shall issue a report and recommendation within  
310.4 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue  
310.5 a final order within 30 days after receipt of the administrative law judge's report.

310.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

310.7 Sec. 15. Minnesota Statutes 2022, section 144E.285, subdivision 6, is amended to read:

310.8 Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law,  
310.9 the ~~board~~ director may temporarily suspend approval of the education program after  
310.10 conducting a preliminary inquiry to determine whether the ~~board~~ director believes that the  
310.11 education program has violated a statute or rule that the ~~board~~ director is empowered to  
310.12 enforce and determining that the continued provision of service by the education program  
310.13 would create an imminent risk to public health or harm to others.

310.14 (b) A temporary suspension order prohibiting the education program from providing  
310.15 emergency medical care training shall give notice of the right to a preliminary hearing  
310.16 according to paragraph (d) and shall state the reasons for the entry of the temporary  
310.17 suspension order.

310.18 (c) Service of a temporary suspension order is effective when the order is served on the  
310.19 education program personally or by certified mail, which is complete upon receipt, refusal,  
310.20 or return for nondelivery to the most recent address provided to the ~~board~~ director for the  
310.21 education program.

310.22 (d) At the time the ~~board~~ director issues a temporary suspension order, the ~~board~~ director  
310.23 shall schedule a hearing, ~~to be held before a group of its members designated by the board,~~  
310.24 that shall begin within 60 days after issuance of the temporary suspension order or within  
310.25 15 working days of the date of the ~~board's~~ director's receipt of a request for a hearing from  
310.26 the education program, whichever is sooner. The hearing shall be on the sole issue of whether  
310.27 there is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing  
310.28 under this paragraph is not subject to chapter 14.

310.29 (e) Evidence presented by the ~~board~~ director or the individual may be in the form of an  
310.30 affidavit. The education program or counsel of record may appear for oral argument.

310.31 (f) Within five working days of the hearing, the ~~board~~ director shall issue its order and,  
310.32 if the suspension is continued, notify the education program of the right to a contested case  
310.33 hearing under chapter 14.

311.1 (g) If an education program requests a contested case hearing within 30 days of receiving  
311.2 notice under paragraph (f), the ~~board~~ director shall initiate a contested case hearing according  
311.3 to chapter 14. The administrative law judge shall issue a report and recommendation within  
311.4 30 days after the closing of the contested case hearing record. The ~~board~~ director shall issue  
311.5 a final order within 30 days after receipt of the administrative law judge's report.

311.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

311.7 Sec. 16. Minnesota Statutes 2022, section 144E.287, is amended to read:

311.8 **144E.287 DIVERSION PROGRAM.**

311.9 The ~~board~~ director shall either conduct a health professionals ~~service~~ services program  
311.10 ~~under sections 214.31 to 214.37~~ or contract for a diversion program ~~under section 214.28~~  
311.11 for professionals regulated ~~by the board~~ under this chapter who are unable to perform their  
311.12 duties with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals,  
311.13 or any other materials, or as a result of any mental, physical, or psychological condition.

311.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

311.15 Sec. 17. Minnesota Statutes 2022, section 144E.305, subdivision 3, is amended to read:

311.16 Subd. 3. **Immunity.** (a) An individual, licensee, health care facility, business, or  
311.17 organization is immune from civil liability or criminal prosecution for submitting in good  
311.18 faith a report to the ~~board~~ director under subdivision 1 or 2 or for otherwise reporting in  
311.19 good faith to the ~~board~~ director violations or alleged violations of sections 144E.001 to  
311.20 144E.33. Reports are classified as confidential data on individuals or protected nonpublic  
311.21 data under section 13.02 while an investigation is active. Except for the ~~board's~~ director's  
311.22 final determination, all communications or information received by or disclosed to the ~~board~~  
311.23 director relating to disciplinary matters of any person or entity subject to the ~~board's~~ director's  
311.24 regulatory jurisdiction are confidential and privileged and any disciplinary hearing shall be  
311.25 closed to the public.

311.26 (b) ~~Members of the board~~ The director, persons employed by the ~~board~~ director, persons  
311.27 engaged in the investigation of violations and in the preparation and management of charges  
311.28 of violations of sections 144E.001 to 144E.33 on behalf of the ~~board~~ director, and persons  
311.29 participating in the investigation regarding charges of violations are immune from civil  
311.30 liability and criminal prosecution for any actions, transactions, or publications, made in  
311.31 good faith, in the execution of, or relating to, their duties under sections 144E.001 to 144E.33.

312.1 ~~(e) For purposes of this section, a member of the board is considered a state employee~~  
312.2 ~~under section 3.736, subdivision 9.~~

312.3 **EFFECTIVE DATE.** This section is effective January 1, 2025.

312.4 Sec. 18. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**  
312.5 **SERVICES ADVISORY COUNCIL.**

312.6 (a) Initial appointments of members to the Emergency Medical Services Advisory  
312.7 Council must be made by January 1, 2025. The terms of initial appointees shall be determined  
312.8 by lot by the secretary of state and shall be as follows:

312.9 (1) eight members shall serve two-year terms; and

312.10 (2) eight members shall serve three-year terms.

312.11 (b) The medical director appointee must convene the first meeting of the Emergency  
312.12 Medical Services Advisory Council by February 1, 2025.

312.13 Sec. 19. **INITIAL MEMBERS AND FIRST MEETING; EMERGENCY MEDICAL**  
312.14 **SERVICES PHYSICIAN ADVISORY COUNCIL.**

312.15 (a) Initial appointments of members to the Emergency Medical Services Physician  
312.16 Advisory Council must be made by January 1, 2025. The terms of initial appointees shall  
312.17 be determined by lot by the secretary of state and shall be as follows:

312.18 (1) five members shall serve two-year terms;

312.19 (2) five members shall serve three-year terms; and

312.20 (3) the term for the medical director appointee to the Emergency Medical Services  
312.21 Physician Advisory Council shall coincide with that member's term on the Emergency  
312.22 Medical Services Advisory Council.

312.23 (b) The medical director appointee must convene the first meeting of the Emergency  
312.24 Medical Services Physician Advisory Council by February 1, 2025.

312.25 Sec. 20. **INITIAL MEMBERS AND FIRST MEETING; LABOR AND EMERGENCY**  
312.26 **MEDICAL SERVICE PROVIDERS ADVISORY COUNCIL.**

312.27 (a) Initial appointments of members to the Labor and Emergency Medical Service  
312.28 Providers Advisory Council must be made by January 1, 2025. The terms of initial appointees  
312.29 shall be determined by lot by the secretary of state and shall be as follows:

312.30 (1) six members shall serve two-year terms; and

313.1 (2) seven members shall serve three-year terms.

313.2 (b) The emergency medical technician instructor appointee must convene the first meeting  
313.3 of the Labor and Emergency Medical Service Providers Advisory Council by February 1,  
313.4 2025.

313.5 Sec. 21. **TRANSITION.**

313.6 Subdivision 1. **Appointment of director; operation of office.** No later than October  
313.7 1, 2024, the governor shall appoint a director-designee of the Office of Emergency Medical  
313.8 Services. The individual appointed as the director-designee of the Office of Emergency  
313.9 Medical Services shall become the governor's appointee as director of the Office of  
313.10 Emergency Medical Services on January 1, 2025. Effective January 1, 2025, the  
313.11 responsibilities to regulate emergency medical services in the state under Minnesota Statutes,  
313.12 chapter 144E, and Minnesota Rules, chapter 4690, are transferred from the Emergency  
313.13 Medical Services Regulatory Board to the Office of Emergency Medical Services and the  
313.14 director of the Office of Emergency Medical Services.

313.15 Subd. 2. **Transfer of responsibilities.** Minnesota Statutes, section 15.039, applies to  
313.16 the transfer of responsibilities from the Emergency Medical Services Regulatory Board to  
313.17 the Office of Emergency Medical Services required by this act. The commissioner of  
313.18 administration, with the approval of the governor, may issue reorganization orders under  
313.19 Minnesota Statutes, section 16B.37, as necessary to carry out the transfer of responsibilities  
313.20 required by this act. The provision of Minnesota Statutes, section 16B.37, subdivision 1,  
313.21 which states that transfers under that section may be made only to an agency that has been  
313.22 in existence for at least one year, does not apply to transfers in this act to the Office of  
313.23 Emergency Medical Services.

313.24 Sec. 22. **REVISOR INSTRUCTION.**

313.25 (a) In Minnesota Statutes, chapter 144E, the revisor of statutes shall replace "board"  
313.26 with "director"; "board's" with "director's"; "Emergency Medical Services Regulatory Board"  
313.27 or "Minnesota Emergency Medical Services Regulatory Board" with "director"; and  
313.28 "board-approved" with "director-approved," except that:

313.29 (1) in Minnesota Statutes, section 144E.11, the revisor of statutes shall not modify the  
313.30 term "county board," "community health board," or "community health boards";

314.1 (2) in Minnesota Statutes, sections 144E.40, subdivision 2; 144E.42, subdivision 2;  
314.2 144E.44; and 144E.45, subdivision 2, the revisor of statutes shall not modify the term "State  
314.3 Board of Investment"; and

314.4 (3) in Minnesota Statutes, sections 144E.50 and 144E.52, the revisor of statutes shall  
314.5 not modify the term "regional emergency medical services board," "regional board," "regional  
314.6 emergency medical services board's," or "regional boards."

314.7 (b) In the following sections of Minnesota Statutes, the revisor of statutes shall replace  
314.8 "Emergency Medical Services Regulatory Board" with "director of the Office of Emergency  
314.9 Medical Services": sections 13.717, subdivision 10; 62J.49, subdivision 2; 144.604; 144.608;  
314.10 147.09; 156.12, subdivision 2; 169.686, subdivision 3; and 299A.41, subdivision 4.

314.11 (c) In the following sections of Minnesota Statutes, the revisor of statutes shall replace  
314.12 "Emergency Medical Services Regulatory Board" with "Office of Emergency Medical  
314.13 Services": sections 144.603 and 161.045, subdivision 3.

314.14 (d) In making the changes specified in this section, the revisor of statutes may make  
314.15 technical and other necessary changes to sentence structure to preserve the meaning of the  
314.16 text.

314.17 Sec. 23. **REPEALER.**

314.18 Minnesota Statutes 2022, sections 144E.001, subdivision 5; 144E.01; 144E.123,  
314.19 subdivision 5; and 144E.50, subdivision 3, are repealed.

314.20 **EFFECTIVE DATE.** This section is effective January 1, 2025.

## 314.21 **ARTICLE 11**

### 314.22 **EMERGENCY MEDICAL SERVICES CONFORMING CHANGES**

314.23 Section 1. Minnesota Statutes 2023 Supplement, section 15A.0815, subdivision 2, is  
314.24 amended to read:

314.25 Subd. 2. **Agency head salaries.** The salary for a position listed in this subdivision shall  
314.26 be determined by the Compensation Council under section 15A.082. The commissioner of  
314.27 management and budget must publish the salaries on the department's website. This  
314.28 subdivision applies to the following positions:

314.29 Commissioner of administration;

314.30 Commissioner of agriculture;

314.31 Commissioner of education;

- 315.1 Commissioner of children, youth, and families;
- 315.2 Commissioner of commerce;
- 315.3 Commissioner of corrections;
- 315.4 Commissioner of health;
- 315.5 Commissioner, Minnesota Office of Higher Education;
- 315.6 Commissioner, Minnesota IT Services;
- 315.7 Commissioner, Housing Finance Agency;
- 315.8 Commissioner of human rights;
- 315.9 Commissioner of human services;
- 315.10 Commissioner of labor and industry;
- 315.11 Commissioner of management and budget;
- 315.12 Commissioner of natural resources;
- 315.13 Commissioner, Pollution Control Agency;
- 315.14 Commissioner of public safety;
- 315.15 Commissioner of revenue;
- 315.16 Commissioner of employment and economic development;
- 315.17 Commissioner of transportation;
- 315.18 Commissioner of veterans affairs;
- 315.19 Executive director of the Gambling Control Board;
- 315.20 Executive director of the Minnesota State Lottery;
- 315.21 Commissioner of Iron Range resources and rehabilitation;
- 315.22 Commissioner, Bureau of Mediation Services;
- 315.23 Ombudsman for mental health and developmental disabilities;
- 315.24 Ombudsperson for corrections;
- 315.25 Chair, Metropolitan Council;
- 315.26 Chair, Metropolitan Airports Commission;
- 315.27 School trust lands director;

316.1 Executive director of pari-mutuel racing; ~~and~~

316.2 Commissioner, Public Utilities Commission; and

316.3 Director of the Office of Emergency Medical Services.

316.4 **EFFECTIVE DATE.** This section is effective January 1, 2025.

316.5 Sec. 2. Minnesota Statutes 2023 Supplement, section 43A.08, subdivision 1a, is amended  
316.6 to read:

316.7 Subd. 1a. **Additional unclassified positions.** Appointing authorities for the following  
316.8 agencies may designate additional unclassified positions according to this subdivision: the  
316.9 Departments of Administration; Agriculture; Children, Youth, and Families; Commerce;  
316.10 Corrections; Direct Care and Treatment; Education; Employment and Economic  
316.11 Development; Explore Minnesota Tourism; Management and Budget; Health; Human  
316.12 Rights; Human Services; Labor and Industry; Natural Resources; Public Safety; Revenue;  
316.13 Transportation; and Veterans Affairs; the Housing Finance and Pollution Control Agencies;  
316.14 the State Lottery; the State Board of Investment; the Office of Administrative Hearings; the  
316.15 Department of Information Technology Services; the Offices of the Attorney General,  
316.16 Secretary of State, and State Auditor; the Minnesota State Colleges and Universities; the  
316.17 Minnesota Office of Higher Education; the Perpich Center for Arts Education; ~~and~~ the  
316.18 Minnesota Zoological Board; and the Office of Emergency Medical Services.

316.19 A position designated by an appointing authority according to this subdivision must  
316.20 meet the following standards and criteria:

316.21 (1) the designation of the position would not be contrary to other law relating specifically  
316.22 to that agency;

316.23 (2) the person occupying the position would report directly to the agency head or deputy  
316.24 agency head and would be designated as part of the agency head's management team;

316.25 (3) the duties of the position would involve significant discretion and substantial  
316.26 involvement in the development, interpretation, and implementation of agency policy;

316.27 (4) the duties of the position would not require primarily personnel, accounting, or other  
316.28 technical expertise where continuity in the position would be important;

316.29 (5) there would be a need for the person occupying the position to be accountable to,  
316.30 loyal to, and compatible with, the governor and the agency head, the employing statutory  
316.31 board or commission, or the employing constitutional officer;

317.1 (6) the position would be at the level of division or bureau director or assistant to the  
317.2 agency head; and

317.3 (7) the commissioner has approved the designation as being consistent with the standards  
317.4 and criteria in this subdivision.

317.5 **EFFECTIVE DATE.** This section is effective January 1, 2025.

317.6 Sec. 3. Minnesota Statutes 2022, section 62J.49, subdivision 1, is amended to read:

317.7 Subdivision 1. **Establishment.** The director of the Office of Emergency Medical Services  
317.8 ~~Regulatory Board~~ established under chapter ~~144~~ 144E shall establish a financial data  
317.9 collection system for all ambulance services licensed in this state. To establish the financial  
317.10 database, the ~~Emergency Medical Services Regulatory Board~~ director may contract with  
317.11 an entity that has experience in ambulance service financial data collection.

317.12 **EFFECTIVE DATE.** This section is effective January 1, 2025.

317.13 Sec. 4. Minnesota Statutes 2023 Supplement, section 152.126, subdivision 6, is amended  
317.14 to read:

317.15 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this subdivision,  
317.16 the data submitted to the board under subdivision 4 is private data on individuals as defined  
317.17 in section 13.02, subdivision 12, and not subject to public disclosure.

317.18 (b) Except as specified in subdivision 5, the following persons shall be considered  
317.19 permissible users and may access the data submitted under subdivision 4 in the same or  
317.20 similar manner, and for the same or similar purposes, as those persons who are authorized  
317.21 to access similar private data on individuals under federal and state law:

317.22 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has  
317.23 delegated the task of accessing the data, to the extent the information relates specifically to  
317.24 a current patient, to whom the prescriber is:

317.25 (i) prescribing or considering prescribing any controlled substance;

317.26 (ii) providing emergency medical treatment for which access to the data may be necessary;

317.27 (iii) providing care, and the prescriber has reason to believe, based on clinically valid  
317.28 indications, that the patient is potentially abusing a controlled substance; or

317.29 (iv) providing other medical treatment for which access to the data may be necessary  
317.30 for a clinically valid purpose and the patient has consented to access to the submitted data,

318.1 and with the provision that the prescriber remains responsible for the use or misuse of data  
318.2 accessed by a delegated agent or employee;

318.3 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has  
318.4 delegated the task of accessing the data, to the extent the information relates specifically to  
318.5 a current patient to whom that dispenser is dispensing or considering dispensing any  
318.6 controlled substance and with the provision that the dispenser remains responsible for the  
318.7 use or misuse of data accessed by a delegated agent or employee;

318.8 (3) a licensed dispensing practitioner or licensed pharmacist to the extent necessary to  
318.9 determine whether corrections made to the data reported under subdivision 4 are accurate;

318.10 (4) a licensed pharmacist who is providing pharmaceutical care for which access to the  
318.11 data may be necessary to the extent that the information relates specifically to a current  
318.12 patient for whom the pharmacist is providing pharmaceutical care: (i) if the patient has  
318.13 consented to access to the submitted data; or (ii) if the pharmacist is consulted by a prescriber  
318.14 who is requesting data in accordance with clause (1);

318.15 (5) an individual who is the recipient of a controlled substance prescription for which  
318.16 data was submitted under subdivision 4, or a guardian of the individual, parent or guardian  
318.17 of a minor, or health care agent of the individual acting under a health care directive under  
318.18 chapter 145C. For purposes of this clause, access by individuals includes persons in the  
318.19 definition of an individual under section 13.02;

318.20 (6) personnel or designees of a health-related licensing board listed in section 214.01,  
318.21 subdivision 2, or of the Office of Emergency Medical Services Regulatory Board, assigned  
318.22 to conduct a bona fide investigation of a complaint received by that board or office that  
318.23 alleges that a specific licensee is impaired by use of a drug for which data is collected under  
318.24 subdivision 4, has engaged in activity that would constitute a crime as defined in section  
318.25 152.025, or has engaged in the behavior specified in subdivision 5, paragraph (a);

318.26 (7) personnel of the board engaged in the collection, review, and analysis of controlled  
318.27 substance prescription information as part of the assigned duties and responsibilities under  
318.28 this section;

318.29 (8) authorized personnel under contract with the board, or under contract with the state  
318.30 of Minnesota and approved by the board, who are engaged in the design, evaluation,  
318.31 implementation, operation, or maintenance of the prescription monitoring program as part  
318.32 of the assigned duties and responsibilities of their employment, provided that access to data  
318.33 is limited to the minimum amount necessary to carry out such duties and responsibilities,

319.1 and subject to the requirement of de-identification and time limit on retention of data specified  
319.2 in subdivision 5, paragraphs (d) and (e);

319.3 (9) federal, state, and local law enforcement authorities acting pursuant to a valid search  
319.4 warrant;

319.5 (10) personnel of the Minnesota health care programs assigned to use the data collected  
319.6 under this section to identify and manage recipients whose usage of controlled substances  
319.7 may warrant restriction to a single primary care provider, a single outpatient pharmacy, and  
319.8 a single hospital;

319.9 (11) personnel of the Department of Human Services assigned to access the data pursuant  
319.10 to paragraph (k);

319.11 (12) personnel of the health professionals services program established under section  
319.12 214.31, to the extent that the information relates specifically to an individual who is currently  
319.13 enrolled in and being monitored by the program, and the individual consents to access to  
319.14 that information. The health professionals services program personnel shall not provide this  
319.15 data to a health-related licensing board ~~or the Emergency Medical Services Regulatory~~  
319.16 ~~Board~~, except as permitted under section 214.33, subdivision 3;

319.17 (13) personnel or designees of a health-related licensing board other than the Board of  
319.18 Pharmacy listed in section 214.01, subdivision 2, assigned to conduct a bona fide  
319.19 investigation of a complaint received by that board that alleges that a specific licensee is  
319.20 inappropriately prescribing controlled substances as defined in this section. For the purposes  
319.21 of this clause, the health-related licensing board may also obtain utilization data; and

319.22 (14) personnel of the board specifically assigned to conduct a bona fide investigation  
319.23 of a specific licensee or registrant. For the purposes of this clause, the board may also obtain  
319.24 utilization data.

319.25 (c) By July 1, 2017, every prescriber licensed by a health-related licensing board listed  
319.26 in section 214.01, subdivision 2, practicing within this state who is authorized to prescribe  
319.27 controlled substances for humans and who holds a current registration issued by the federal  
319.28 Drug Enforcement Administration, and every pharmacist licensed by the board and practicing  
319.29 within the state, shall register and maintain a user account with the prescription monitoring  
319.30 program. Data submitted by a prescriber, pharmacist, or their delegate during the registration  
319.31 application process, other than their name, license number, and license type, is classified  
319.32 as private pursuant to section 13.02, subdivision 12.

320.1 (d) Notwithstanding paragraph (b), beginning January 1, 2021, a prescriber or an agent  
320.2 or employee of the prescriber to whom the prescriber has delegated the task of accessing  
320.3 the data, must access the data submitted under subdivision 4 to the extent the information  
320.4 relates specifically to the patient:

320.5 (1) before the prescriber issues an initial prescription order for a Schedules II through  
320.6 IV opiate controlled substance to the patient; and

320.7 (2) at least once every three months for patients receiving an opiate for treatment of  
320.8 chronic pain or participating in medically assisted treatment for an opioid addiction.

320.9 (e) Paragraph (d) does not apply if:

320.10 (1) the patient is receiving palliative care, or hospice or other end-of-life care;

320.11 (2) the patient is being treated for pain due to cancer or the treatment of cancer;

320.12 (3) the prescription order is for a number of doses that is intended to last the patient five  
320.13 days or less and is not subject to a refill;

320.14 (4) the prescriber and patient have a current or ongoing provider/patient relationship of  
320.15 a duration longer than one year;

320.16 (5) the prescription order is issued within 14 days following surgery or three days  
320.17 following oral surgery or follows the prescribing protocols established under the opioid  
320.18 prescribing improvement program under section 256B.0638;

320.19 (6) the controlled substance is prescribed or administered to a patient who is admitted  
320.20 to an inpatient hospital;

320.21 (7) the controlled substance is lawfully administered by injection, ingestion, or any other  
320.22 means to the patient by the prescriber, a pharmacist, or by the patient at the direction of a  
320.23 prescriber and in the presence of the prescriber or pharmacist;

320.24 (8) due to a medical emergency, it is not possible for the prescriber to review the data  
320.25 before the prescriber issues the prescription order for the patient; or

320.26 (9) the prescriber is unable to access the data due to operational or other technological  
320.27 failure of the program so long as the prescriber reports the failure to the board.

320.28 (f) Only permissible users identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),  
320.29 (10), and (11), may directly access the data electronically. No other permissible users may  
320.30 directly access the data electronically. If the data is directly accessed electronically, the  
320.31 permissible user shall implement and maintain a comprehensive information security program  
320.32 that contains administrative, technical, and physical safeguards that are appropriate to the

321.1 user's size and complexity, and the sensitivity of the personal information obtained. The  
321.2 permissible user shall identify reasonably foreseeable internal and external risks to the  
321.3 security, confidentiality, and integrity of personal information that could result in the  
321.4 unauthorized disclosure, misuse, or other compromise of the information and assess the  
321.5 sufficiency of any safeguards in place to control the risks.

321.6 (g) The board shall not release data submitted under subdivision 4 unless it is provided  
321.7 with evidence, satisfactory to the board, that the person requesting the information is entitled  
321.8 to receive the data.

321.9 (h) The board shall maintain a log of all persons who access the data for a period of at  
321.10 least three years and shall ensure that any permissible user complies with paragraph (c)  
321.11 prior to attaining direct access to the data.

321.12 (i) Section 13.05, subdivision 6, shall apply to any contract the board enters into pursuant  
321.13 to subdivision 2. A vendor shall not use data collected under this section for any purpose  
321.14 not specified in this section.

321.15 (j) The board may participate in an interstate prescription monitoring program data  
321.16 exchange system provided that permissible users in other states have access to the data only  
321.17 as allowed under this section, and that section 13.05, subdivision 6, applies to any contract  
321.18 or memorandum of understanding that the board enters into under this paragraph.

321.19 (k) With available appropriations, the commissioner of human services shall establish  
321.20 and implement a system through which the Department of Human Services shall routinely  
321.21 access the data for the purpose of determining whether any client enrolled in an opioid  
321.22 treatment program licensed according to chapter 245A has been prescribed or dispensed a  
321.23 controlled substance in addition to that administered or dispensed by the opioid treatment  
321.24 program. When the commissioner determines there have been multiple prescribers or multiple  
321.25 prescriptions of controlled substances, the commissioner shall:

321.26 (1) inform the medical director of the opioid treatment program only that the  
321.27 commissioner determined the existence of multiple prescribers or multiple prescriptions of  
321.28 controlled substances; and

321.29 (2) direct the medical director of the opioid treatment program to access the data directly,  
321.30 review the effect of the multiple prescribers or multiple prescriptions, and document the  
321.31 review.

322.1 If determined necessary, the commissioner of human services shall seek a federal waiver  
322.2 of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section  
322.3 2.34, paragraph (c), prior to implementing this paragraph.

322.4 (l) The board shall review the data submitted under subdivision 4 on at least a quarterly  
322.5 basis and shall establish criteria, in consultation with the advisory task force, for referring  
322.6 information about a patient to prescribers and dispensers who prescribed or dispensed the  
322.7 prescriptions in question if the criteria are met.

322.8 (m) The board shall conduct random audits, on at least a quarterly basis, of electronic  
322.9 access by permissible users, as identified in paragraph (b), clauses (1), (2), (3), (4), (7), (8),  
322.10 (10), and (11), to the data in subdivision 4, to ensure compliance with permissible use as  
322.11 defined in this section. A permissible user whose account has been selected for a random  
322.12 audit shall respond to an inquiry by the board, no later than 30 days after receipt of notice  
322.13 that an audit is being conducted. Failure to respond may result in deactivation of access to  
322.14 the electronic system and referral to the appropriate health licensing board, or the  
322.15 commissioner of human services, for further action. The board shall report the results of  
322.16 random audits to the chairs and ranking minority members of the legislative committees  
322.17 with jurisdiction over health and human services policy and finance and government data  
322.18 practices.

322.19 (n) A permissible user who has delegated the task of accessing the data in subdivision  
322.20 4 to an agent or employee shall audit the use of the electronic system by delegated agents  
322.21 or employees on at least a quarterly basis to ensure compliance with permissible use as  
322.22 defined in this section. When a delegated agent or employee has been identified as  
322.23 inappropriately accessing data, the permissible user must immediately remove access for  
322.24 that individual and notify the board within seven days. The board shall notify all permissible  
322.25 users associated with the delegated agent or employee of the alleged violation.

322.26 (o) A permissible user who delegates access to the data submitted under subdivision 4  
322.27 to an agent or employee shall terminate that individual's access to the data within three  
322.28 business days of the agent or employee leaving employment with the permissible user. The  
322.29 board may conduct random audits to determine compliance with this requirement.

322.30 **EFFECTIVE DATE.** This section is effective January 1, 2025.

323.1 Sec. 5. Minnesota Statutes 2022, section 214.025, is amended to read:

323.2 **214.025 COUNCIL OF HEALTH BOARDS.**

323.3 The health-related licensing boards may establish a Council of Health Boards consisting  
323.4 of representatives of the health-related licensing boards ~~and the Emergency Medical Services~~  
323.5 ~~Regulatory Board~~. When reviewing legislation or legislative proposals relating to the  
323.6 regulation of health occupations, the council shall include the commissioner of health or a  
323.7 designee and the director of the Office of Emergency Medical Services or a designee.

323.8 **EFFECTIVE DATE.** This section is effective January 1, 2025.

323.9 Sec. 6. Minnesota Statutes 2022, section 214.04, subdivision 2a, is amended to read:

323.10 Subd. 2a. **Performance of executive directors.** The governor may request that a  
323.11 health-related licensing board ~~or the Emergency Medical Services Regulatory Board~~ review  
323.12 the performance of the board's executive director. Upon receipt of the request, the board  
323.13 must respond by establishing a performance improvement plan or taking disciplinary or  
323.14 other corrective action, including dismissal. The board shall include the governor's  
323.15 representative as a voting member of the board in the board's discussions and decisions  
323.16 regarding the governor's request. The board shall report to the governor on action taken by  
323.17 the board, including an explanation if no action is deemed necessary.

323.18 **EFFECTIVE DATE.** This section is effective January 1, 2025.

323.19 Sec. 7. Minnesota Statutes 2022, section 214.29, is amended to read:

323.20 **214.29 PROGRAM REQUIRED.**

323.21 Each health-related licensing board, ~~including the Emergency Medical Services~~  
323.22 ~~Regulatory Board under chapter 144E~~, shall either conduct a health professionals service  
323.23 program under sections 214.31 to 214.37 or contract for a diversion program under section  
323.24 214.28.

323.25 **EFFECTIVE DATE.** This section is effective January 1, 2025.

323.26 Sec. 8. Minnesota Statutes 2022, section 214.31, is amended to read:

323.27 **214.31 AUTHORITY.**

323.28 Two or more of the health-related licensing boards listed in section 214.01, subdivision  
323.29 2, may jointly conduct a health professionals services program to protect the public from  
323.30 persons regulated by the boards who are unable to practice with reasonable skill and safety

324.1 by reason of illness, use of alcohol, drugs, chemicals, or any other materials, or as a result  
324.2 of any mental, physical, or psychological condition. The program does not affect a board's  
324.3 authority to discipline violations of a board's practice act. ~~For purposes of sections 214.31~~  
324.4 ~~to 214.37, the emergency medical services regulatory board shall be included in the definition~~  
324.5 ~~of a health-related licensing board under chapter 144E.~~

324.6 **EFFECTIVE DATE.** This section is effective January 1, 2025.

324.7 Sec. 9. Minnesota Statutes 2022, section 214.355, is amended to read:

324.8 **214.355 GROUNDS FOR DISCIPLINARY ACTION.**

324.9 Each health-related licensing board, ~~including the Emergency Medical Services~~  
324.10 ~~Regulatory Board under chapter 144E,~~ shall consider it grounds for disciplinary action if a  
324.11 regulated person violates the terms of the health professionals services program participation  
324.12 agreement or leaves the program except upon fulfilling the terms for successful completion  
324.13 of the program as set forth in the participation agreement.

324.14 **EFFECTIVE DATE.** This section is effective January 1, 2025.

324.15

**ARTICLE 12**

324.16

**AMBULANCE SERVICE PERSONNEL AND EMERGENCY MEDICAL  
RESPONDERS**

324.17

324.18 Section 1. Minnesota Statutes 2022, section 144E.001, subdivision 3a, is amended to read:

324.19 Subd. 3a. **Ambulance service personnel.** "Ambulance service personnel" means  
324.20 individuals who are authorized by a licensed ambulance service to provide emergency care  
324.21 for the ambulance service and are:

324.22 (1) EMTs, AEMTs, or paramedics;

324.23 (2) Minnesota registered nurses who are: (i) EMTs, are currently practicing nursing, and  
324.24 ~~have passed a paramedic practical skills test, as approved by the board and administered by~~  
324.25 ~~an educational program approved by the board~~ been approved by the ambulance service  
324.26 medical director; (ii) on the roster of an ambulance service on or before January 1, 2000;  
324.27 ~~or~~ (iii) after petitioning the board, deemed by the board to have training and skills equivalent  
324.28 to an EMT, as determined on a case-by-case basis; or (iv) certified as a certified flight  
324.29 registered nurse or certified emergency nurse; or

324.30 (3) Minnesota licensed physician assistants who are: (i) EMTs, are currently practicing  
324.31 as physician assistants, and ~~have passed a paramedic practical skills test, as approved by~~  
324.32 ~~the board and administered by an educational program approved by the board~~ been approved

325.1 by the ambulance service medical director; (ii) on the roster of an ambulance service on or  
325.2 before January 1, 2000; or (iii) after petitioning the board, deemed by the board to have  
325.3 training and skills equivalent to an EMT, as determined on a case-by-case basis.

325.4 Sec. 2. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 6, is amended  
325.5 to read:

325.6 Subd. 6. **Basic life support.** (a) Except as provided in ~~paragraph (f)~~ subdivision 6a, a  
325.7 basic life-support ambulance shall be staffed by at least ~~two EMTs, one of whom must~~  
325.8 ~~accompany the patient and provide a level of care so as to ensure that:~~

325.9 (1) one individual who is:

325.10 (i) certified as an EMT;

325.11 (ii) a Minnesota registered nurse who meets the qualification requirements in section  
325.12 144E.001, subdivision 3a, clause (2); or

325.13 (iii) a Minnesota licensed physician assistant who meets the qualification requirements  
325.14 in section 144E.001, subdivision 3a, clause (3); and

325.15 (2) one individual to drive the ambulance who:

325.16 (i) either meets one of the qualification requirements in clause (1) or is a registered  
325.17 emergency medical responder driver; and

325.18 (ii) satisfies the requirements in subdivision 10.

325.19 (b) An individual who meets one of the qualification requirements in paragraph (a),  
325.20 clause (1), must accompany the patient and provide a level of care so as to ensure that:

325.21 (1) life-threatening situations and potentially serious injuries are recognized;

325.22 (2) patients are protected from additional hazards;

325.23 (3) basic treatment to reduce the seriousness of emergency situations is administered;

325.24 and

325.25 (4) patients are transported to an appropriate medical facility for treatment.

325.26 ~~(b)~~ (c) A basic life-support service shall provide basic airway management.

325.27 ~~(e)~~ (d) A basic life-support service shall provide automatic defibrillation.

325.28 ~~(d)~~ (e) A basic life-support service shall administer opiate antagonists consistent with  
325.29 protocols established by the service's medical director.

326.1 ~~(e)~~ (f) A basic life-support service licensee's medical director may authorize ambulance  
326.2 service personnel to perform intravenous infusion and use equipment that is within the  
326.3 licensure level of the ambulance service. Ambulance service personnel must be properly  
326.4 trained. Documentation of authorization for use, guidelines for use, continuing education,  
326.5 and skill verification must be maintained in the licensee's files.

326.6 ~~(f) For emergency ambulance calls and interfacility transfers, an ambulance service may~~  
326.7 ~~staff its basic life-support ambulances with one EMT, who must accompany the patient,~~  
326.8 ~~and one registered emergency medical responder driver. For purposes of this paragraph,~~  
326.9 ~~"ambulance service" means either an ambulance service whose primary service area is~~  
326.10 ~~mainly located outside the metropolitan counties listed in section 473.121, subdivision 4,~~  
326.11 ~~and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or an~~  
326.12 ~~ambulance service based in a community with a population of less than 2,500.~~

326.13 Sec. 3. Minnesota Statutes 2022, section 144E.101, is amended by adding a subdivision  
326.14 to read:

326.15 Subd. 6a. Variance; staffing of basic life-support ambulance. (a) Upon application  
326.16 from an ambulance service that includes evidence demonstrating hardship, the board may  
326.17 grant a variance from the staff requirements in subdivision 6, paragraph (a), and may  
326.18 authorize a basic life-support ambulance to be staffed, for all emergency calls and interfacility  
326.19 transfers, with one individual who meets the qualification requirements in paragraph (b) to  
326.20 drive the ambulance and one individual who meets one of the qualification requirements in  
326.21 subdivision 6, paragraph (a), clause (1), and who must accompany the patient. The variance  
326.22 applies to basic life-support ambulances until the ambulance service renews its license.  
326.23 When the variance expires, the ambulance service may apply for a new variance under this  
326.24 subdivision.

326.25 (b) In order to drive an ambulance under a variance granted under this subdivision, an  
326.26 individual must:

326.27 (1) hold a valid driver's license from any state;

326.28 (2) have attended an emergency vehicle driving course approved by the ambulance  
326.29 service;

326.30 (3) have completed a course on cardiopulmonary resuscitation approved by the ambulance  
326.31 service; and

326.32 (4) register with the board according to a process established by the board.

327.1 (c) If an individual serving as a driver under this subdivision commits or has a record  
327.2 of committing an act listed in section 144E.27, subdivision 5, paragraph (a), the board may  
327.3 temporarily suspend or prohibit the individual from driving an ambulance or place conditions  
327.4 on the individual's ability to drive an ambulance using the procedures and authority in  
327.5 section 144E.27, subdivisions 5 and 6.

327.6 Sec. 4. Minnesota Statutes 2023 Supplement, section 144E.101, subdivision 7, as amended  
327.7 by Laws 2024, chapter 85, section 32, is amended to read:

327.8 Subd. 7. **Advanced life support.** (a) Except as provided in paragraphs (f) and (g), an  
327.9 advanced life-support ambulance shall be staffed by at least:

327.10 (1) one EMT or one AEMT and one paramedic;

327.11 (2) one EMT or one AEMT and one registered nurse who: (i) is an EMT or an AEMT,  
327.12 is currently practicing nursing, and ~~has passed a paramedic practical skills test approved by~~  
327.13 ~~the board and administered by an education program~~ has been approved by the ambulance  
327.14 service medical director; or (ii) is certified as a certified flight registered nurse or certified  
327.15 emergency nurse; or

327.16 (3) one EMT or one AEMT and one physician assistant who is an EMT or an AEMT,  
327.17 is currently practicing as a physician assistant, and ~~has passed a paramedic practical skills~~  
327.18 ~~test approved by the board and administered by an education program~~ has been approved  
327.19 by the ambulance service medical director.

327.20 (b) An advanced life-support service shall provide basic life support, as specified under  
327.21 subdivision 6, paragraph ~~(a)~~ (b), advanced airway management, manual defibrillation,  
327.22 administration of intravenous fluids and pharmaceuticals, and administration of opiate  
327.23 antagonists.

327.24 (c) In addition to providing advanced life support, an advanced life-support service may  
327.25 staff additional ambulances to provide basic life support according to subdivision 6 and  
327.26 section 144E.103, subdivision 1.

327.27 (d) An ambulance service providing advanced life support shall have a written agreement  
327.28 with its medical director to ensure medical control for patient care 24 hours a day, seven  
327.29 days a week. The terms of the agreement shall include a written policy on the administration  
327.30 of medical control for the service. The policy shall address the following issues:

327.31 (1) two-way communication for physician direction of ambulance service personnel;

327.32 (2) patient triage, treatment, and transport;

328.1 (3) use of standing orders; and

328.2 (4) the means by which medical control will be provided 24 hours a day.

328.3 The agreement shall be signed by the licensee's medical director and the licensee or the  
328.4 licensee's designee and maintained in the files of the licensee.

328.5 (e) When an ambulance service provides advanced life support, the authority of a  
328.6 paramedic, Minnesota registered nurse-EMT, or Minnesota registered physician  
328.7 assistant-EMT to determine the delivery of patient care prevails over the authority of an  
328.8 EMT.

328.9 (f) Upon application from an ambulance service that includes evidence demonstrating  
328.10 hardship, the board may grant a variance from the staff requirements in paragraph (a), clause  
328.11 (1), and may authorize an advanced life-support ambulance to be staffed by a registered  
328.12 emergency medical responder driver with a paramedic for all emergency calls and interfacility  
328.13 transfers. The variance shall apply to advanced life-support ambulance services until the  
328.14 ambulance service renews its license. When the variance expires, an ambulance service  
328.15 may apply for a new variance under this paragraph. ~~This paragraph applies only to an  
328.16 ambulance service whose primary service area is mainly located outside the metropolitan  
328.17 counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato,  
328.18 Moorhead, Rochester, and St. Cloud, or an ambulance service based in a community with  
328.19 a population of less than 1,000 persons.~~

328.20 (g) After an initial emergency ambulance call, each subsequent emergency ambulance  
328.21 response, until the initial ambulance is again available, and interfacility transfers, may be  
328.22 staffed by one registered emergency medical responder driver and an EMT or paramedic.  
328.23 ~~This paragraph applies only to an ambulance service whose primary service area is mainly  
328.24 located outside the metropolitan counties listed in section 473.121, subdivision 4, and outside  
328.25 the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud, or an ambulance service  
328.26 based in a community with a population of less than 1,000 persons.~~

328.27 (h) An individual who staffs an advanced life-support ambulance as a driver must also  
328.28 meet the requirements in subdivision 10.

328.29 Sec. 5. Minnesota Statutes 2022, section 144E.27, subdivision 3, is amended to read:

328.30 Subd. 3. **Renewal.** (a) The board may renew the registration of an emergency medical  
328.31 responder who:

328.32 (1) successfully completes a board-approved refresher course; ~~and~~

329.1 (2) successfully completes a course in cardiopulmonary resuscitation approved by the  
329.2 board or by the licensee's medical director. This course may be a component of a  
329.3 board-approved refresher course; and

329.4 ~~(2)~~ (3) submits a completed renewal application to the board before the registration  
329.5 expiration date.

329.6 (b) The board may renew the lapsed registration of an emergency medical responder  
329.7 who:

329.8 (1) successfully completes a board-approved refresher course; ~~and~~

329.9 (2) successfully completes a course in cardiopulmonary resuscitation approved by the  
329.10 board or by the licensee's medical director. This course may be a component of a  
329.11 board-approved refresher course; and

329.12 ~~(2)~~ (3) submits a completed renewal application to the board within ~~12~~ 48 months after  
329.13 the registration expiration date.

329.14 Sec. 6. Minnesota Statutes 2022, section 144E.27, subdivision 5, is amended to read:

329.15 Subd. 5. **Denial, suspension, revocation; emergency medical responders and**  
329.16 **drivers.** (a) This subdivision applies to individuals seeking registration or registered as an  
329.17 emergency medical responder and to individuals seeking registration or registered as a driver  
329.18 of a basic life-support ambulance under section 144E.101, subdivision 6a. The board may  
329.19 deny, suspend, revoke, place conditions on, or refuse to renew the registration of an individual  
329.20 who the board determines:

329.21 (1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an  
329.22 agreement for corrective action, or an order that the board issued or is otherwise empowered  
329.23 to enforce;

329.24 (2) misrepresents or falsifies information on an application form for registration;

329.25 (3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor  
329.26 relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any  
329.27 misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or  
329.28 alcohol;

329.29 (4) is actually or potentially unable to provide emergency medical services or drive an  
329.30 ambulance with reasonable skill and safety to patients by reason of illness, use of alcohol,  
329.31 drugs, chemicals, or any other material, or as a result of any mental or physical condition;

330.1 (5) engages in unethical conduct, including, but not limited to, conduct likely to deceive,  
330.2 defraud, or harm the public, or demonstrating a willful or careless disregard for the health,  
330.3 welfare, or safety of the public;

330.4 (6) maltreats or abandons a patient;

330.5 (7) violates any state or federal controlled substance law;

330.6 (8) engages in unprofessional conduct or any other conduct which has the potential for  
330.7 causing harm to the public, including any departure from or failure to conform to the  
330.8 minimum standards of acceptable and prevailing practice without actual injury having to  
330.9 be established;

330.10 (9) for emergency medical responders, provides emergency medical services under  
330.11 lapsed or nonrenewed credentials;

330.12 (10) is subject to a denial, corrective, disciplinary, or other similar action in another  
330.13 jurisdiction or by another regulatory authority;

330.14 (11) engages in conduct with a patient that is sexual or may reasonably be interpreted  
330.15 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning  
330.16 to a patient; or

330.17 (12) makes a false statement or knowingly provides false information to the board, or  
330.18 fails to cooperate with an investigation of the board as required by section 144E.30.

330.19 (b) Before taking action under paragraph (a), the board shall give notice to an individual  
330.20 of the right to a contested case hearing under chapter 14. If an individual requests a contested  
330.21 case hearing within 30 days after receiving notice, the board shall initiate a contested case  
330.22 hearing according to chapter 14.

330.23 (c) The administrative law judge shall issue a report and recommendation within 30  
330.24 days after closing the contested case hearing record. The board shall issue a final order  
330.25 within 30 days after receipt of the administrative law judge's report.

330.26 (d) After six months from the board's decision to deny, revoke, place conditions on, or  
330.27 refuse renewal of an individual's registration for disciplinary action, the individual shall  
330.28 have the opportunity to apply to the board for reinstatement.

330.29 Sec. 7. Minnesota Statutes 2022, section 144E.27, subdivision 6, is amended to read:

330.30 Subd. 6. **Temporary suspension; emergency medical responders and drivers**. (a)  
330.31 This subdivision applies to emergency medical responders registered under this section and  
330.32 to individuals registered as drivers of basic life-support ambulances under section 144E.101,

331.1 subdivision 6a. In addition to any other remedy provided by law, the board may temporarily  
331.2 suspend the registration of an individual after conducting a preliminary inquiry to determine  
331.3 whether the board believes that the individual has violated a statute or rule that the board  
331.4 is empowered to enforce and determining that the continued provision of service by the  
331.5 individual would create an imminent risk to public health or harm to others.

331.6 (b) A temporary suspension order prohibiting an individual from providing emergency  
331.7 medical care or from driving a basic life-support ambulance shall give notice of the right  
331.8 to a preliminary hearing according to paragraph (d) and shall state the reasons for the entry  
331.9 of the temporary suspension order.

331.10 (c) Service of a temporary suspension order is effective when the order is served on the  
331.11 individual personally or by certified mail, which is complete upon receipt, refusal, or return  
331.12 for nondelivery to the most recent address provided to the board for the individual.

331.13 (d) At the time the board issues a temporary suspension order, the board shall schedule  
331.14 a hearing, to be held before a group of its members designated by the board, that shall begin  
331.15 within 60 days after issuance of the temporary suspension order or within 15 working days  
331.16 of the date of the board's receipt of a request for a hearing from the individual, whichever  
331.17 is sooner. The hearing shall be on the sole issue of whether there is a reasonable basis to  
331.18 continue, modify, or lift the temporary suspension. A hearing under this paragraph is not  
331.19 subject to chapter 14.

331.20 (e) Evidence presented by the board or the individual may be in the form of an affidavit.  
331.21 The individual or the individual's designee may appear for oral argument.

331.22 (f) Within five working days of the hearing, the board shall issue its order and, if the  
331.23 suspension is continued, notify the individual of the right to a contested case hearing under  
331.24 chapter 14.

331.25 (g) If an individual requests a contested case hearing within 30 days after receiving  
331.26 notice under paragraph (f), the board shall initiate a contested case hearing according to  
331.27 chapter 14. The administrative law judge shall issue a report and recommendation within  
331.28 30 days after the closing of the contested case hearing record. The board shall issue a final  
331.29 order within 30 days after receipt of the administrative law judge's report.

331.30 Sec. 8. Minnesota Statutes 2022, section 144E.28, subdivision 3, is amended to read:

331.31 Subd. 3. **Reciprocity.** The board may certify an individual who possesses a current  
331.32 National Registry of Emergency Medical Technicians registration certification from another  
331.33 jurisdiction if the individual submits a board-approved application form. The board

332.1 certification classification shall be the same as the National Registry's classification.

332.2 Certification shall be for the duration of the applicant's ~~registration~~ certification period in  
332.3 another jurisdiction, not to exceed two years.

332.4 Sec. 9. Minnesota Statutes 2022, section 144E.28, subdivision 8, is amended to read:

332.5 Subd. 8. **Reinstatement.** (a) Within four years of a certification expiration date, a person  
332.6 whose certification has expired under subdivision 7, paragraph (d), may have the certification  
332.7 reinstated upon submission of:

332.8 (1) evidence to the board of training equivalent to the continuing education requirements  
332.9 of subdivision 7 or, for community paramedics, evidence to the board of training equivalent  
332.10 to the continuing education requirements of subdivision 9, paragraph (c); and

332.11 (2) a board-approved application form.

332.12 (b) If more than four years have passed since a certificate expiration date, an applicant  
332.13 must complete the initial certification process required under subdivision 1.

332.14 (c) Beginning July 1, 2024, through December 31, 2025, and notwithstanding paragraph  
332.15 (b), a person whose certification as an EMT, AEMT, paramedic, or community paramedic  
332.16 expired more than four years ago but less than ten years ago may have the certification  
332.17 reinstated upon submission of:

332.18 (1) evidence to the board of the training required under paragraph (a), clause (1). This  
332.19 training must have been completed within the 24 months prior to the date of the application  
332.20 for reinstatement;

332.21 (2) a board-approved application form; and

332.22 (3) a recommendation from an ambulance service medical director.

332.23 This paragraph expires December 31, 2025.

332.24 Sec. 10. Minnesota Statutes 2022, section 144E.285, subdivision 1, is amended to read:

332.25 Subdivision 1. **Approval required.** (a) All education programs for an EMR, EMT,  
332.26 AEMT, or paramedic must be approved by the board.

332.27 (b) To be approved by the board, an education program must:

332.28 (1) submit an application prescribed by the board that includes:

332.29 (i) ~~type and length~~ type and length of course to be offered;

- 333.1 (ii) names, addresses, and qualifications of the program medical director, program  
333.2 education coordinator, and instructors;
- 333.3 ~~(iii) names and addresses of clinical sites, including a contact person and telephone~~  
333.4 ~~number;~~
- 333.5 ~~(iv)~~ (iii) admission criteria for students; and
- 333.6 ~~(v)~~ (iv) materials and equipment to be used;
- 333.7 (2) for each course, implement the most current version of the United States Department  
333.8 of Transportation EMS Education Standards, or its equivalent as determined by the board  
333.9 applicable to EMR, EMT, AEMT, or paramedic education;
- 333.10 (3) have a program medical director and a program coordinator;
- 333.11 (4) utilize instructors who meet the requirements of section 144E.283 for teaching at  
333.12 least 50 percent of the course content. The remaining 50 percent of the course may be taught  
333.13 by guest lecturers approved by the education program coordinator or medical director;
- 333.14 ~~(5) have at least one instructor for every ten students at the practical skill stations;~~
- 333.15 ~~(6) maintain a written agreement with a licensed hospital or licensed ambulance service~~  
333.16 ~~designating a clinical training site;~~
- 333.17 ~~(7)~~ (5) retain documentation of program approval by the board, course outline, and  
333.18 student information;
- 333.19 ~~(8)~~ (6) notify the board of the starting date of a course prior to the beginning of a course;  
333.20 and
- 333.21 ~~(9)~~ (7) submit the appropriate fee as required under section 144E.29; and.
- 333.22 ~~(10) maintain a minimum average yearly pass rate as set by the board on an annual basis.~~  
333.23 ~~The pass rate will be determined by the percent of candidates who pass the exam on the~~  
333.24 ~~first attempt. An education program not meeting this yearly standard shall be placed on~~  
333.25 ~~probation and shall be on a performance improvement plan approved by the board until~~  
333.26 ~~meeting the pass rate standard. While on probation, the education program may continue~~  
333.27 ~~providing classes if meeting the terms of the performance improvement plan as determined~~  
333.28 ~~by the board. If an education program having probation status fails to meet the pass rate~~  
333.29 ~~standard after two years in which an EMT initial course has been taught, the board may~~  
333.30 ~~take disciplinary action under subdivision 5.~~

334.1 Sec. 11. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision  
334.2 to read:

334.3 Subd. 1a. **EMR education program requirements.** The National EMS Education  
334.4 Standards established by the National Highway Traffic Safety Administration of the United  
334.5 States Department of Transportation specify the minimum requirements for knowledge and  
334.6 skills for emergency medical responders. An education program applying for approval to  
334.7 teach EMRs must comply with the requirements under subdivision 1, paragraph (b). A  
334.8 medical director of an emergency medical responder group may establish additional  
334.9 knowledge and skill requirements for EMRs.

334.10 Sec. 12. Minnesota Statutes 2022, section 144E.285, is amended by adding a subdivision  
334.11 to read:

334.12 Subd. 1b. **EMT education program requirements.** In addition to the requirements  
334.13 under subdivision 1, paragraph (b), an education program applying for approval to teach  
334.14 EMTs must:

334.15 (1) include in the application prescribed by the board the names and addresses of clinical  
334.16 sites, including a contact person and telephone number;

334.17 (2) maintain a written agreement with at least one clinical training site that is of a type  
334.18 recognized by the National EMS Education Standards established by the National Highway  
334.19 Traffic Safety Administration; and

334.20 (3) maintain a minimum average yearly pass rate as set by the board. An education  
334.21 program not meeting this standard must be placed on probation and must comply with a  
334.22 performance improvement plan approved by the board until the program meets the pass-rate  
334.23 standard. While on probation, the education program may continue to provide classes if the  
334.24 program meets the terms of the performance improvement plan, as determined by the board.  
334.25 If an education program that is on probation status fails to meet the pass-rate standard after  
334.26 two years in which an EMT initial course has been taught, the board may take disciplinary  
334.27 action under subdivision 5.

334.28 Sec. 13. Minnesota Statutes 2022, section 144E.285, subdivision 2, is amended to read:

334.29 Subd. 2. **AEMT and paramedic education program requirements.** (a) In addition to  
334.30 the requirements under subdivision 1, paragraph (b), an education program applying for  
334.31 approval to teach AEMTs and paramedics must:

335.1 (1) be administered by an educational institution accredited by the Commission of  
335.2 Accreditation of Allied Health Education Programs (CAAHEP);

335.3 (2) include in the application prescribed by the board the names and addresses of clinical  
335.4 sites, including a contact person and telephone number; and

335.5 (3) maintain a written agreement with a licensed hospital or licensed ambulance service  
335.6 designating a clinical training site.

335.7 (b) An AEMT and paramedic education program that is administered by an educational  
335.8 institution not accredited by CAAHEP, but that is in the process of completing the  
335.9 accreditation process, may be granted provisional approval by the board upon verification  
335.10 of submission of its self-study report and the appropriate review fee to CAAHEP.

335.11 (c) An educational institution that discontinues its participation in the accreditation  
335.12 process must notify the board immediately and provisional approval shall be withdrawn.

335.13 ~~(d) This subdivision does not apply to a paramedic education program when the program~~  
335.14 ~~is operated by an advanced life support ambulance service licensed by the Emergency~~  
335.15 ~~Medical Services Regulatory Board under this chapter, and the ambulance service meets~~  
335.16 ~~the following criteria:~~

335.17 ~~(1) covers a rural primary service area that does not contain a hospital within the primary~~  
335.18 ~~service area or contains a hospital within the primary service area that has been designated~~  
335.19 ~~as a critical access hospital under section 144.1483, clause (9);~~

335.20 ~~(2) has tax-exempt status in accordance with the Internal Revenue Code, section~~  
335.21 ~~501(c)(3);~~

335.22 ~~(3) received approval before 1991 from the commissioner of health to operate a paramedic~~  
335.23 ~~education program;~~

335.24 ~~(4) operates an AEMT and paramedic education program exclusively to train paramedics~~  
335.25 ~~for the local ambulance service; and~~

335.26 ~~(5) limits enrollment in the AEMT and paramedic program to five candidates per~~  
335.27 ~~biennium.~~

335.28 Sec. 14. Minnesota Statutes 2022, section 144E.285, subdivision 4, is amended to read:

335.29 Subd. 4. **Reapproval.** An education program shall apply to the board for reapproval at  
335.30 least ~~three months~~ 30 days prior to the expiration date of its approval and must:

336.1 (1) submit an application prescribed by the board specifying any changes from the  
336.2 information provided for prior approval and any other information requested by the board  
336.3 to clarify incomplete or ambiguous information presented in the application; ~~and~~

336.4 (2) comply with the requirements under subdivision 1, paragraph (b), clauses (2) to ~~(10)~~.  
336.5 (7);

336.6 (3) be subject to a site visit by the board;

336.7 (4) for education programs that teach EMRs, comply with the requirements in subdivision  
336.8 1a;

336.9 (5) for education programs that teach EMTs, comply with the requirements in subdivision  
336.10 1b; and

336.11 (6) for education programs that teach AEMTs and paramedics, comply with the  
336.12 requirements in subdivision 2 and maintain accreditation with CAAHEP.

336.13 Sec. 15. REPEALER.

336.14 Minnesota Statutes 2022, section 144E.27, subdivisions 1 and 1a, are repealed.

336.15 **ARTICLE 13**

336.16 **MISCELLANEOUS**

336.17 Section 1. Minnesota Statutes 2022, section 16A.055, subdivision 1a, is amended to read:

336.18 Subd. 1a. ~~Additional duties~~ **Program evaluation and organizational development**  
336.19 **services.** The commissioner may assist state agencies by providing analytical, statistical,  
336.20 program evaluation using experimental or quasi-experimental design, and organizational  
336.21 development services to state agencies in order to assist the agency to achieve the agency's  
336.22 mission and to operate efficiently and effectively. For purposes of this section, "experimental  
336.23 design" means a method of evaluating the impact of a service that uses random assignment  
336.24 to assign participants into groups that respectively receive the studied service and those that  
336.25 receive service as usual, so that any difference in outcomes found at the end of the evaluation  
336.26 can be attributed to the studied service; and "quasi-experimental design" means a method  
336.27 of evaluating the impact of a service that uses strategies other than random assignment to  
336.28 establish statistically similar groups that respectively receive the service and those that  
336.29 receive service as usual, so that any difference in outcomes found at the end of the evaluation  
336.30 can be attributed to the studied service.

337.1 Sec. 2. Minnesota Statutes 2022, section 16A.055, is amended by adding a subdivision to  
337.2 read:

337.3 Subd. 1b. **Consultation to develop performance measures for grants.** (a) The  
337.4 commissioner must, in consultation with the commissioners of health, human services, and  
337.5 children, youth, and families, develop an ongoing consultation schedule to create, review,  
337.6 and revise, as necessary, performance measures, data collection, and program evaluation  
337.7 plans for all state-funded grants administered by the commissioners of health, human  
337.8 services, and children, youth, and families that distribute at least \$1,000,000 annually.

337.9 (b) Following the development of the ongoing consultation schedule under paragraph  
337.10 (a), the commissioner and the commissioner of the administering agency must conduct a  
337.11 grant program consultation in accordance with the ongoing consultation schedule. Each  
337.12 grant program consultation must include a review of performance measures, data collection,  
337.13 program evaluation plans, and reporting for each grant program. Following each consultation,  
337.14 the commissioner and the commissioner of the administering agency may revise evaluation  
337.15 metrics of a grant program. The commissioner may provide continuing support to the grant  
337.16 program in accordance with subdivision 1a.

337.17 Sec. 3. **[137.095] EVIDENCE IN SUPPORT OF APPROPRIATION.**

337.18 Subdivision 1. **Written report.** Prior to the introduction of a bill proposing to appropriate  
337.19 money to the Board of Regents of the University of Minnesota to benefit the University of  
337.20 Minnesota's health sciences schools and colleges, the proponents of the bill are requested  
337.21 to submit a written report to the chairs and ranking minority members of the legislative  
337.22 committees with jurisdiction over higher education and health and human services policy  
337.23 and finance setting out the information described in subdivision 2. The University of  
337.24 Minnesota's health sciences schools and colleges are medicine, nursing, public health,  
337.25 pharmacy, dentistry, and veterinary medicine.

337.26 Subd. 2. **Contents of report.** (a) The report requested under this section must include  
337.27 the following information as specifically as possible:

337.28 (1) the dollar amount requested;

337.29 (2) how the requested dollar amount was calculated;

337.30 (3) the necessity for the appropriation's purpose to be funded by public funds;

337.31 (4) University of Minnesota budgeting considerations and decisions impacting the  
337.32 necessity analysis required by clause (3);

338.1 (5) all goals, outcomes, and purposes of the appropriation;

338.2 (6) performance measures as defined by the University of Minnesota that the University  
338.3 of Minnesota will utilize to ensure the funds are dedicated to the successful achievement  
338.4 of the identified goals, outcomes, and purposes; and

338.5 (7) the extent to which the appropriation advances recruitment from, and training for  
338.6 and retention of, health professionals from and in greater Minnesota and from underserved  
338.7 communities in metropolitan areas.

338.8 (b) This subdivision only applies when the Board of Regents of the University of  
338.9 Minnesota approves a legislative funding request for the University of Minnesota's health  
338.10 sciences schools and colleges.

338.11 Subd. 3. **Certifications for academic health.** A report submitted under this section  
338.12 must include, in addition to the information listed in subdivision 2, a certification, by the  
338.13 University of Minnesota Vice President and Budget Director, that:

338.14 (1) the appropriation will not be used to cover academic health clinical revenue deficits;

338.15 (2) the goals, outcomes, and purposes of the appropriation are aligned with state goals  
338.16 for population health improvement; and

338.17 (3) the appropriation is aligned with the University of Minnesota's strategic plan for its  
338.18 health sciences schools and colleges, including but not limited to shared goals and strategies  
338.19 for the health professional schools.

338.20 Subd. 4. **Right to request.** The chair of a standing committee in either house of the  
338.21 legislature may request and obtain the reports submitted pursuant to this section from the  
338.22 chair of a legislative committee with jurisdiction over higher education or health and human  
338.23 services policy and finance.

338.24 Sec. 4. Minnesota Statutes 2023 Supplement, section 142A.03, is amended by adding a  
338.25 subdivision to read:

338.26 Subd. 2a. **Grant consultation.** The commissioner must consult with the commissioner  
338.27 of management and budget to create, review, and revise grant program performance measures  
338.28 and to evaluate grant programs administered by the commissioner in accordance with section  
338.29 16A.055, subdivisions 1a and 1b.

339.1 Sec. 5. Minnesota Statutes 2022, section 144.05, is amended by adding a subdivision to  
339.2 read:

339.3 Subd. 8. **Grant consultation.** The commissioner must consult with the commissioner  
339.4 of management and budget to create, review, and revise grant program performance measures  
339.5 and to evaluate grant programs administered by the commissioner in accordance with section  
339.6 16A.055, subdivisions 1a and 1b.

339.7 Sec. 6. Minnesota Statutes 2022, section 144.292, subdivision 6, is amended to read:

339.8 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of  
339.9 reviewing current medical care, the provider must not charge a fee.

339.10 (b) When a provider or its representative makes copies of patient records upon a patient's  
339.11 request under this section, the provider or its representative may charge the patient or the  
339.12 patient's representative no more than ~~75 cents per page, plus \$10 for time spent retrieving~~  
339.13 ~~and copying the records, unless other law or a rule or contract provide for a lower maximum~~  
339.14 ~~charge. This limitation does not apply to x-rays. The provider may charge a patient no more~~  
339.15 ~~than the actual cost of reproducing x-rays, plus no more than \$10 for the time spent retrieving~~  
339.16 ~~and copying the x-rays~~ the following amount, unless other law or a rule or contract provide  
339.17 for a lower maximum charge:

339.18 (1) for paper copies, \$1 per page, plus \$10 for time spent retrieving and copying the  
339.19 records;

339.20 (2) for x-rays, a total of \$30 for retrieving and reproducing x-rays; and

339.21 (3) for electronic copies, a total of \$20 for retrieving the records.

339.22 ~~(c) The respective maximum charges of 75 cents per page and \$10 for time provided in~~  
339.23 ~~this subdivision are in effect for calendar year 1992 and may be adjusted annually each~~  
339.24 ~~calendar year as provided in this subdivision. The permissible maximum charges shall~~  
339.25 ~~change each year by an amount that reflects the change, as compared to the previous year,~~  
339.26 ~~in the Consumer Price Index for all Urban Consumers, Minneapolis-St. Paul (CPI-U),~~  
339.27 ~~published by the Department of Labor. For any copies of paper records provided under~~  
339.28 ~~paragraph (b), clause (1), a provider or the provider's representative may not charge more~~  
339.29 than a total of:

339.30 (1) \$10 if there are no records available;

339.31 (2) \$30 for copies of records of up to 25 pages;

339.32 (3) \$50 for copies of records of up to 100 pages;

340.1 (4) \$50, plus an additional 20 cents per page for pages 101 and above; or

340.2 (5) \$500 for any request.

340.3 (d) A provider or its representative may charge ~~the~~ a \$10 retrieval fee, but must not  
340.4 charge a per page fee or x-ray fee to provide copies of records requested by a patient or the  
340.5 patient's authorized representative if the request for copies of records is for purposes of  
340.6 appealing a denial of Social Security disability income or Social Security disability benefits  
340.7 under title II or title XVI of the Social Security Act; ~~except that no fee shall be charged to~~  
340.8 a patient who is receiving public assistance, or to a patient who is represented by an attorney  
340.9 on behalf of a civil legal services program or a volunteer attorney program based on  
340.10 indigency. Notwithstanding the foregoing, a provider or its representative must not charge  
340.11 a fee, including a retrieval fee, to provide copies of records requested by a patient or the  
340.12 patient's authorized representative if the request for copies of records is for purposes of  
340.13 appealing a denial of Social Security disability income or Social Security disability benefits  
340.14 under title II or title XVI of the Social Security Act when the patient is receiving public  
340.15 assistance, represented by an attorney on behalf of a civil legal services program, or  
340.16 represented by a volunteer attorney program based on indigency. The patient or the patient's  
340.17 representative must submit one of the following to show that they are entitled to receive  
340.18 records without charge under this paragraph:

340.19 (1) a public assistance statement from the county or state administering assistance;

340.20 (2) a request for records on the letterhead of the civil legal services program or volunteer  
340.21 attorney program based on indigency; or

340.22 (3) a benefits statement from the Social Security Administration.

340.23 For the purpose of further appeals, a patient may receive no more than two medical record  
340.24 updates without charge, but only for medical record information previously not provided.

340.25 For purposes of this paragraph, a patient's authorized representative does not include units  
340.26 of state government engaged in the adjudication of Social Security disability claims.

340.27 **EFFECTIVE DATE.** This section is effective January 1, 2025.

340.28 **Sec. 7. [144.2925] CONSTRUCTION.**

340.29 Sections 144.291 to 144.298 must be construed to protect the privacy of a patient's health  
340.30 records in a more stringent manner than provided in Code of Federal Regulations, title 45,  
340.31 part 164. For purposes of this section, "more stringent" has the meaning given to that term  
340.32 in Code of Federal Regulations, title 45, section 160.202, with respect to a use or disclosure

341.1 or the need for express legal permission from an individual to disclose individually  
341.2 identifiable health information.

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

341.4 Sec. 8. Minnesota Statutes 2022, section 144.293, subdivision 2, is amended to read:

341.5 Subd. 2. **Patient consent to release of records.** A provider, or a person who receives  
341.6 health records from a provider, may not release a patient's health records to a person without:

341.7 (1) a signed and dated consent from the patient or the patient's legally authorized  
341.8 representative authorizing the release;

341.9 (2) specific authorization in Minnesota law; or

341.10 (3) a representation from a provider that holds a signed and dated consent from the  
341.11 patient authorizing the release.

341.12 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
341.13 applies to health records released on or after that date.

341.14 Sec. 9. Minnesota Statutes 2022, section 144.293, subdivision 4, is amended to read:

341.15 Subd. 4. **Duration of consent.** Except as provided in this section, a consent is valid for  
341.16 one year or for a period specified in the consent or for a different period provided by  
341.17 Minnesota law.

341.18 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
341.19 applies to health records released on or after that date.

341.20 Sec. 10. Minnesota Statutes 2022, section 144.293, subdivision 9, is amended to read:

341.21 Subd. 9. **Documentation of release.** (a) In cases where a provider releases health records  
341.22 without patient consent as authorized by Minnesota law, the release must be documented  
341.23 in the patient's health record. In the case of a release under section 144.294, subdivision 2,  
341.24 the documentation must include the date and circumstances under which the release was  
341.25 made, the person or agency to whom the release was made, and the records that were released.

341.26 (b) When a health record is released using a representation from a provider that holds a  
341.27 consent from the patient, the releasing provider shall document:

341.28 (1) the provider requesting the health records;

341.29 (2) the identity of the patient;

342.1 (3) the health records requested; and

342.2 (4) the date the health records were requested.

342.3 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
342.4 applies to health records released on or after that date.

342.5 Sec. 11. Minnesota Statutes 2022, section 144.293, subdivision 10, is amended to read:

342.6 Subd. 10. **Warranties regarding consents, requests, and disclosures.** (a) When  
342.7 requesting health records using consent, a person warrants that the consent:

342.8 (1) contains no information known to the person to be false; and

342.9 (2) accurately states the patient's desire to have health records disclosed or that there is  
342.10 specific authorization in Minnesota law.

342.11 (b) When requesting health records using consent, or a representation of holding a  
342.12 consent, a provider warrants that the request:

342.13 (1) contains no information known to the provider to be false;

342.14 (2) accurately states the patient's desire to have health records disclosed or that there is  
342.15 specific authorization in Minnesota law; and

342.16 (3) does not exceed any limits imposed by the patient in the consent.

342.17 (c) When disclosing health records, a person releasing health records warrants that the  
342.18 person:

342.19 (1) has complied with the requirements of this section regarding disclosure of health  
342.20 records;

342.21 (2) knows of no information related to the request that is false; and

342.22 (3) has complied with the limits set by the patient in the consent.

342.23 **EFFECTIVE DATE.** This section is effective the day following final enactment and  
342.24 applies to health records released on or after that date.

342.25 Sec. 12. Minnesota Statutes 2023 Supplement, section 245.991, subdivision 1, is amended  
342.26 to read:

342.27 Subdivision 1. **Establishment.** The commissioner of human services must establish the  
342.28 projects for assistance in transition from homelessness program to prevent or end  
342.29 homelessness for people with serious mental illness, substance use disorder, or co-occurring

343.1 substance use disorder and ensure the commissioner achieves the goals of the housing  
343.2 mission statement in section 245.461, subdivision 4.

343.3 Sec. 13. Minnesota Statutes 2023 Supplement, section 245C.31, subdivision 1, is amended  
343.4 to read:

343.5 Subdivision 1. **Board determines disciplinary or corrective action.** (a) The  
343.6 commissioner shall notify a health-related licensing board as defined in section 214.01,  
343.7 subdivision 2, if the commissioner determines that an individual who is licensed by the  
343.8 health-related licensing board and who is included on the board's roster list provided in  
343.9 accordance with subdivision 3a is responsible for substantiated maltreatment under section  
343.10 626.557 or chapter 260E, in accordance with subdivision 2. ~~Upon receiving notification~~  
343.11 Except as provided in paragraph (b), the health-related licensing board shall make a  
343.12 determination as to whether to impose disciplinary or corrective action under chapter 214,  
343.13 rather than the commissioner making the decision regarding disqualification.

343.14 (b) The prohibition on disqualification in paragraph (a) does not apply to a background  
343.15 study of an individual regulated by a health-related licensing board if the individual's study  
343.16 is related to child foster care, adult foster care, or family child care licensure.

343.17 Sec. 14. Minnesota Statutes 2022, section 256.01, is amended by adding a subdivision to  
343.18 read:

343.19 Subd. 2c. **Grant consultation.** The commissioner must consult with the commissioner  
343.20 of management and budget to create, review, and revise grant program performance measures  
343.21 and to evaluate grant programs administered by the commissioner in accordance with section  
343.22 16A.055, subdivisions 1a and 1b.

343.23 Sec. 15. Minnesota Statutes 2022, section 256.01, subdivision 41, is amended to read:

343.24 Subd. 41. **Reports on interagency agreements and intra-agency transfers.** (a)  
343.25 Beginning October 31, 2024, and annually thereafter, the commissioner of human services  
343.26 shall provide ~~quarterly reports~~ a report to the chairs and ranking minority members of the  
343.27 legislative committees with jurisdiction over health and human services policy and finance  
343.28 on:

343.29 (1) interagency agreements or service-level agreements and any renewals or extensions  
343.30 of existing interagency or service-level agreements with a state department under section  
343.31 15.01, state agency under section 15.012, or the Department of Information Technology

344.1 Services, with a value of more than \$100,000, or related agreements with the same department  
344.2 or agency with a cumulative value of more than \$100,000; and

344.3 (2) transfers of appropriations of more than \$100,000 between accounts within or between  
344.4 agencies.

344.5 The report must include the statutory citation authorizing the agreement, transfer or dollar  
344.6 amount, purpose, and effective date of the agreement, the duration of the agreement, and a  
344.7 copy of the agreement.

344.8 (b) This subdivision expires December 31, 2034.

344.9 Sec. 16. Minnesota Statutes 2022, section 256B.795, is amended to read:

344.10 **256B.795 MATERNAL AND INFANT HEALTH REPORT.**

344.11 (a) The commissioner of human services, in consultation with the commissioner of  
344.12 health, shall submit a biennial report beginning April 15, 2022, to the chairs and ranking  
344.13 minority members of the legislative committees with jurisdiction over health policy and  
344.14 finance on the effectiveness of state maternal and infant health policies and programs  
344.15 addressing health disparities in prenatal and postpartum health outcomes. For each reporting  
344.16 period, the commissioner shall determine the number of women enrolled in the medical  
344.17 assistance program who are pregnant or are in the 12-month postpartum period of eligibility  
344.18 and the percentage of women in that group who, during each reporting period:

344.19 (1) received prenatal services;

344.20 (2) received doula services;

344.21 (3) gave birth by primary cesarean section;

344.22 (4) gave birth to an infant who received care in the neonatal intensive care unit;

344.23 (5) gave birth to an infant who was premature or who had a low birth weight;

344.24 (6) experienced postpartum hemorrhage;

344.25 (7) received postpartum care within six weeks of giving birth; and

344.26 (8) received a prenatal and postpartum follow-up home visit from a public health nurse.

344.27 (b) These measurements must be determined through an analysis of the utilization data  
344.28 from claims submitted during each reporting period and by any other appropriate means.

344.29 The measurements for each metric must be determined in the aggregate stratified by race  
344.30 and ethnicity.

345.1 (c) The commissioner shall establish a baseline for the metrics described in paragraph  
345.2 (a) using calendar year 2017. The initial report due April 15, 2022, must contain the baseline  
345.3 metrics and the metrics data for calendar years 2019 and 2020. The following reports due  
345.4 biennially thereafter must contain the metrics for the preceding two calendar years.

345.5 (d) This section expires December 31, 2034.

345.6 Sec. 17. Minnesota Statutes 2022, section 256K.45, subdivision 2, is amended to read:

345.7 Subd. 2. **Homeless youth report.** (a) The commissioner shall prepare a biennial report,  
345.8 beginning ~~in February 2015~~ February 1, 2025, which provides meaningful information to  
345.9 the chairs and ranking minority members of the legislative committees having with  
345.10 jurisdiction over ~~the issue of~~ homeless youth, that includes, but is not limited to: (1) a list  
345.11 of the areas of the state with the greatest need for services and housing for homeless youth,  
345.12 and the level and nature of the needs identified; (2) details about grants made, including  
345.13 shelter-linked youth mental health grants under section 256K.46; (3) the distribution of  
345.14 funds throughout the state based on population need; (4) follow-up information, if available,  
345.15 on the status of homeless youth and whether they have stable housing two years after services  
345.16 are provided; and (5) any other outcomes for populations served to determine the  
345.17 effectiveness of the programs and use of funding.

345.18 (b) This subdivision expires December 31, 2034.

345.19 Sec. 18. Minnesota Statutes 2023 Supplement, section 260.761, is amended by adding a  
345.20 subdivision to read:

345.21 Subd. 8. **Missing child notification.** A child-placing agency or individual petitioner  
345.22 shall notify an Indian child's Tribe or Tribes by telephone and by email or facsimile  
345.23 immediately but no later than 24 hours after receiving information on a missing child as  
345.24 defined under section 260C.212, subdivision 13, paragraph (a).

345.25 Sec. 19. 2024 H.F. No. 5237, article 22, section 2, subdivision 4, if enacted, is amended  
345.26 to read:

345.27 Subd. 4. **Central Office; Health Care** (3,216,000) 3,216,000

345.28 The appropriation in fiscal year 2025 is a

345.29 onetime appropriation.

346.1 Sec. 20. 2024 H.F. No. 5237, article 22, section 2, subdivision 5, if enacted, is amended  
346.2 to read:

346.3 **Subd. 5. Central Office; Behavioral Health, Deaf**  
346.4 **and Hard-of-Hearing, and Housing Services** (136,000) 136,000

346.5 The appropriation in fiscal year 2025 is a  
346.6 onetime appropriation.

346.7 **Extended Availability.** \$136,000 of the  
346.8 general fund appropriation in fiscal year 2025  
346.9 is available until June 30, 2027.

346.10 Sec. 21. **ANNUAL REPORT TO LEGISLATURE; USE OF APPROPRIATION**  
346.11 **FUNDS.**

346.12 By January 15, 2025, and every year thereafter, the Board of Regents of the University  
346.13 of Minnesota must submit a report to the chairs and ranking minority members of the  
346.14 legislative committees with primary jurisdiction over higher education and health and human  
346.15 services policy and finance on the use of all appropriations for the benefit of the University  
346.16 of Minnesota's health sciences schools and colleges, including:

346.17 (1) changes to the University of Minnesota's anticipated uses of each appropriation;

346.18 (2) the results of the performance measures required by Minnesota Statutes, section  
346.19 137.095, subdivision 2, clause (6); and

346.20 (3) current and anticipated achievement of the goals, outcomes, and purposes of each  
346.21 appropriation.

346.22 Sec. 22. **DIRECTION TO COMMISSIONER OF HEALTH; HEALTH**  
346.23 **PROFESSIONS WORKFORCE ADVISORY COUNCIL.**

346.24 Subdivision 1. **Health professions workforce advisory council.** The commissioner of  
346.25 health, in consultation with the University of Minnesota and the Minnesota State HealthForce  
346.26 Center of Excellence, shall provide recommendations to the legislature for the creation of  
346.27 a health professions workforce advisory council to:

346.28 (1) research and advise the legislature and the Minnesota Office of Higher Education  
346.29 on the status of the health workforce who are in training and on the need for additional or  
346.30 different training opportunities;

- 347.1 (2) provide information and analysis on health workforce needs and trends, upon request,  
347.2 to the legislature, any state department, or any other entity the advisory council deems  
347.3 appropriate;
- 347.4 (3) review and comment on legislation relevant to Minnesota's health workforce; and
- 347.5 (4) study and provide recommendations regarding the following:
- 347.6 (i) health workforce supply, including:
- 347.7 (A) employment trends and demand;
- 347.8 (B) strategies that entities in Minnesota are using or may use to address health workforce  
347.9 shortages, recruitment, and retention; and
- 347.10 (C) future investments to increase the supply of health care professionals, with particular  
347.11 focus on critical areas of need within Minnesota;
- 347.12 (ii) options for training and educating the health workforce, including:
- 347.13 (A) increasing the diversity of health professions workers to reflect Minnesota's  
347.14 communities;
- 347.15 (B) addressing the maldistribution of primary, mental health, nursing, and dental providers  
347.16 in greater Minnesota and in underserved communities in metropolitan areas;
- 347.17 (C) increasing interprofessional training and clinical practice;
- 347.18 (D) addressing the need for increased quality faculty to train an increased workforce;  
347.19 and
- 347.20 (E) developing advancement paths or career ladders for health care professionals;
- 347.21 (iii) increasing funding for strategies to diversify and address gaps in the health workforce,  
347.22 including:
- 347.23 (A) increasing access to financing for graduate medical education;
- 347.24 (B) expanding pathway programs to increase awareness of the health care professions  
347.25 among high school, undergraduate, and community college students and engaging the current  
347.26 health workforce in those programs;
- 347.27 (C) reducing or eliminating tuition for entry-level health care positions that offer  
347.28 opportunities for future advancement in high-demand settings and expanding other existing  
347.29 financial support programs such as loan forgiveness and scholarship programs;

348.1 (D) incentivizing recruitment from greater Minnesota and recruitment and retention for  
348.2 providers practicing in greater Minnesota and in underserved communities in metropolitan  
348.3 areas; and

348.4 (E) expanding existing programs, or investing in new programs, that provide wraparound  
348.5 support services to the existing health care workforce, especially people of color and  
348.6 professionals from other underrepresented identities, to acquire training and advance within  
348.7 the health care workforce; and

348.8 (iv) other Minnesota health workforce priorities as determined by the advisory council.

348.9 Subd. 2. Report to the legislature. On or before February 1, 2025, the commissioner  
348.10 of health shall submit a report to the chairs and ranking minority members of the legislative  
348.11 committees with jurisdiction over health and human services and higher education finance  
348.12 and policy with recommendations for the creation of a health professions workforce advisory  
348.13 council as described in subdivision 1. The report must include recommendations regarding:

348.14 (1) membership of the advisory council;

348.15 (2) funding sources and estimated costs for the advisory council;

348.16 (3) existing sources of workforce data for the advisory council to perform its duties;

348.17 (4) necessity for and options to obtain new data for the advisory council to perform its  
348.18 duties;

348.19 (5) additional duties of the advisory council;

348.20 (6) proposed legislation to establish the advisory council;

348.21 (7) similar health workforce advisory councils in other states; and

348.22 (8) advisory council reporting requirements.

348.23 Sec. 23. REQUEST FOR INFORMATION; EVALUATION OF STATEWIDE  
348.24 HEALTH CARE NEEDS AND CAPACITY AND PROJECTIONS OF FUTURE  
348.25 HEALTH CARE NEEDS.

348.26 (a) By November 1, 2024, the commissioner of health must publish a request for  
348.27 information to assist the commissioner in a future comprehensive evaluation of current  
348.28 health care needs and capacity in the state and projections of future health care needs in the  
348.29 state based on population and provider characteristics. The request for information:

349.1 (1) must provide guidance on defining the scope of the study and assist in answering  
349.2 methodological questions that will inform the development of a request for proposals to  
349.3 contract for performance of the study; and

349.4 (2) may address topics that include but are not limited to how to define health care  
349.5 capacity, expectations for capacity by geography or service type, how to consider health  
349.6 centers that have areas of particular expertise or services that generally have a higher margin,  
349.7 how hospital-based services should be considered as compared with evolving  
349.8 nonhospital-based services, the role of technology in service delivery, health care workforce  
349.9 supply issues, and other issues related to data or methods.

349.10 (b) By February 1, 2025, the commissioner must submit a report to the chairs and ranking  
349.11 minority members of the legislative committees with jurisdiction over health care, with the  
349.12 results of the request for information and recommendations regarding conducting a  
349.13 comprehensive evaluation of current health care needs and capacity in the state and  
349.14 projections of future health care needs in the state.

349.15 Sec. 24. **REPEALER.**

349.16 Minnesota Statutes 2022, section 256B.79, subdivision 6, is repealed.

## 349.17 **ARTICLE 14**

### 349.18 **APPROPRIATIONS**

349.19 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

349.20 The sums shown in the columns marked "Appropriations" are added to or, if shown in  
349.21 parentheses, subtracted from the appropriations in Laws 2023, chapter 61, article 9; Laws  
349.22 2023, chapter 70, article 20; and Laws 2023, chapter 74, section 6, to the agencies and for  
349.23 the purposes specified in this article. The appropriations are from the general fund or other  
349.24 named fund and are available for the fiscal years indicated for each purpose. The figures  
349.25 "2024" and "2025" used in this article mean that the addition to or subtraction from the  
349.26 appropriation listed under them is available for the fiscal year ending June 30, 2024, or June  
349.27 30, 2025, respectively. Base adjustments mean the addition to or subtraction from the base  
349.28 level adjustment set in Laws 2023, chapter 61, article 9; Laws 2023, chapter 70, article 20;  
349.29 and Laws 2023, chapter 74, section 6. Supplemental appropriations and reductions to  
349.30 appropriations for the fiscal year ending June 30, 2024, are effective the day following final  
349.31 enactment unless a different effective date is explicit.

349.32  
349.33

**APPROPRIATIONS**  
**Available for the Year**

	<u>Ending June 30</u>	
	<u>2024</u>	<u>2025</u>
350.1		
350.2		
350.3	<b>Sec. 2. <u>COMMISSIONER OF HUMAN</u></b>	
350.4	<b><u>SERVICES</u></b>	
350.5	<b><u>Subdivision 1. Total Appropriation</u></b>	<b><u>\$ (22,695,000) \$ 23,032,000</u></b>
350.6	<u>Appropriations by Fund</u>	
350.7	<u>2024</u>	<u>2025</u>
350.8	<u>General</u>	<u>(22,695,000) 23,132,000</u>
350.9	<u>Health Care Access</u>	<u>-0- (100,000)</u>
350.10	<u>The amounts that may be spent for each</u>	
350.11	<u>purpose are specified in the following</u>	
350.12	<u>subdivisions.</u>	
350.13	<b><u>Subd. 2. Central Office; Operations</u></b>	<b><u>-0- (1,907,000)</u></b>
350.14	<b><u>Base Level Adjustment.</u></b> <u>The general fund</u>	
350.15	<u>base is increased by \$239,000 in fiscal year</u>	
350.16	<u>2026 and increased by \$181,000 in fiscal year</u>	
350.17	<u>2027.</u>	
350.18	<b><u>Subd. 3. Central Office; Health Care</u></b>	
350.19	<u>Appropriations by Fund</u>	
350.20	<u>General</u>	<u>-0- 540,000</u>
350.21	<u>Health Care Access</u>	<u>(1,000,000) -0-</u>
350.22	<b><u>Base Level Adjustment.</u></b> <u>The general fund</u>	
350.23	<u>base is increased by \$1,063,000 in fiscal year</u>	
350.24	<u>2026 and increased by \$1,063,000 in fiscal</u>	
350.25	<u>year 2027.</u>	
350.26	<b><u>Subd. 4. Central Office; Behavioral Health, Deaf</u></b>	
350.27	<b><u>and Hard-of-Hearing, and Housing Services</u></b>	
350.28		<b><u>-0- 2,036,000</u></b>
350.29	<u>(a) The appropriation in fiscal year 2025 is a</u>	
350.30	<u>onetime appropriation.</u>	
350.31	<b><u>(b) Medical Assistance Mental Health</u></b>	
350.32	<b><u>Benefit Development.</u></b> <u>\$1,227,000 in fiscal</u>	
350.33	<u>year 2025 is to: (1) conduct an analysis to</u>	
350.34	<u>identify existing or pending Medicaid</u>	
	<u>Clubhouse benefits in other states, federal</u>	

- 351.1 authorities used, populations served, service  
 351.2 and reimbursement design, and accreditation  
 351.3 standards; (2) consult with providers,  
 351.4 advocates, Tribal Nations, counties, people  
 351.5 with lived experience as or with a child in a  
 351.6 mental health crisis, and other interested  
 351.7 community members to develop a covered  
 351.8 benefit under medical assistance to provide  
 351.9 residential mental health crisis stabilization  
 351.10 for children; and (3) develop a First Episode  
 351.11 Psychosis Coordinated Specialty Care  
 351.12 (FEP-CSC) medical assistance benefit. This  
 351.13 is a onetime appropriation and is available  
 351.14 until June 30, 2027.
- 351.15 **Subd. 5. Forecasted Programs; MinnesotaCare** -0- 343,000
- 351.16 (a) This appropriation is from the health care  
 351.17 access fund.
- 351.18 **(b) Base Level Adjustment.** The health care  
 351.19 access fund base is increased by \$1,165,000  
 351.20 in fiscal year 2026 and increased by  
 351.21 \$1,713,000 in fiscal year 2027.
- 351.22 **Subd. 6. Forecasted Programs; Medical**  
 351.23 **Assistance**
- 351.24 Appropriations by Fund
- |                                  |           |                  |
|----------------------------------|-----------|------------------|
| 351.25 <u>General</u>            | -0-       | <u>6,527,000</u> |
| 351.26 <u>Health Care Access</u> | 1,000,000 | <u>(443,000)</u> |
- 351.27 **(a) Additional Payment for Behavioral**  
 351.28 **Health Services Provided by Hospitals.**  
 351.29 \$5,814,000 in fiscal year 2025 is from the  
 351.30 general fund for behavioral health services  
 351.31 provided by hospitals under Minnesota  
 351.32 Statutes, section 256.969, subdivision 2b,  
 351.33 paragraph (a), clause (4). The increase in  
 351.34 payments shall be made by increasing the  
 351.35 adjustment under Minnesota Statutes, section

352.1 256.969, subdivision 2b, paragraph (e), clause  
 352.2 (2).

352.3 (b) Base Level Adjustment. The health care  
 352.4 access fund base is decreased by \$1,265,000  
 352.5 in fiscal year 2026 and decreased by  
 352.6 \$1,813,000 in fiscal year 2027.

352.7	<u>Subd. 7. Forecasted Programs; Behavioral</u>		
352.8	<u>Health Fund</u>	<u>-0-</u>	<u>127,000</u>

352.9	<u>Subd. 8. Grant Programs; Adult Mental Health</u>		
352.10	<u>Grants</u>	<u>(22,695,000)</u>	<u>14,568,000</u>

352.11 (a) Youable Emotional Health. \$300,000 in  
 352.12 fiscal year 2025 is for a grant to Youable  
 352.13 Emotional Health for day treatment  
 352.14 transportation costs on nonschool days, student  
 352.15 nutrition, and student learning experiences  
 352.16 such as technology, arts, and outdoor activity.

352.17 This is a onetime appropriation.  
 352.18 Notwithstanding Minnesota Statutes, section  
 352.19 16B.98, subdivision 14, the amount for  
 352.20 administrative costs under this paragraph is  
 352.21 \$0.

352.22 (b) Comunidades Latinas Unidas En  
 352.23 Servercio Certified Community Behavioral  
 352.24 Health Clinic Services. \$1,500,000 in fiscal  
 352.25 year 2025 is for a payment to Comunidades  
 352.26 Latinas Unidas En Servercio (CLUES) to  
 352.27 provide comprehensive integrated health care  
 352.28 through the certified community behavioral  
 352.29 health clinic (CCBHC) model of service  
 352.30 delivery as required under Minnesota Statutes,  
 352.31 section 245.735. Funds must be used to  
 352.32 provide evidence-based services under the  
 352.33 CCBHC service model and must not be used  
 352.34 to supplant available medical assistance  
 352.35 funding. By June 30, 2026, CLUES must

353.1 report to the commissioner of human services  
 353.2 on:  
 353.3 (1) the number of people served;  
 353.4 (2) outcomes for people served; and  
 353.5 (3) whether the funding reduced behavioral  
 353.6 health racial and ethnic disparities.

353.7 This is a onetime appropriation and is  
 353.8 available until June 30, 2026. Notwithstanding  
 353.9 Minnesota Statutes, section 16B.98,  
 353.10 subdivision 14, the amount for administrative  
 353.11 costs under this paragraph is \$0.

353.12 **(c) Grant to PFund Foundation. \$1,000,000**  
 353.13 in fiscal year 2025 is for a payment to the  
 353.14 PFund Foundation for grants in Minnesota to  
 353.15 support the medical, mental health, and social  
 353.16 service needs of LGBTQIA2S+ individuals.

353.17 This is a onetime appropriation.

353.18 **(d) Adult Mental Health Initiative**  
 353.19 **Appropriation Cancellation and**  
 353.20 **Appropriation. \$11,768,000 of the fiscal year**  
 353.21 **2024 appropriation for the adult mental health**  
 353.22 **initiative is canceled and \$11,768,000 in fiscal**  
 353.23 **year 2025 is for the adult mental health**  
 353.24 **initiative. This is a onetime appropriation.**

353.25 **Subd. 9. Grant Programs; Child Mental Health**  
 353.26 **Grants**

-0-

7,350,000

353.27 **(a) School-Linked Behavioral Health**  
 353.28 **Grants. \$3,000,000 in fiscal year 2025 is for**  
 353.29 **school-linked behavioral health grants under**  
 353.30 **Minnesota Statutes, section 245.4901. This is**  
 353.31 **a onetime appropriation and is available until**  
 353.32 **June 30, 2027. Notwithstanding Minnesota**  
 353.33 **Statutes, section 16B.98, subdivision 14, the**

354.1 amount for administrative costs under this  
 354.2 paragraph is \$0.  
 354.3 **(b) Respite Care Services.** \$2,650,000 in  
 354.4 fiscal year 2025 is for respite care services  
 354.5 under Minnesota Statutes, section 245.4889,  
 354.6 subdivision 1, paragraph (b), clause (3). This  
 354.7 is a onetime appropriation and is available  
 354.8 until June 30, 2027. Notwithstanding  
 354.9 Minnesota Statutes, section 16B.98,  
 354.10 subdivision 14, the amount for administrative  
 354.11 costs under this paragraph is \$515,000.

354.12 **(c) Grant to Volunteers of America.**  
 354.13 \$1,700,000 in fiscal year 2025 is for a grant  
 354.14 to Volunteers of America for program  
 354.15 consolidation, workforce training, and the  
 354.16 development of a trauma-informed locked  
 354.17 setting environment. This is a onetime  
 354.18 appropriation and is available until June 30,  
 354.19 2027. Notwithstanding Minnesota Statutes,  
 354.20 section 16B.98, subdivision 14, the amount  
 354.21 for administrative costs under this paragraph  
 354.22 is \$0.

354.23 **Subd. 10. Direct Care and Treatment; Mental**  
 354.24 **Health and Substance Abuse** -0- (6,109,000)

354.25 **Base Level Adjustments.** The general fund  
 354.26 base is decreased by \$7,566,000 in fiscal year  
 354.27 2026 and decreased by \$7,566,000 in fiscal  
 354.28 year 2027.

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

354.30 **Sec. 3. COMMISSIONER OF HEALTH**

354.31 **Subdivision 1. Total Appropriation** **\$ (2,690,000) \$ (251,000)**

354.32 **Appropriations by Fund**

354.33 2024 2025

355.1	<u>General</u>	<u>(2,694,000)</u>	<u>2,485,000</u>
355.2	<u>State Government</u>		
355.3	<u>Special Revenue</u>	<u>4,000</u>	<u>(2,736,000)</u>
355.4	<u>The amount that may be spent for each</u>		
355.5	<u>purpose is specified in the following</u>		
355.6	<u>subdivisions.</u>		
355.7	<b><u>Subd. 2. Health Improvement</u></b>	<u>(2,694,000)</u>	<u>2,075,000</u>
355.8	<u>(a) Stillbirth Prevention Grant. \$210,000 in</u>		
355.9	<u>fiscal year 2025 is for a grant to Healthy Birth</u>		
355.10	<u>Day, Inc., to operate a stillbirth prevention</u>		
355.11	<u>through tracking fetal movement pilot</u>		
355.12	<u>program. This is a onetime appropriation and</u>		
355.13	<u>is available until June 30, 2028. In accordance</u>		
355.14	<u>with Minnesota Statutes, section 16B.98,</u>		
355.15	<u>subdivision 14, the commissioner may use</u>		
355.16	<u>\$10,000 of this appropriation for</u>		
355.17	<u>administrative costs.</u>		
355.18	<b><u>(b) Grant to Chosen Vessels Midwifery</u></b>		
355.19	<b><u>Services. \$263,000 in fiscal year 2025 is for</u></b>		
355.20	<b><u>a grant to Chosen Vessels Midwifery Services</u></b>		
355.21	<b><u>for a program to provide education, support,</u></b>		
355.22	<b><u>and encouragement for African American</u></b>		
355.23	<b><u>mothers to breastfeed their infants for the first</u></b>		
355.24	<b><u>year of life or longer. Chosen Vessel</u></b>		
355.25	<b><u>Midwifery Services must combine the midwife</u></b>		
355.26	<b><u>model of care with the cultural tradition of</u></b>		
355.27	<b><u>mutual aid to inspire African American</u></b>		
355.28	<b><u>women to breastfeed their infants and to</u></b>		
355.29	<b><u>provide support to those who do. This is a</u></b>		
355.30	<b><u>onetime appropriation and is available until</u></b>		
355.31	<b><u>June 30, 2026. In accordance with Minnesota</u></b>		
355.32	<b><u>Statutes, section 16B.98, subdivision 14, the</u></b>		
355.33	<b><u>commissioner may use \$13,000 of this</u></b>		
355.34	<b><u>appropriation for administrative costs.</u></b>		

356.1 **(c) American Indian Birth Center Planning**  
356.2 **Grant.** \$368,000 in fiscal year 2025 is for a  
356.3 grant to the Birth Justice Collaborative to plan  
356.4 for and engage the community in the  
356.5 development of an American Indian-focused  
356.6 birth center to improve access to culturally  
356.7 centered prenatal and postpartum care with  
356.8 the goal of improving maternal and child  
356.9 health outcomes. The Birth Justice  
356.10 Collaborative must report to the commissioner  
356.11 on the plan to develop an American  
356.12 Indian-focused birth center. This is a onetime  
356.13 appropriation. In accordance with Minnesota  
356.14 Statutes, section 16B.98, subdivision 14, the  
356.15 commissioner may use \$18,000 of this  
356.16 appropriation for administrative costs.

356.17 **(d) Grant to Birth Justice Collaborative for**  
356.18 **African American-Focused Homeplace**  
356.19 **Model.** \$263,000 in fiscal year 2025 is for a  
356.20 grant to the Birth Justice Collaborative for  
356.21 planning and community engagement to  
356.22 develop a replicable African  
356.23 American-focused Homeplace model. The  
356.24 model's purpose must be to improve access to  
356.25 culturally centered healing and care during  
356.26 pregnancy and the postpartum period, with  
356.27 the goal of improving maternal and child  
356.28 health outcomes. The Birth Justice  
356.29 Collaborative must report to the commissioner  
356.30 on the needs of and plan to develop an African  
356.31 American-focused Homeplace model in  
356.32 Hennepin County. The report must outline  
356.33 potential state and public partnerships and  
356.34 financing strategies and must provide a  
356.35 timeline for development. This is a onetime  
356.36 appropriation. In accordance with Minnesota

357.1 Statutes, section 16B.98, subdivision 14, the  
 357.2 commissioner may use \$13,000 of this  
 357.3 appropriation for administrative costs.

357.4 **(e) Request for Information; Evaluation of**  
 357.5 **Statewide Health Care Needs and Capacity.**  
 357.6 \$250,000 in fiscal year 2025 is for a request  
 357.7 for information for a future evaluation of  
 357.8 statewide health care needs and capacity and  
 357.9 projections of future health care needs. This  
 357.10 is a onetime appropriation.

357.11 **(f) Reports on Prior Authorization**  
 357.12 **Requests.** \$191,000 in fiscal year 2025 is for  
 357.13 the purposes of Minnesota Statutes, section  
 357.14 62M.19. This appropriation is available until  
 357.15 June 30, 2027. The base for this appropriation  
 357.16 is \$21,000 in fiscal year 2026 and \$22,000 in  
 357.17 fiscal year 2027.

357.18 **(g) Base Level Adjustment.** The general fund  
 357.19 base is increased by \$247,000 in fiscal year  
 357.20 2026 and increased by \$318,000 in fiscal year  
 357.21 2027.

357.22 **Subd. 3. Health Protection**

357.23	<u>Appropriations by Fund</u>		
357.24	<u>General</u>	<u>-0-</u>	<u>410,000</u>
357.25	<u>State Government</u>		
357.26	<u>Special Revenue</u>	<u>4,000</u>	<u>(2,736,000)</u>

357.27 **(a) Translation of Competency Evaluation**  
 357.28 **for Nursing Assistant Registry.** \$20,000 in  
 357.29 fiscal year 2025 is from the general fund for  
 357.30 translation of competency evaluation materials  
 357.31 for the nursing assistant registry. This is a  
 357.32 onetime appropriation.

357.33 **(b) Hospital Closure, Relocation, or Service**  
 357.34 **Cessation.** \$9,000 in fiscal year 2025 is from

358.1 the general fund for activities under Minnesota  
 358.2 Statutes, section 144.555.

358.3 **(c) Natural Organic Reduction.** \$140,000 in  
 358.4 fiscal year 2025 is from the state government  
 358.5 special revenue fund for the licensure of  
 358.6 natural organic reduction facilities. The base  
 358.7 for this appropriation is \$85,000 in fiscal year  
 358.8 2026 and \$16,000 in fiscal year 2027.

358.9 **(d) Groundwater Thermal Exchange Device**  
 358.10 **Permitting.** \$4,000 in fiscal year 2024 and  
 358.11 \$4,000 in fiscal year 2025 are from the state  
 358.12 government special revenue fund for costs  
 358.13 related to issuing permits for groundwater  
 358.14 thermal exchange devices.

358.15 **(e) Base Level Adjustment.** The general fund  
 358.16 base is increased by \$390,000 in fiscal year  
 358.17 2026 and increased by \$185,000 in fiscal year  
 358.18 2027. The state government special revenue  
 358.19 fund base is decreased by \$2,791,000 in fiscal  
 358.20 year 2026 and decreased by \$2,860,000 in  
 358.21 fiscal year 2027.

358.22 Sec. 4. **BOARD OF PHARMACY**

358.23	<u>Appropriations by Fund</u>		
358.24	<u>General</u>	<u>1,500,000</u>	<u>-0-</u>
358.25	<u>State Government</u>		
358.26	<u>Special Revenue</u>	<u>-0-</u>	<u>27,000</u>

358.27 **(a) Legal Costs.** \$1,500,000 in fiscal year  
 358.28 2024 is from the general fund for legal costs.  
 358.29 This is a onetime appropriation.

358.30 **(b) Base Level Adjustment.** The state  
 358.31 government special revenue fund base is  
 358.32 increased by \$27,000 in fiscal year 2026 and  
 358.33 increased by \$27,000 in fiscal year 2027.

359.1 **Sec. 5. RARE DISEASE ADVISORY**  
 359.2 **COUNCIL** \$ -0- \$ 342,000

359.3 This is a onetime appropriation and is  
 359.4 available until June 30, 2027.

359.5 **Sec. 6. COMMISSIONER OF MANAGEMENT**  
 359.6 **AND BUDGET**

359.7	<u>Appropriations by Fund</u>	
359.8	<u>2024</u>	<u>2025</u>
359.9	<u>General</u>	<u>-0-</u> <u>(232,000)</u>
359.10	<u>Health Care Access</u>	<u>-0-</u> <u>100,000</u>

359.11 (a) **Insulin safety net program.** \$100,000 in  
 359.12 fiscal year 2025 is from the health care access  
 359.13 fund for the insulin safety net program in  
 359.14 Minnesota Statutes, section 151.74.

359.15 (b) **Transfer.** The commissioner must transfer  
 359.16 from the health care access fund to the insulin  
 359.17 safety net program account in the special  
 359.18 revenue fund the amount certified by the  
 359.19 commissioner of administration under  
 359.20 Minnesota Statutes, section 151.741,  
 359.21 subdivision 5, paragraph (b), estimated to be  
 359.22 \$100,000 in fiscal year 2025, for  
 359.23 reimbursement to manufacturers for insulin  
 359.24 dispensed under the insulin safety net program  
 359.25 in Minnesota Statutes, section 151.74. The  
 359.26 base for this transfer is estimated to be  
 359.27 \$100,000 in fiscal year 2026 and \$100,000 in  
 359.28 fiscal year 2027.

359.29 (c) **Base Level Adjustment.** The health care  
 359.30 access fund base is increased by \$100,000 in  
 359.31 fiscal year 2026 and increased by \$100,000 in  
 359.32 fiscal year 2027.

359.33 **Sec. 7. BOARD OF DIRECTORS OF MNSURE** \$ -0- \$ 2,330,000

360.1 (a) Information Technology to Implement  
 360.2 Federal Deferred Action for Childhood  
 360.3 Arrivals Regulatory Requirements.  
 360.4 \$2,330,000 in fiscal year 2025 is for  
 360.5 information technology to implement federal  
 360.6 Deferred Action for Childhood Arrivals  
 360.7 regulatory requirements. This is a onetime  
 360.8 appropriation and is available until June 30,  
 360.9 2027.

360.10 (b) Transfer to Enterprise Account. The  
 360.11 Board of Directors of MNsure must transfer  
 360.12 \$2,330,000 in fiscal year 2025 from the  
 360.13 general fund to the enterprise account under  
 360.14 Minnesota Statutes, section 62V.07. This is a  
 360.15 onetime transfer.

360.16 Sec. 8. COMMISSIONER OF COMMERCE    \$                    -0- \$                    149,000

360.17 (a) Defrayal of Costs for Mandated  
 360.18 Coverage of Orthotic and Prosthetic  
 360.19 Devices. The general fund base is increased  
 360.20 by \$558,000 in fiscal year 2026 and increased  
 360.21 by \$539,000 in fiscal year 2027. The base  
 360.22 includes \$520,000 in fiscal year 2026 and  
 360.23 \$540,000 in fiscal year 2027 for the estimated  
 360.24 amount of defrayal costs for mandated  
 360.25 coverage of orthotic and prosthetic devices  
 360.26 and \$38,000 in fiscal year 2026 and \$19,000  
 360.27 in fiscal year 2027 for administrative costs to  
 360.28 implement mandated coverage of orthotic and  
 360.29 prosthetic devices.

360.30 (b) Defrayal of Costs for Mandated  
 360.31 Coverage of Abortions and  
 360.32 Abortion-Related Services. The general fund  
 360.33 base is increased by \$338,000 in fiscal year  
 360.34 2026 and increased by \$319,000 in fiscal year  
 360.35 2027. The base includes \$300,000 in fiscal



362.1 year 2025 is for review and related  
362.2 investigatory and enforcement actions for  
362.3 conversion transactions under Minnesota  
362.4 Statutes, sections 145D.30 to 145D.37.  
362.5 **(b) Base Level Adjustment.** The general fund  
362.6 base is increased by \$53,000 in fiscal year  
362.7 2026 and increased by \$53,000 in fiscal year  
362.8 2027.

362.9 Sec. 10. Laws 2023, chapter 22, section 4, subdivision 2, is amended to read:

362.10 Subd. 2. **Grants to navigators.**

362.11 (a) \$1,936,000 in fiscal year 2024 is  
362.12 appropriated from the health care access fund  
362.13 to the commissioner of human services for  
362.14 grants to organizations with a MNsure grant  
362.15 services navigator assister contract in good  
362.16 standing as of the date of enactment. The grant  
362.17 payment to each organization must be in  
362.18 proportion to the number of medical assistance  
362.19 and MinnesotaCare enrollees each  
362.20 organization assisted that resulted in a  
362.21 successful enrollment in the second quarter of  
362.22 fiscal years 2020 and 2023, as determined by  
362.23 MNsure's navigator payment process. This is  
362.24 a onetime appropriation and is available until  
362.25 June 30, 2025.

362.26 (b) \$3,000,000 in fiscal year 2024 is  
362.27 appropriated from the health care access fund  
362.28 to the commissioner of human services for  
362.29 grants to organizations with a MNsure grant  
362.30 services navigator assister contract for  
362.31 successful enrollments in medical assistance  
362.32 and MinnesotaCare. This is a onetime  
362.33 appropriation and is available until June 30,  
362.34 2025.

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

363.2 Sec. 11. Laws 2023, chapter 57, article 1, section 6, is amended to read:

363.3 Sec. 6. **PREMIUM SECURITY ACCOUNT TRANSFER; OUT.**

363.4 ~~\$275,775,000~~ \$284,605,000 in fiscal year 2026 is transferred from the premium security  
 363.5 plan account under Minnesota Statutes, section 62E.25, subdivision 1, to the general fund.  
 363.6 This is a onetime transfer.

363.7 Sec. 12. Laws 2023, chapter 70, article 20, section 2, subdivision 5, is amended to read:

363.8 Subd. 5. **Central Office; Health Care**

363.9	Appropriations by Fund		
363.10	General	35,807,000	31,349,000
363.11	Health Care Access	30,668,000	50,168,000

363.12 (a) **Medical assistance and MinnesotaCare**

363.13 **accessibility improvements.** \$4,000,000 in  
 363.14 fiscal year 2024 is from the general fund for  
 363.15 interactive voice response upgrades and  
 363.16 translation services for medical assistance and  
 363.17 MinnesotaCare enrollees with limited English  
 363.18 proficiency. This appropriation is available  
 363.19 until June 30, 2025.

363.20 (b) **Transforming service delivery.** \$155,000

363.21 in fiscal year 2024 and \$180,000 in fiscal year  
 363.22 2025 are from the general fund for  
 363.23 transforming service delivery projects.

363.24 (c) **Improving the Minnesota eligibility**

363.25 **technology system functionality.** \$1,604,000  
 363.26 in fiscal year 2024 and \$711,000 in fiscal year  
 363.27 2025 are from the general fund for improving  
 363.28 the Minnesota eligibility technology system  
 363.29 functionality. The base for this appropriation  
 363.30 is \$1,421,000 in fiscal year 2026 and \$0 in  
 363.31 fiscal year 2027.

364.1 **(d) Actuarial and economic analyses.**

364.2 \$2,500,000 is from the health care access fund  
364.3 for actuarial and economic analyses and to  
364.4 prepare and submit a state innovation waiver  
364.5 under section 1332 of the federal Affordable  
364.6 Care Act for a Minnesota public option health  
364.7 care plan. This is a onetime appropriation and  
364.8 is available until June 30, 2025.

364.9 **(e) Contingent appropriation for Minnesota  
364.10 public option health care plan. ~~\$22,000,000~~**

364.11 \$21,000,000 in fiscal year 2025 is from the  
364.12 health care access fund to implement a  
364.13 Minnesota public option health care plan. This  
364.14 is a onetime appropriation and is available  
364.15 upon approval of a state innovation waiver  
364.16 under section 1332 of the federal Affordable  
364.17 Care Act. This appropriation is available until  
364.18 June 30, 2027.

364.19 **(f) Carryforward authority.** Notwithstanding

364.20 Minnesota Statutes, section 16A.28,  
364.21 subdivision 3, \$2,367,000 of the appropriation  
364.22 in fiscal year 2024 is available until June 30,  
364.23 2027.

364.24 **(g) Base level adjustment.** The general fund

364.25 base is \$32,315,000 in fiscal year 2026 and  
364.26 \$27,536,000 in fiscal year 2027. The health  
364.27 care access fund base is \$28,168,000 in fiscal  
364.28 year 2026 and \$28,168,000 in fiscal year 2027.

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

365.1 Sec. 13. Laws 2023, chapter 70, article 20, section 2, subdivision 31, as amended by Laws  
 365.2 2023, chapter 75, section 12, is amended to read:

365.3 Subd. 31. **Direct Care and Treatment - Mental**  
 365.4 **Health and Substance Abuse** -0- 6,109,000

365.5 ~~(a) Keeping Nurses at the Bedside Act;~~  
 365.6 ~~contingent appropriation. The appropriation~~  
 365.7 ~~in this subdivision is contingent upon~~  
 365.8 ~~legislative enactment by the 93rd Legislature~~  
 365.9 ~~of provisions substantially similar to 2023 S.F.~~  
 365.10 ~~No. 1561, the second engrossment, article 2.~~

365.11 ~~(b) Base level adjustment.~~ The general fund  
 365.12 base is increased by \$7,566,000 in fiscal year  
 365.13 2026 and increased by \$7,566,000 in fiscal  
 365.14 year 2027.

365.15 Sec. 14. Laws 2023, chapter 70, article 20, section 3, subdivision 2, is amended to read:

365.16 Subd. 2. **Health Improvement**

365.17	Appropriations by Fund		
365.18	General	229,600,000	210,030,000
365.19	State Government		
365.20	Special Revenue	12,392,000	12,682,000
365.21	Health Care Access	49,051,000	53,290,000
365.22	Federal TANF	11,713,000	11,713,000

365.23 (a) **Studies of telehealth expansion and**  
 365.24 **payment parity.** \$1,200,000 in fiscal year  
 365.25 2024 is from the general fund for studies of  
 365.26 telehealth expansion and payment parity. This  
 365.27 is a onetime appropriation and is available  
 365.28 until June 30, 2025.

365.29 (b) **Advancing equity through capacity**  
 365.30 **building and resource allocation grant**  
 365.31 **program.** \$916,000 in fiscal year 2024 and  
 365.32 \$916,000 in fiscal year 2025 are from the  
 365.33 general fund for grants under Minnesota

366.1 Statutes, section 144.9821. This is a onetime  
366.2 appropriation.

366.3 **(c) Grant to Minnesota Community Health**  
366.4 **Worker Alliance.** \$971,000 in fiscal year  
366.5 2024 and \$971,000 in fiscal year 2025 are  
366.6 from the general fund for Minnesota Statutes,  
366.7 section 144.1462.

366.8 **(d) Community solutions for healthy child**  
366.9 **development grants.** \$2,730,000 in fiscal year  
366.10 2024 and \$2,730,000 in fiscal year 2025 are  
366.11 from the general fund for grants under  
366.12 Minnesota Statutes, section 145.9257. The  
366.13 base for this appropriation is \$2,415,000 in  
366.14 fiscal year 2026 and \$2,415,000 in fiscal year  
366.15 2027.

366.16 **(e) Comprehensive Overdose and Morbidity**  
366.17 **Prevention Act.** \$9,794,000 in fiscal year  
366.18 2024 and \$10,458,000 in fiscal year 2025 are  
366.19 from the general fund for comprehensive  
366.20 overdose and morbidity prevention strategies  
366.21 under Minnesota Statutes, section 144.0528.  
366.22 The base for this appropriation is \$10,476,000  
366.23 in fiscal year 2026 and \$10,476,000 in fiscal  
366.24 year 2027.

366.25 **(f) Emergency preparedness and response.**  
366.26 \$10,486,000 in fiscal year 2024 and  
366.27 \$14,314,000 in fiscal year 2025 are from the  
366.28 general fund for public health emergency  
366.29 preparedness and response, the sustainability  
366.30 of the strategic stockpile, and COVID-19  
366.31 pandemic response transition. The base for  
366.32 this appropriation is \$11,438,000 in fiscal year  
366.33 2026 and \$11,362,000 in fiscal year 2027.

367.1 **(g) Healthy Beginnings, Healthy Families.**  
367.2 (1) \$8,440,000 in fiscal year 2024 and  
367.3 \$7,305,000 in fiscal year 2025 are from the  
367.4 general fund for grants under Minnesota  
367.5 Statutes, sections 145.9571 to 145.9576. The  
367.6 base for this appropriation is \$1,500,000 in  
367.7 fiscal year 2026 and \$1,500,000 in fiscal year  
367.8 2027. (2) Of the amount in clause (1),  
367.9 \$400,000 in fiscal year 2024 is to support the  
367.10 transition from implementation of activities  
367.11 under Minnesota Statutes, section 145.4235,  
367.12 to implementation of activities under  
367.13 Minnesota Statutes, sections 145.9571 to  
367.14 145.9576. The commissioner shall award four  
367.15 sole-source grants of \$100,000 each to Face  
367.16 to Face, Cradle of Hope, Division of Indian  
367.17 Work, and Minnesota Prison Doula Project.  
367.18 The amount in this clause is a onetime  
367.19 appropriation.

367.20 **(h) Help Me Connect.** \$463,000 in fiscal year  
367.21 2024 and \$921,000 in fiscal year 2025 are  
367.22 from the general fund for the Help Me  
367.23 Connect program under Minnesota Statutes,  
367.24 section 145.988.

367.25 **(i) Home visiting.** \$2,000,000 in fiscal year  
367.26 2024 and \$2,000,000 in fiscal year 2025 are  
367.27 from the general fund for home visiting under  
367.28 Minnesota Statutes, section 145.87, to provide  
367.29 home visiting to priority populations under  
367.30 Minnesota Statutes, section 145.87,  
367.31 subdivision 1, paragraph (e).

367.32 **(j) No Surprises Act enforcement.**  
367.33 \$1,210,000 in fiscal year 2024 and \$1,090,000  
367.34 in fiscal year 2025 are from the general fund  
367.35 for implementation of the federal No Surprises

368.1 Act under Minnesota Statutes, section  
368.2 62Q.021, and an assessment of the feasibility  
368.3 of a statewide provider directory. The general  
368.4 fund base for this appropriation is \$855,000  
368.5 in fiscal year 2026 and \$855,000 in fiscal year  
368.6 2027.

368.7 **(k) Office of African American Health.**  
368.8 \$1,000,000 in fiscal year 2024 and \$1,000,000  
368.9 in fiscal year 2025 are from the general fund  
368.10 for grants under the authority of the Office of  
368.11 African American Health under Minnesota  
368.12 Statutes, section 144.0756.

368.13 **(l) Office of American Indian Health.**  
368.14 \$1,000,000 in fiscal year 2024 and \$1,000,000  
368.15 in fiscal year 2025 are from the general fund  
368.16 for grants under the authority of the Office of  
368.17 American Indian Health under Minnesota  
368.18 Statutes, section 144.0757.

368.19 **(m) Public health system transformation**  
368.20 **grants.** (1) \$9,844,000 in fiscal year 2024 and  
368.21 \$9,844,000 in fiscal year 2025 are from the  
368.22 general fund for grants under Minnesota  
368.23 Statutes, section 145A.131, subdivision 1,  
368.24 paragraph (f).

368.25 (2) \$535,000 in fiscal year 2024 and \$535,000  
368.26 in fiscal year 2025 are from the general fund  
368.27 for grants under Minnesota Statutes, section  
368.28 145A.14, subdivision 2b.

368.29 (3) \$321,000 in fiscal year 2024 and \$321,000  
368.30 in fiscal year 2025 are from the general fund  
368.31 for grants under Minnesota Statutes, section  
368.32 144.0759.

368.33 **(n) Health care workforce.** (1) \$1,010,000  
368.34 in fiscal year 2024 and \$2,550,000 in fiscal

369.1 year 2025 are from the health care access fund  
369.2 for rural training tracks and rural clinicals  
369.3 grants under Minnesota Statutes, sections  
369.4 144.1505 and 144.1507. The base for this  
369.5 appropriation is \$4,060,000 in fiscal year 2026  
369.6 and \$3,600,000 in fiscal year 2027.

369.7 (2) \$420,000 in fiscal year 2024 and \$420,000  
369.8 in fiscal year 2025 are from the health care  
369.9 access fund for immigrant international  
369.10 medical graduate training grants under  
369.11 Minnesota Statutes, section 144.1911.

369.12 (3) \$5,654,000 in fiscal year 2024 and  
369.13 \$5,550,000 in fiscal year 2025 are from the  
369.14 health care access fund for site-based clinical  
369.15 training grants under Minnesota Statutes,  
369.16 section 144.1508. The base for this  
369.17 appropriation is \$4,657,000 in fiscal year 2026  
369.18 and \$3,451,000 in fiscal year 2027.

369.19 (4) \$1,000,000 in fiscal year 2024 and  
369.20 \$1,000,000 in fiscal year 2025 are from the  
369.21 health care access fund for mental health for  
369.22 health care professional grants. This is a  
369.23 onetime appropriation and is available until  
369.24 June 30, 2027.

369.25 (5) \$502,000 in fiscal year 2024 and \$502,000  
369.26 in fiscal year 2025 are from the health care  
369.27 access fund for workforce research and data  
369.28 analysis of shortages, maldistribution of health  
369.29 care providers in Minnesota, and the factors  
369.30 that influence decisions of health care  
369.31 providers to practice in rural areas of  
369.32 Minnesota.

369.33 (o) **School health.** \$800,000 in fiscal year  
369.34 2024 and \$1,300,000 in fiscal year 2025 are

370.1 from the general fund for grants under  
370.2 Minnesota Statutes, section 145.903. The base  
370.3 for this appropriation is \$2,300,000 in fiscal  
370.4 year 2026 and \$2,300,000 in fiscal year 2027.

370.5 (p) **Long COVID.** \$3,146,000 in fiscal year  
370.6 2024 and \$3,146,000 in fiscal year 2025 are  
370.7 from the general fund for grants and to  
370.8 implement Minnesota Statutes, section  
370.9 145.361.

370.10 (q) **Workplace safety grants.** \$4,400,000 in  
370.11 fiscal year 2024 is from the general fund for  
370.12 grants to health care entities to improve  
370.13 employee safety or security. This is a onetime  
370.14 appropriation and is available until June 30,  
370.15 2027. The commissioner may use up to ten  
370.16 percent of this appropriation for  
370.17 administration.

370.18 (r) **Clinical dental education innovation**  
370.19 **grants.** \$1,122,000 in fiscal year 2024 and  
370.20 \$1,122,000 in fiscal year 2025 are from the  
370.21 general fund for clinical dental education  
370.22 innovation grants under Minnesota Statutes,  
370.23 section 144.1913.

370.24 (s) **Emmett Louis Till Victims Recovery**  
370.25 **Program.** \$500,000 in fiscal year 2024 is from  
370.26 the general fund for a grant to the Emmett  
370.27 Louis Till Victims Recovery Program. The  
370.28 commissioner must not use any of this  
370.29 appropriation for administration. This is a  
370.30 onetime appropriation and is available until  
370.31 June 30, 2025.

370.32 (t) **Center for health care affordability.**  
370.33 \$2,752,000 in fiscal year 2024 and \$3,989,000  
370.34 in fiscal year 2025 are from the general fund

371.1 to establish a center for health care  
371.2 affordability and to implement Minnesota  
371.3 Statutes, section 62J.312. The general fund  
371.4 base for this appropriation is \$3,988,000 in  
371.5 fiscal year 2026 and \$3,988,000 in fiscal year  
371.6 2027.

371.7 **(u) Federally qualified health centers**  
371.8 **apprenticeship program.** \$690,000 in fiscal  
371.9 year 2024 and \$690,000 in fiscal year 2025  
371.10 are from the general fund for grants under  
371.11 Minnesota Statutes, section 145.9272.

371.12 **(v) Alzheimer's public information**  
371.13 **program.** \$80,000 in fiscal year 2024 and  
371.14 \$80,000 in fiscal year 2025 are from the  
371.15 general fund for grants to community-based  
371.16 organizations to co-create culturally specific  
371.17 messages to targeted communities and to  
371.18 promote public awareness materials online  
371.19 through diverse media channels.

371.20 **(w) ~~Keeping Nurses at the Bedside Act;~~**  
371.21 **~~contingent appropriation~~ Nurse and Patient**  
371.22 **Safety Act.** ~~The appropriations in this~~  
371.23 ~~paragraph are contingent upon legislative~~  
371.24 ~~enactment of 2023 Senate File 1384 by the~~  
371.25 ~~93rd Legislature.~~ The appropriations in this  
371.26 paragraph are available until June 30, 2027.

371.27 (1) \$5,317,000 in fiscal year 2024 and  
371.28 \$5,317,000 in fiscal year 2025 are from the  
371.29 general fund for loan forgiveness under  
371.30 Minnesota Statutes, section 144.1501, for  
371.31 eligible nurses who have agreed to work as  
371.32 hospital nurses in accordance with Minnesota  
371.33 Statutes, section 144.1501, subdivision 2,  
371.34 paragraph (a), clause (7).

372.1 (2) \$66,000 in fiscal year 2024 and \$66,000  
372.2 in fiscal year 2025 are from the general fund  
372.3 for loan forgiveness under Minnesota Statutes,  
372.4 section 144.1501, for eligible nurses who have  
372.5 agreed to teach in accordance with Minnesota  
372.6 Statutes, section 144.1501, subdivision 2,  
372.7 paragraph (a), clause (3).

372.8 ~~(3) \$545,000 in fiscal year 2024 and \$879,000~~  
372.9 ~~in fiscal year 2025 are from the general fund~~  
372.10 ~~to administer Minnesota Statutes, section~~  
372.11 ~~144.7057; to perform the evaluation duties~~  
372.12 ~~described in Minnesota Statutes, section~~  
372.13 ~~144.7058; to continue prevention of violence~~  
372.14 ~~in health care program activities; to analyze~~  
372.15 ~~potential links between adverse events and~~  
372.16 ~~understaffing; to convene stakeholder groups~~  
372.17 ~~and create a best practices toolkit; and for a~~  
372.18 ~~report on the current status of the state's~~  
372.19 ~~nursing workforce employed by hospitals. The~~  
372.20 ~~base for this appropriation is \$624,000 in fiscal~~  
372.21 ~~year 2026 and \$454,000 in fiscal year 2027.~~

372.22 **(x) Supporting healthy development of**  
372.23 **babies.** \$260,000 in fiscal year 2024 and  
372.24 \$260,000 in fiscal year 2025 are from the  
372.25 general fund for a grant to the Amherst H.  
372.26 Wilder Foundation for the African American  
372.27 Babies Coalition initiative. The base for this  
372.28 appropriation is \$520,000 in fiscal year 2026  
372.29 and \$0 in fiscal year 2027. Any appropriation  
372.30 in fiscal year 2026 is available until June 30,  
372.31 2027. This paragraph expires on June 30,  
372.32 2027.

372.33 **(y) Health professional education loan**  
372.34 **forgiveness.** \$2,780,000 in fiscal year 2024  
372.35 is from the general fund for eligible mental

373.1 health professional loan forgiveness under  
373.2 Minnesota Statutes, section 144.1501. This is  
373.3 a onetime appropriation. The commissioner  
373.4 may use up to ten percent of this appropriation  
373.5 for administration.

373.6 **(z) Primary care residency expansion grant**  
373.7 **program.** \$400,000 in fiscal year 2024 and  
373.8 \$400,000 in fiscal year 2025 are from the  
373.9 general fund for a psychiatry resident under  
373.10 Minnesota Statutes, section 144.1506.

373.11 **(aa) Pediatric primary care mental health**  
373.12 **training grant program.** \$1,000,000 in fiscal  
373.13 year 2024 and \$1,000,000 in fiscal year 2025  
373.14 are from the general fund for grants under  
373.15 Minnesota Statutes, section 144.1509. The  
373.16 commissioner may use up to ten percent of  
373.17 this appropriation for administration.

373.18 **(bb) Mental health cultural community**  
373.19 **continuing education grant program.**  
373.20 \$500,000 in fiscal year 2024 and \$500,000 in  
373.21 fiscal year 2025 are from the general fund for  
373.22 grants under Minnesota Statutes, section  
373.23 144.1511. The commissioner may use up to  
373.24 ten percent of this appropriation for  
373.25 administration.

373.26 **(cc) Labor trafficking services grant**  
373.27 **program.** \$500,000 in fiscal year 2024 and  
373.28 \$500,000 in fiscal year 2025 are from the  
373.29 general fund for grants under Minnesota  
373.30 Statutes, section 144.3885.

373.31 **(dd) Palliative Care Advisory Council.**  
373.32 ~~\$40,000~~ \$44,000 in fiscal year 2024 and  
373.33 ~~\$40,000~~ \$44,000 in fiscal year 2025 are from

374.1 the general fund for ~~grants under~~ Minnesota  
374.2 Statutes, section 144.059.

374.3 **(ee) Analysis of a universal health care**  
374.4 **financing system.** \$1,815,000 in fiscal year  
374.5 2024 and \$580,000 in fiscal year 2025 are  
374.6 from the general fund to the commissioner to  
374.7 contract for an analysis of the benefits and  
374.8 costs of a legislative proposal for a universal  
374.9 health care financing system and a similar  
374.10 analysis of the current health care financing  
374.11 system. The base for this appropriation is  
374.12 \$580,000 in fiscal year 2026 and \$0 in fiscal  
374.13 year 2027. This appropriation is available until  
374.14 June 30, 2027.

374.15 **(ff) Charitable assets public interest review.**  
374.16 (1) The appropriations under this paragraph  
374.17 are contingent upon legislative enactment of  
374.18 2023 House File 402 by the 93rd Legislature.

374.19 (2) \$1,584,000 in fiscal year 2024 and  
374.20 \$769,000 in fiscal year 2025 are from the  
374.21 general fund to review certain health care  
374.22 entity transactions; to conduct analyses of the  
374.23 impacts of health care transactions on health  
374.24 care cost, quality, and competition; and to  
374.25 issue public reports on health care transactions  
374.26 in Minnesota and their impacts. The base for  
374.27 this appropriation is \$710,000 in fiscal year  
374.28 2026 and \$710,000 in fiscal year 2027.

374.29 **(gg) Study of the development of a statewide**  
374.30 **registry for provider orders for**  
374.31 **life-sustaining treatment.** ~~\$365,000~~ \$225,000  
374.32 in fiscal year 2024 ~~and \$365,000 in fiscal year~~  
374.33 ~~2025 are~~ is from the general fund for a study  
374.34 of the development of a statewide registry for

- 375.1 provider orders for life-sustaining treatment.
- 375.2 This is a onetime appropriation.
- 375.3 **(hh) Task Force on Pregnancy Health and**
- 375.4 **Substance Use Disorders.** \$199,000 in fiscal
- 375.5 year 2024 and \$100,000 in fiscal year 2025
- 375.6 are from the general fund for the Task Force
- 375.7 on Pregnancy Health and Substance Use
- 375.8 Disorders. This is a onetime appropriation and
- 375.9 is available until June 30, 2025.
- 375.10 **(ii) 988 Suicide and crisis lifeline.** \$4,000,000
- 375.11 in fiscal year 2024 is from the general fund
- 375.12 for 988 national suicide prevention lifeline
- 375.13 grants under Minnesota Statutes, section
- 375.14 145.561. This is a onetime appropriation.
- 375.15 **(jj) Equitable Health Care Task Force.**
- 375.16 \$779,000 in fiscal year 2024 and \$749,000 in
- 375.17 fiscal year 2025 are from the general fund for
- 375.18 the Equitable Health Care Task Force. This is
- 375.19 a onetime appropriation.
- 375.20 **(kk) Psychedelic Medicine Task Force.**
- 375.21 \$338,000 in fiscal year 2024 and \$171,000 in
- 375.22 fiscal year 2025 are from the general fund for
- 375.23 the Psychedelic Medicine Task Force. This is
- 375.24 a onetime appropriation.
- 375.25 **(ll) Medical education and research costs.**
- 375.26 \$300,000 in fiscal year 2024 and \$300,000 in
- 375.27 fiscal year 2025 are from the general fund for
- 375.28 the medical education and research costs
- 375.29 program under Minnesota Statutes, section
- 375.30 62J.692.
- 375.31 **(mm) Special Guerilla Unit Veterans grant**
- 375.32 **program.** \$250,000 in fiscal year 2024 and
- 375.33 \$250,000 in fiscal year 2025 are from the
- 375.34 general fund for a grant to the Special

376.1 Guerrilla Units Veterans and Families of the  
376.2 United States of America to offer  
376.3 programming and culturally specific and  
376.4 specialized assistance to support the health  
376.5 and well-being of Special Guerilla Unit  
376.6 Veterans. The base for this appropriation is  
376.7 \$500,000 in fiscal year 2026 and \$0 in fiscal  
376.8 year 2027. Any amount appropriated in fiscal  
376.9 year 2026 is available until June 30, 2027.

376.10 This paragraph expires June 30, 2027.

376.11 **(nn) Safe harbor regional navigator.**

376.12 \$300,000 in fiscal year 2024 and \$300,000 in  
376.13 fiscal year 2025 are for a regional navigator  
376.14 in northwestern Minnesota. The commissioner  
376.15 may use up to ten percent of this appropriation  
376.16 for administration.

376.17 **(oo) Network adequacy.** \$798,000 in fiscal  
376.18 year 2024 and \$491,000 in fiscal year 2025  
376.19 are from the general fund for reviews of  
376.20 provider networks under Minnesota Statutes,  
376.21 section 62K.10, to determine network  
376.22 adequacy.

376.23 **(pp) Grant to Minnesota Alliance for**  
376.24 **Volunteer Advancement.** \$278,000 in fiscal  
376.25 year 2024 is from the general fund for a grant  
376.26 to the Minnesota Alliance for Volunteer  
376.27 Advancement to administer needs-based  
376.28 volunteerism subgrants targeting  
376.29 underresourced nonprofit organizations in  
376.30 greater Minnesota. Subgrants must be used to  
376.31 support the ongoing efforts of selected  
376.32 organizations to address and minimize  
376.33 disparities in access to human services through  
376.34 increased volunteerism. Subgrant applicants  
376.35 must demonstrate that the populations to be

377.1 served by the subgrantee are underserved or  
377.2 suffer from or are at risk of homelessness,  
377.3 hunger, poverty, lack of access to health care,  
377.4 or deficits in education. The Minnesota  
377.5 Alliance for Volunteer Advancement must  
377.6 give priority to organizations that are serving  
377.7 the needs of vulnerable populations. This is a  
377.8 onetime appropriation and is available until  
377.9 June 30, 2025.

377.10 ~~(pp)~~ (qq)(1) TANF Appropriations. TANF  
377.11 funds must be used as follows:

377.12 (i) \$3,579,000 in fiscal year 2024 and  
377.13 \$3,579,000 in fiscal year 2025 are from the  
377.14 TANF fund for home visiting and nutritional  
377.15 services listed under Minnesota Statutes,  
377.16 section 145.882, subdivision 7, clauses (6) and  
377.17 (7). Funds must be distributed to community  
377.18 health boards according to Minnesota Statutes,  
377.19 section 145A.131, subdivision 1;

377.20 (ii) \$2,000,000 in fiscal year 2024 and  
377.21 \$2,000,000 in fiscal year 2025 are from the  
377.22 TANF fund for decreasing racial and ethnic  
377.23 disparities in infant mortality rates under  
377.24 Minnesota Statutes, section 145.928,  
377.25 subdivision 7;

377.26 (iii) \$4,978,000 in fiscal year 2024 and  
377.27 \$4,978,000 in fiscal year 2025 are from the  
377.28 TANF fund for the family home visiting grant  
377.29 program under Minnesota Statutes, section  
377.30 145A.17. \$4,000,000 of the funding in fiscal  
377.31 year 2024 and \$4,000,000 in fiscal year 2025  
377.32 must be distributed to community health  
377.33 boards under Minnesota Statutes, section  
377.34 145A.131, subdivision 1. \$978,000 of the  
377.35 funding in fiscal year 2024 and \$978,000 in



379.1 (a) **Outcomes and evaluation consultation.**  
379.2 \$450,000 in fiscal year 2024 and \$450,000 in  
379.3 fiscal year 2025 are for outcomes and  
379.4 evaluation consultation requirements.

379.5 (b) **Department of Children, Youth, and**  
379.6 **Families.** \$11,931,000 in fiscal year 2024 and  
379.7 \$2,066,000 in fiscal year 2025 are to establish  
379.8 the Department of Children, Youth, and  
379.9 Families. This is a onetime appropriation.

379.10 ~~(e) **Keeping Nurses at the Bedside Act**~~  
379.11 ~~**impact evaluation; contingent**~~  
379.12 ~~**appropriation.** \$232,000 in fiscal year 2025~~  
379.13 ~~is for the Keeping Nurses at the Bedside Act~~  
379.14 ~~impact evaluation. This appropriation is~~  
379.15 ~~contingent upon legislative enactment by the~~  
379.16 ~~93rd Legislature of a provision substantially~~  
379.17 ~~similar to the impact evaluation provision in~~  
379.18 ~~2023 S.F. No. 2995, the third engrossment,~~  
379.19 ~~article 3, section 22. This is a onetime~~  
379.20 ~~appropriation and is available until June 30,~~  
379.21 ~~2029.~~

379.22 ~~(d)~~ (c) **Health care subcabinet.** \$551,000 in  
379.23 fiscal year 2024 and \$664,000 in fiscal year  
379.24 2025 are to hire an executive director for the  
379.25 health care subcabinet and to provide staffing  
379.26 and administrative support for the health care  
379.27 subcabinet.

379.28 ~~(e)~~ (d) **Base level adjustment.** The general  
379.29 fund base is \$1,114,000 in fiscal year 2026  
379.30 and \$1,114,000 in fiscal year 2027.

379.31 Sec. 16. **APPROPRIATIONS GIVEN EFFECT ONCE.**

379.32 If an appropriation or transfer in this article is enacted more than once during the 2024  
379.33 regular session, the appropriation or transfer must be given effect once.

380.1 **Sec. 17. EXPIRATION OF UNCODIFIED LANGUAGE.**

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

380.4 Delete the title and insert:

380.5 "A bill for an act

380.6 relating to state government; modifying provisions governing the Department of  
 380.7 Human Services, human services health care policy, health care finance, and  
 380.8 licensing policy; modifying provisions governing the Department of Health, health  
 380.9 policy, health insurance, and health care; modifying provisions governing pharmacy  
 380.10 practice and behavioral health; establishing an Office of Emergency Medical  
 380.11 Services and making conforming changes, specifying and transferring office duties,  
 380.12 establishing advisory councils, and modifying provisions relating to ambulance  
 380.13 service personnel and emergency medical responders; establishing consultation  
 380.14 and report requirements for certain state-funded grants and appropriations;  
 380.15 modifying health record copy charges; establishing expirations of certain reports;  
 380.16 making technical changes; requiring reports, information, and recommendations;  
 380.17 appropriating money; amending Minnesota Statutes 2022, sections 16A.055,  
 380.18 subdivision 1a, by adding a subdivision; 43A.24, by adding a subdivision;  
 380.19 62A.0411; 62A.15, subdivision 4, by adding a subdivision; 62A.28, subdivision  
 380.20 2; 62D.02, subdivision 7; 62D.04, subdivision 5; 62D.12, subdivision 19; 62D.14,  
 380.21 subdivision 1; 62D.20, subdivision 1; 62D.22, subdivision 5, by adding a  
 380.22 subdivision; 62J.49, subdivision 1; 62J.61, subdivision 5; 62M.01, subdivision 3;  
 380.23 62M.02, subdivisions 1a, 5, 11, 12, 21, by adding a subdivision; 62M.04,  
 380.24 subdivision 1; 62M.05, subdivision 3a; 62M.07, subdivisions 2, 4, by adding a  
 380.25 subdivision; 62M.10, subdivisions 7, 8; 62M.17, subdivision 2; 62Q.097, by adding  
 380.26 a subdivision; 62Q.14; 62Q.19, subdivisions 3, 5, by adding a subdivision; 62Q.73,  
 380.27 subdivision 2; 62V.05, subdivision 12; 62V.08; 62V.11, subdivision 4; 103I.621,  
 380.28 subdivisions 1, 2; 144.05, subdivisions 6, 7, by adding a subdivision; 144.058;  
 380.29 144.0724, subdivisions 2, 3a, 4, 6, 7, 8, 9, 11; 144.1464, subdivisions 1, 2, 3;  
 380.30 144.1501, subdivision 5; 144.1911, subdivision 2; 144.212, by adding a subdivision;  
 380.31 144.216, subdivision 2, by adding subdivisions; 144.218, by adding a subdivision;  
 380.32 144.292, subdivision 6; 144.293, subdivisions 2, 4, 9, 10; 144.493, by adding a  
 380.33 subdivision; 144.494, subdivision 2; 144.551, subdivision 1; 144.555, subdivisions  
 380.34 1a, 1b, 2, by adding subdivisions; 144.605, by adding a subdivision; 144.7067,  
 380.35 subdivision 2; 144.99, subdivision 3; 144A.10, subdivisions 15, 16; 144A.471, by  
 380.36 adding a subdivision; 144A.474, subdivision 13; 144A.61, subdivision 3a; 144A.70,  
 380.37 subdivisions 3, 5, 6, 7; 144A.71, subdivision 2, by adding a subdivision; 144A.72,  
 380.38 subdivision 1; 144A.73; 144E.001, subdivision 3a, by adding subdivisions;  
 380.39 144E.101, by adding a subdivision; 144E.16, subdivisions 5, 7; 144E.19,  
 380.40 subdivision 3; 144E.27, subdivisions 3, 5, 6; 144E.28, subdivisions 3, 5, 6, 8;  
 380.41 144E.285, subdivisions 1, 2, 4, 6, by adding subdivisions; 144E.287; 144E.305,  
 380.42 subdivision 3; 144G.08, subdivision 29; 144G.10, by adding a subdivision;  
 380.43 144G.16, subdivision 6; 146B.03, subdivision 7a; 146B.10, subdivisions 1, 3;  
 380.44 149A.02, subdivisions 3, 3b, 16, 23, 26a, 27, 35, 37c, by adding subdivisions;  
 380.45 149A.03; 149A.65; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;  
 380.46 149A.72, subdivisions 3, 9; 149A.73, subdivision 1; 149A.74, subdivision 1;  
 380.47 149A.93, subdivision 3; 149A.94, subdivisions 1, 3, 4; 149A.97, subdivision 2;  
 380.48 151.01, subdivisions 23, 27; 151.065, by adding subdivisions; 151.066, subdivisions  
 380.49 1, 2, 3; 151.212, by adding a subdivision; 151.37, by adding a subdivision; 151.74,  
 380.50 subdivision 6; 214.025; 214.04, subdivision 2a; 214.29; 214.31; 214.355; 245.462,  
 380.51 subdivision 6; 245.4663, subdivision 2; 245A.043, subdivisions 2, 4, by adding  
 380.52 subdivisions; 245A.07, subdivision 6; 245C.05, subdivision 5; 245C.10, subdivision  
 380.53 18; 245C.14, subdivision 1, by adding a subdivision; 245C.15, subdivisions 3, 4;  
 380.54 245C.22, subdivision 4; 245C.24, subdivisions 2, 5; 245C.30, by adding a

381.1 subdivision; 245F.09, subdivision 2; 245F.14, by adding a subdivision; 245F.17;  
381.2 245G.07, subdivision 4; 245G.08, subdivisions 5, 6; 245G.10, by adding a  
381.3 subdivision; 245G.22, subdivisions 6, 7; 245I.02, subdivisions 17, 19; 245I.04,  
381.4 subdivision 6; 245I.10, subdivision 9; 245I.11, subdivision 1, by adding a  
381.5 subdivision; 245I.20, subdivision 4; 245I.23, subdivision 14; 256.01, subdivision  
381.6 41, by adding a subdivision; 256.9657, subdivision 8, by adding a subdivision;  
381.7 256.969, by adding subdivisions; 256B.035; 256B.056, subdivisions 1a, 10;  
381.8 256B.0622, subdivisions 2a, 3a, 7a, 7d; 256B.0623, subdivision 5; 256B.0625,  
381.9 subdivisions 10, 12, 32, 39, by adding subdivisions; 256B.0757, subdivisions 4a,  
381.10 4d; 256B.0943, subdivisions 3, 12; 256B.0947, subdivision 5; 256B.69, subdivision  
381.11 2; 256B.76, subdivision 6; 256B.795; 256I.04, subdivision 2f; 256K.45, subdivision  
381.12 2; 256L.12, subdivision 7; 256R.02, subdivision 20; 259.52, subdivisions 2, 4;  
381.13 260E.33, subdivision 2, as amended; 317A.811, subdivision 1; 524.3-801, as  
381.14 amended; Minnesota Statutes 2023 Supplement, sections 15A.0815, subdivision  
381.15 2; 43A.08, subdivision 1a; 62J.84, subdivision 10; 62Q.46, subdivision 1; 62Q.473,  
381.16 by adding subdivisions; 142A.03, by adding a subdivision; 144.0526, subdivision  
381.17 1; 144.1501, subdivision 2; 144.1505, subdivision 2; 144.651, subdivision 10a;  
381.18 144A.4791, subdivision 10; 144E.101, subdivisions 6, 7, as amended; 145.561,  
381.19 subdivision 4; 145D.01, subdivision 1; 151.555, subdivisions 1, 4, 5, 6, 7, 8, 9,  
381.20 11, 12; 151.74, subdivision 3; 152.126, subdivision 6; 245.4889, subdivision 1;  
381.21 245.735, subdivision 3; 245.991, subdivision 1; 245A.03, subdivision 2, as  
381.22 amended; 245A.043, subdivision 3; 245A.07, subdivision 1, as amended; 245A.11,  
381.23 subdivision 7; 245A.16, subdivision 1, as amended; 245A.211, subdivision 4;  
381.24 245A.242, subdivision 2; 245C.02, subdivision 13e; 245C.08, subdivision 1;  
381.25 245C.15, subdivisions 2, 4a; 245C.31, subdivision 1; 245G.22, subdivisions 2, 17;  
381.26 254B.04, subdivision 1a; 256.0471, subdivision 1, as amended; 256.9631; 256.969,  
381.27 subdivision 2b; 256B.0622, subdivisions 7b, 8; 256B.0625, subdivisions 3a, 5m,  
381.28 9, 13e, as amended, 13f, 13k, 16; 256B.064, subdivision 4; 256B.0671, subdivisions  
381.29 3, 5; 256B.0701, subdivision 6; 256B.0947, subdivision 7; 256B.764; 256D.01,  
381.30 subdivision 1a; 256I.05, subdivisions 1a, 11; 256L.03, subdivision 1; 256L.04,  
381.31 subdivision 10; 260.761, by adding a subdivision; 2024 H.F. No. 5237, article 22,  
381.32 section 2, subdivisions 4, if enacted, 5, if enacted; Laws 2020, chapter 73, section  
381.33 8; Laws 2023, chapter 22, section 4, subdivision 2; Laws 2023, chapter 57, article  
381.34 1, section 6; Laws 2023, chapter 70, article 1, section 35; article 20, sections 2,  
381.35 subdivisions 5, 31; 3, subdivision 2; 12, as amended; Laws 2024, chapter 80, article  
381.36 2, sections 6, subdivisions 2, 3, by adding subdivisions; 10, subdivision 1; proposing  
381.37 coding for new law in Minnesota Statutes, chapters 62A; 62C; 62D; 62J; 62M;  
381.38 62Q; 137; 144; 144A; 144E; 145D; 149A; 151; 214; 245C; 256B; repealing  
381.39 Minnesota Statutes 2022, sections 62A.041, subdivision 3; 144.218, subdivision  
381.40 3; 144.497; 144E.001, subdivision 5; 144E.01; 144E.123, subdivision 5; 144E.27,  
381.41 subdivisions 1, 1a; 144E.50, subdivision 3; 151.74, subdivision 16; 245C.125;  
381.42 256B.79, subdivision 6; 256D.19, subdivisions 1, 2; 256D.20, subdivisions 1, 2,  
381.43 3, 4; 256D.23, subdivisions 1, 2, 3; 256R.02, subdivision 46; Minnesota Statutes  
381.44 2023 Supplement, sections 62J.312, subdivision 6; 62Q.522, subdivisions 3, 4;  
381.45 245C.08, subdivision 2; Laws 2024, chapter 80, article 2, section 6, subdivision  
381.46 4."

382.1 We request the adoption of this report and repassage of the bill.

382.2 Senate Conferees:

382.3 ..... ..

382.4 Melissa Wiklund Alice Mann

382.5 .....

382.6 Robert Kupec

382.7 House Conferees:

382.8 ..... ..

382.9 Tina Liebling Robert Bierman

382.10 .....

382.11 Liz Reyer