SENATE
STATE OF MINNESOTA
NINETY-SECOND SESSION

S.F. No. 2360

(SENATE AUTHORS: BENSON, Abeler and Draheim)

DATE	D-PG	OFFICIAL STATUS
04/06/2021	1215	Introduction and first reading Referred to Health and Human Services Finance and Policy
04/07/2021	1313	Authors added Abeler; Draheim
04/12/2021		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to health; modifying provisions governing health care, human services, and licensing and background studies; establishing a budget for health and human services; making technical and conforming changes; transferring money; appropriating money; amending Minnesota Statutes 2020, sections 16A.151, subdivision 2; 62J.495, subdivisions 1, 2, 3, 4; 62J.498; 62J.4981; 62J.4982; 62J.701; 62J.72, subdivision 3; 62J.84, subdivision 6; 62W.11; 62W.13; 144.05, by adding a subdivision; 144.057, subdivision 1; 144.1205, subdivisions 2, 4, 8, 9, by adding a subdivision; 144.125, subdivisions 1, 2; 144.1481, subdivision 1; 144.216, by adding subdivisions; 144.218, by adding a subdivision; 144.225, subdivision 7; 144.226, subdivision 1; 144.551, subdivision 1; 144E.001, by adding a subdivision; 144E.27; 144E.28, subdivisions 1, 3, 7, 8; 144E.283; 144E.285, subdivisions 1, 2, 4, by adding subdivisions; 145.902; 148.995, subdivision 2; 148.996, subdivisions 2, 4, by adding a subdivision; 151.01, subdivision 29, by adding subdivisions; 151.065, subdivisions 1, 3, 7; 151.066, subdivision 3; 151.555, subdivisions 1, 7, 11, by adding a subdivision; 245C.02, subdivision 4a; 245C.05, subdivisions 2c, 5; 245C.08, subdivision 1; 245C.32, subdivision 1a; 245F.03; 245G.02, subdivision 2; 245G.06, subdivision 3; 245G.11, subdivision 7; 254B.05, subdivisions 1, 5, by adding a subdivision; 256.01, subdivision 28, by adding a subdivision; 256.042, subdivision 4; 256.043, subdivision 4; 256.969, by adding a subdivision; 256.9695, subdivision 1; 256.983; 256B.055, subdivision 6; 256B.056, subdivision 10; 256B.057, subdivision 3; 256B.06, subdivision 4; 256B.0625, subdivisions 3c, 3d, 3e, 9, 13, 13c, 13e, 13g, by adding subdivisions; 256B.0631, subdivision 1, by adding a subdivision; 256B.0638, subdivisions 3, 5, 6; 256B.0659, subdivision 13; 256B.196, subdivision 2; 256B.69, subdivision 6d, by adding a subdivision; 256B.6928, subdivision 5; 256B.75; 256L.01, subdivision 5; 256L.04, subdivision 7b; 256L.05, subdivision 3a; 256L.15, by adding a subdivision; 260E.31, subdivision 1; 295.53, subdivision 1; 326.71, subdivision 4; 326.75, subdivisions 1, 2, 3; proposing coding for new law in Minnesota Statutes, chapters 62A; 62J; 62Q; 144; 145; 148; 151; 256B; 363A; repealing Minnesota Statutes 2020, sections 16A.724, subdivision 2; 144E.27, subdivisions 1, 1a; 151.19, subdivision 3.

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

ARTICLE 1
HEALTH CARE; DEPARTMENT OF HUMAN SERVICES

Section 1. Minnesota Statutes 2020, section 245F.03, is amended to read:

245F.03 APPLICATION.

(a) This chapter establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more unrelated persons.

(b) This chapter does not apply to a withdrawal management program licensed as a hospital under sections 144.50 to 144.581. A withdrawal management program located in a hospital licensed under sections 144.50 to 144.581 that chooses to be licensed under this chapter is deemed to be in compliance with section 245F.13. This chapter does not apply when a license holder is providing pre-treatment coordination services under section 254B.05, subdivision 4a.

(c) Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to withdrawal management programs licensed under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 2. Minnesota Statutes 2020, section 245G.02, subdivision 2, is amended to read:

Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county or recovery community organization that is providing a service for which the county or recovery community organization is an eligible vendor under section 254B.05. This chapter does not apply to an organization whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of client placement, education, support group services, or self-help programs. This chapter does not apply to the activities of a licensed professional in private practice. A license holder providing the initial set of substance use disorder services allowable under section 254A.03, subdivision 3, paragraph (c), to an individual referred to a licensed nonresidential substance use disorder treatment program after a positive screen for alcohol or substance misuse is exempt from sections 245G.05; 245G.06, subdivisions 1, 2, and 4; 245G.07, subdivisions 1, paragraph (a), clauses (2) to (4), and 2, clauses (1) to (7); and 245G.17. This chapter does not apply when a license holder is providing pretreatment coordination services under section 254B.05, subdivision 4a.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 3. Minnesota Statutes 2020, section 245G.06, subdivision 3, is amended to read:

Subd. 3. **Documentation of treatment services and pretreatment services; treatment plan review.** (a) A review of all treatment services must be documented weekly and include a review of:

(1) ~~care~~ treatment coordination activities, including any pretreatment coordination services;

(2) medical and other appointments the client attended;

(3) issues related to medications that are not documented in the medication administration record; and

(4) issues related to attendance for treatment services, including the reason for any client absence from a treatment service.

(b) A note must be entered immediately following any significant event. A significant event is an event that impacts the client's relationship with other clients, staff, the client's family, or the client's treatment plan.

(c) A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

(1) indicate the date, type, and amount of each treatment service provided and the client's response to each service;

(2) address each goal in the treatment plan and whether the methods to address the goals are effective;

(3) include monitoring of any physical and mental health problems;

(4) document the participation of others;

(5) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and

(6) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

(d) Each entry in a client's record must be accurate, legible, signed, and dated. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 4. Minnesota Statutes 2020, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.

(c) County staff who conduct chemical use assessments under Minnesota Rules, part 9530.6615, and are employed as of July 1, 2022, are qualified to provide treatment coordination under section 245G.07, subdivision 1, paragraph (a), clause (5). County staff who conduct chemical use assessments under Minnesota Rules, part 9530.6615, and are employed after July 1, 2021, are qualified to provide treatment coordination under section 245G.07, subdivision 1, paragraph (a), clause (5), if the county staff person completes the classroom instruction in paragraph (a), clause (3).

EFFECTIVE DATE. This section is effective July 1, 2022.

Sec. 5. Minnesota Statutes 2020, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, ~~or~~ outpatient treatment services, and are licensed by tribal government are eligible vendors. American Indian programs are eligible vendors of peer support services according to section 245G.07, subdivision 2, clause (8). An alcohol and drug counselor as defined in section 245G.11, subdivision 5, must be available to recovery peers for ongoing consultation, as needed.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 245G.05. A county is an eligible vendor of ~~care~~ treatment coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery support services according to section 245G.07, subdivision 2, clause (8). An alcohol and drug counselor as defined in section 245G.11, subdivision 5, must be available to recovery peers for ongoing consultation, as needed.

(d) Nonresidential programs licensed under chapter 245G, withdrawal management programs licensed under chapter 245F, American Indian programs described in paragraph (a), and counties are eligible vendors of pretreatment coordination services as defined under section 254B.05, subdivision 4a, when the individual providing the services meets the staffing credentials in section 245G.11, subdivisions 1 and 7.

(e) A recovery community organization that meets certification requirements identified by the commissioner is an eligible vendor of peer support services.

~~(e)~~ (f) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or

nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 6. Minnesota Statutes 2020, section 254B.05, is amended by adding a subdivision to read:

Subd. 4a. **Pretreatment coordination services.** (a) An enrolled provider may provide pretreatment coordination services to an individual prior to the individual's comprehensive assessment under section 245G.05, to facilitate an individual's access to a comprehensive assessment. The total pretreatment coordination services must not exceed 36 units per eligibility determination.

(b) An individual providing pretreatment coordination services must meet the staff qualifications in section 245G.11, subdivision 7. Section 245G.05 and Minnesota Rules, parts 9530.6600 to 9530.6655, do not apply to pretreatment coordination services.

(c) To be eligible for pretreatment coordination services, an individual must screen positive for alcohol or substance misuse using a screening tool approved by the commissioner. The provider may bill the screening as a pretreatment coordination service.

(d) Pretreatment coordination services include:

(1) assisting with connecting an individual with a qualified comprehensive assessment provider;

(2) identifying barriers that might inhibit an individual's ability to participate in a comprehensive assessment; and

(3) assisting with connecting an individual with resources to mitigate an individual's immediate safety risks.

(e) A license holder is authorized to provide up to 36 units of pretreatment coordination services, excluding travel time, and must document the following information in the client's case file:

(1) the dates, number of units, and description of pretreatment coordination services provided;

(2) identifying an individual's safety concerns and developing a plan to address those concerns;

(3) assisting an individual with scheduling an appointment for a comprehensive assessment and confirming that the individual and provider keep the appointment; and

(4) assisting an individual with accessing resources for obtaining a comprehensive assessment authorizing substance use disorder treatment services.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 7. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

(3) ~~care~~ treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) medication-assisted therapy services that are licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according

to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; ~~and~~

(12) room and board facilities that meet the requirements of subdivision 1a; and

(13) pretreatment coordination services provided according to subdivision 4a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific programs as defined in section 254B.01, subdivision 4a, or programs or subprograms serving special populations, if the program or subprogram meets the following requirements:

(i) is designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background;

(ii) is governed with significant input from individuals of that specific background; and

(iii) employs individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except when the common social background of the individuals served is a traumatic brain injury or cognitive disability and the program employs treatment staff who have the necessary professional training, as approved by the

commissioner, to serve clients with the specific disabilities that the program is designed to serve;

(3) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; and

(4) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. The interactive video equipment and connection must comply with Medicare standards in effect at the time the service is provided.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 8. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

Subd. 28. **Statewide health information exchange.** (a) The commissioner has the authority to join and participate as a member in a legal entity developing and operating a statewide health information exchange or to develop and operate an encounter alerting service that shall meet the following criteria:

(1) the legal entity must meet all constitutional and statutory requirements to allow the commissioner to participate; and

(2) the commissioner or the commissioner's designated representative must have the right to participate in the governance of the legal entity under the same terms and conditions and subject to the same requirements as any other member in the legal entity and in that role shall act to advance state interests and lessen the burdens of government.

(b) Notwithstanding chapter 16C, the commissioner may pay the state's prorated share of development-related expenses of the legal entity retroactively from October 29, 2007, regardless of the date the commissioner joins the legal entity as a member.

Sec. 9. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to read:

Subd. 42. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of human services to the legislature is mandated by statute and the enabling

legislation does not include a date for the submission of a final report, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1,2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years after the date of enactment if the mandate requires the submission of an annual report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report unless the enacting legislation provides for a different expiration date.

(d) The commissioner shall submit a list to the chairs and ranking minority members of the legislative committee with jurisdiction over human services by February 15 of each year, beginning February 15, 2022, of all reports set to expire during the following calendar year in accordance with this section.

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

Sec. 10. Minnesota Statutes 2020, section 256.042, subdivision 4, is amended to read:

Subd. 4. **Grants.** (a) The commissioner of human services shall submit a report ~~of the grants proposed by the advisory council to be awarded for the upcoming fiscal year~~ to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by March 1 of each year, beginning March 1, 2020, describing the priorities and specific activities the advisory council intends to address for the upcoming fiscal year based on the projected funds available for grant distribution.

(b) ~~The commissioner of human services shall award grants from the opiate epidemic response fund under section 256.043.~~ The grants shall be awarded to proposals selected by the advisory council that address the priorities in subdivision 1, paragraph (a), clauses (1) to (4), unless otherwise appropriated by the legislature. The advisory council shall determine grant awards and funding amounts based on the funds appropriated to the commissioner under section 256.043, subdivision 3, paragraph (e). The commissioner shall award the grants from the opiate epidemic response fund and administer the grants in compliance with section 16B.97. No more than three percent of the grant amount may be used by a grantee for administration.

Sec. 11. Minnesota Statutes 2020, section 256.043, subdivision 4, is amended to read:

Subd. 4. **Settlement; sunset.** (a) If the state receives a total sum of $250,000,000 either as a result of a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or resulting from a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency, against one or more opioid manufacturers or opioid wholesale drug distributors or consulting firms working for an opioid manufacturer or opioid wholesale drug distributor related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state, or other alleged illegal actions that contributed to the excessive use of opioids, or from the fees collected under sections 151.065, subdivisions 1 and 3, and 151.066, that are deposited into the opiate epidemic response fund established in this section, or from a combination of both, the fees specified in section 151.065, subdivisions 1, clause (16), and 3, clause (14), shall be reduced to $5,260, and the opiate registration fee in section 151.066, subdivision 3, shall be repealed.

(b) The commissioner of management and budget shall inform the Board of Pharmacy, the governor, and the legislature when the amount specified in paragraph (a) has been reached. The board shall apply the reduced license fee for the next licensure period.

(c) Notwithstanding paragraph (a), the reduction of the license fee in section 151.065, subdivisions 1 and 3, and the repeal of the registration fee in section 151.066 shall not occur before July 1, 2024.

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

Sec. 12. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Alternate inpatient payment rate.** Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by 99 percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6).

EFFECTIVE DATE. This section is effective January 1, 2022.

Sec. 13. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge ratios, and policy adjusters shall not be changed. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the preliminary payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address of the person to contact regarding the appeal. Facts to be considered in any appeal of base year information are limited to those in existence ~~12~~ 18 months after the last day of the calendar year that is the base year for the payment rates in dispute.

Sec. 14. Minnesota Statutes 2020, section 256.983, is amended to read:

256.983 FRAUD PREVENTION INVESTIGATIONS.

Subdivision 1. **Programs established.** Within the limits of available appropriations, the commissioner of human services shall require the maintenance of budget neutral fraud prevention investigation programs in the counties or tribal agencies participating in the fraud prevention investigation project established under this section. If funds are sufficient, the commissioner may also extend fraud prevention investigation programs to other counties or tribal agencies provided the expansion is budget neutral to the state. Under any expansion, the commissioner has the final authority in decisions regarding the creation and realignment of individual county, tribal agency, or regional operations.

Subd. 2. **County and tribal agency proposals.** Each participating county and tribal agency shall develop and submit an annual staffing and funding proposal to the commissioner no later than April 30 of each year. Each proposal shall include, but not be limited to, the staffing and funding of the fraud prevention investigation program, a job description for

investigators involved in the fraud prevention investigation program, and the organizational structure of the county or tribal agency unit, training programs for case workers, and the operational requirements which may be directed by the commissioner. The proposal shall be approved, to include any changes directed or negotiated by the commissioner, no later than June 30 of each year.

Subd. 3. **Department responsibilities.** The commissioner shall establish training programs which shall be attended by all investigative and supervisory staff of the involved county and tribal agencies. The commissioner shall also develop the necessary operational guidelines, forms, and reporting mechanisms, which shall be used by the involved county or tribal agencies. An individual's application or redetermination form for public assistance benefits, including child care assistance programs and medical care programs, must include an authorization for release by the individual to obtain documentation for any information on that form which is involved in a fraud prevention investigation. The authorization for release is effective for six months after public assistance benefits have ceased.

Subd. 4. **Funding.** (a) County and tribal agency reimbursement shall be made through the settlement provisions applicable to the Supplemental Nutrition Assistance Program (SNAP), MFIP, child care assistance programs, the medical assistance program, and other federal and state-funded programs.

(b) The commissioner will maintain program compliance if for any three consecutive month period, a county or tribal agency fails to comply with fraud prevention investigation program guidelines, or fails to meet the cost-effectiveness standards developed by the commissioner. This result is contingent on the commissioner providing written notice, including an offer of technical assistance, within 30 days of the end of the third or subsequent month of noncompliance. The county or tribal agency shall be required to submit a corrective action plan to the commissioner within 30 days of receipt of a notice of noncompliance. Failure to submit a corrective action plan or, continued deviation from standards of more than ten percent after submission of a corrective action plan, will result in denial of funding for each subsequent month, or billing the county or tribal agency for fraud prevention investigation (FPI) service provided by the commissioner, or reallocation of program grant funds, or investigative resources, or both, to other counties or tribal agencies. The denial of funding shall apply to the general settlement received by the county or tribal agency on a quarterly basis and shall not reduce the grant amount applicable to the FPI project.

Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency may conduct investigations of financial misconduct by child care providers as described in chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the

commissioner to determine whether an investigation under this chapter may compromise an ongoing investigation.

(b) If, upon investigation, a preponderance of evidence shows a provider committed an intentional program violation, intentionally gave the county or tribe materially false information on the provider's billing forms, provided false attendance records to a county, tribe, or the commissioner, or committed financial misconduct as described in section 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies. The county or tribe must send notice in accordance with the requirements of section 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law enforcement authority determines that there is insufficient evidence warranting the action and a county, tribe, or the commissioner does not pursue an additional administrative remedy under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and administrative proceedings related to the provider's alleged misconduct conclude and any appeal rights are exhausted.

(c) For the purposes of this section, an intentional program violation includes intentionally making false or misleading statements; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under chapters 119B and 245E.

(d) A provider has the right to administrative review under section 119B.161 if: (1) payment is suspended under chapter 245E; or (2) the provider's authorization was denied or revoked under section 119B.13, subdivision 6, paragraph (d), clause (2).

Sec. 15. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for ~~60 days~~ six months postpartum.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are applying for the continuation of medical assistance coverage following the end of the ~~60-day~~ six months postpartum period to update their income and asset information and to submit any required income or asset verification.

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

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

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

(e) Each person applying for or receiving medical assistance under section 256B.055, subdivision 7, and any other person whose resources are required by law to be disclosed to determine the applicant's or recipient's eligibility must authorize the commissioner to obtain information from financial institutions to identify unreported accounts as required in section 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner may determine that the applicant or recipient is ineligible for medical assistance. For purposes of this paragraph, an authorization to identify unreported accounts meets the requirements of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not be furnished to the financial institution.

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

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 17. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

Subd. 3. **Qualified Medicare beneficiaries.** (a) A person ~~who is entitled to Part A Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty guidelines, and whose assets are no more than $10,000 for a single individual and $18,000 for a married couple or family of two or more,~~ is eligible for medical assistance reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act~~.~~ if:

(1) the person is entitled to Medicare Part A benefits;

(2) the person's income is equal to or less than 100 percent of the federal poverty guidelines; and

(3) the person's assets are no more than (i) $10,000 for a single individual, or (ii) $18,000 for a married couple or family of two or more; or, when the resource limits for eligibility for the Medicare Part D extra help low income subsidy (LIS) exceed either amount in item (i) or (ii), the person's assets are no more than the LIS resource limit in United States Code, title 42, section 1396d, subsection (p).

(b) Reimbursement of the Medicare coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person were a medical assistance recipient with Medicare coverage. Increases in benefits under Title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

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

Sec. 18. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality

according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) chemical dependency treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and ~~60 days~~ six months postpartum~~, to the extent federal funds are available under title XXI of the Social Security Act, and the state children's health insurance program~~.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter

256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner shall notify the revisor of statutes when federal approval has been obtained.

Sec. 19. Minnesota Statutes 2020, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services ~~Policy Committee~~ Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a ~~13-member~~ 14-member Health Services ~~Policy Committee~~ Advisory Council, which consists of ~~12~~ 13 voting members and one nonvoting member. The Health Services ~~Policy Committee~~ Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under ~~the medical assistance and MinnesotaCare programs~~ Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services ~~Policy Committee~~ Advisory Council shall meet at least quarterly. The Health Services ~~Policy Committee~~ Advisory Council shall annually ~~elect~~ select a ~~physician~~ chair from among its members~~,~~ who shall work directly with the commissioner's medical director~~,~~ to establish the agenda for each meeting. The Health Services ~~Policy Committee shall also~~ Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental ~~subcommittee~~ subcouncil to operate under the Health Services ~~Policy Committee~~ Advisory Council. The dental ~~subcommittee~~ subcouncil consists of general dentists, dental specialists, safety net providers, dental hygienists, health plan company and county and public health representatives, health researchers, consumers, and a designee of the commissioner of health. The dental ~~subcommittee~~ subcouncil shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9, paragraph (b).

~~(c) The Health Services Policy Committee shall study approaches to making provider reimbursement under the medical assistance and MinnesotaCare programs contingent on patient participation in a patient-centered decision-making process, and shall evaluate the impact of these approaches on health care quality, patient satisfaction, and health care costs. The committee shall present findings and recommendations to the commissioner and the legislative committees with jurisdiction over health care by January 15, 2010.~~

~~(d)~~ (c) The Health Services ~~Policy Committee shall~~ Advisory Council may monitor and track the practice patterns of ~~physicians providing services to medical assistance and MinnesotaCare enrollees~~ health care providers who serve MHCP recipients under fee-for-service, managed care, and county-based purchasing. The ~~committee~~ monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across ~~physicians~~ providers, or which are associated with high medical costs. The commissioner, based upon the findings of the ~~committee~~ Health Services Advisory Council, ~~shall regularly~~ may notify ~~physicians~~ providers whose practice patterns indicate below average quality or higher than average utilization or costs. Managed care and county-based purchasing plans shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make ~~this~~ these data available to the ~~committee~~ Health Services Advisory Council.

~~(e) The Health Services Policy Committee shall review caesarean section rates for the fee-for-service medical assistance population. The committee may develop best practices policies related to the minimization of caesarean sections, including but not limited to standards and guidelines for health care providers and health care facilities.~~

Sec. 20. Minnesota Statutes 2020, section 256B.0625, subdivision 3d, is amended to read:

Subd. 3d. **Health Services ~~Policy Committee~~ Advisory Council members.** (a) The Health Services ~~Policy Committee~~ Advisory Council consists of:

(1) ~~seven~~ six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, ~~one of whom must be actively engaged in the treatment of persons with mental illness, and~~ three of whom must represent health plans currently under contract to serve ~~medical assistance~~ MHCP recipients;

(2) two voting members who are licensed physician specialists actively practicing their specialty in Minnesota;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota;

(4) one voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, and actively engaged in the treatment of persons with mental illness;

~~(4) one consumer~~ (5) two consumers who shall serve as ~~a~~ voting ~~member~~ members; and

~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services ~~Policy Committee~~ Advisory Council shall not be employed by the ~~Department of Human Services~~ state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

Subd. 3e. **Health Services ~~Policy Committee~~ Advisory Council terms and compensation.** ~~Committee~~ Members shall serve staggered three-year terms, with one-third of the voting members' terms expiring annually. Members may be reappointed by the commissioner. The commissioner may require more frequent Health Services ~~Policy Committee~~ Advisory Council meetings as needed. An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each ~~committee~~ council member in attendance except the medical director. The Health Services ~~Policy Committee~~ Advisory Council does not expire as provided in section 15.059, subdivision 6.

Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; ~~and~~

(15) full-mouth debridement, limited to one every five years~~.~~<u>; and</u>

<u>(16) nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures.</u>

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

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

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

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

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

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

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

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

Sec. 23. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9c. **Uniform prior authorization for dental services.** (a) For purposes of this subdivision, "dental benefits administrator" means an organization licensed under chapter 62C or 62D that contracts with a managed care plan or county-based purchasing plan to provide covered dental care services to enrollees of the plan.

(b) By January 1, 2022, the commissioner, in consultation with interested stakeholders, shall develop uniform prior authorization criteria for all dental services requiring prior authorization. The commissioner shall publish a list of the dental services requiring prior authorization and the process for obtaining prior authorization on the department's website.

Dental services on the list and the process for obtaining prior authorization approval must be consistent. The commissioner shall require that dental providers, managed care plans, county-based purchasing plans, and dental benefit administrators use the dental services on the list regardless of whether the services are provided through a fee-for-service system or through a prepaid medical assistance program.

(c) Managed care plans and county-based purchasing plans may require prior authorization for additional dental services not on the list described in paragraph (b) if a uniform process for obtaining prior approvals is applied, including a process for reconsideration when a prior approval request is denied that can be utilized by both the patient and the patient's dental provider.

Sec. 24. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 9d. **Uniform credentialing process.** (a) For purposes of this subdivision, "dental benefits administrator" has the meaning given in subdivision 9c.

(b) By January 1, 2022, the commissioner, in consultation with interested stakeholders, shall develop a uniform credentialing process for dental providers. Upon federal approval, the credentialing process must be accepted by all managed care plans, county-based purchasing plans, and dental benefits administrators that contract with the commissioner or subcontract with plans to provide dental services to medical assistance or MinnesotaCare enrollees.

(c) The process developed in this subdivision must include a uniform credentialing application that must be available in electronic format and accessible on the department's website. The process developed under this subdivision must include an option to submit a completed application electronically. The uniform credentialing application must be available to providers for free.

(d) If applicable, a managed care plan, county-based purchasing plan, dental benefits administrator, contractor, or vendor that reviews and approves a credentialing application must notify a provider regarding a deficiency on a submitted credentialing application form no later than 30 business days after receiving the application form from the provider.

Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed

by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, a physician assistant, or an advanced practice registered nurse employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner~~.~~ or the drug appears on the 90-day supply list published by the commissioner. The 90-day supply list shall be published by the commissioner on the department's website. The commissioner may add to, delete from, and otherwise modify the 90-day supply list after providing public notice and the opportunity for a 15-day public comment period. The 90-day supply list may include cost-effective generic drugs and shall not include controlled substances.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the Formulary Committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A

pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

(g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed pharmacist in accordance with section 151.37, subdivision 16.

Sec. 26. Minnesota Statutes 2020, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and

have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least twice per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee ~~expires June 30, 2022~~ does not expire as provided in section 15.059, subdivision 6.

Sec. 27. Minnesota Statutes 2020, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be ~~$10.48~~ $10.77 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be ~~$10.48~~ $10.77 per ~~bag~~ claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be ~~$10.48~~ $10.77 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the

percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be either the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration or NADAC, whichever is lower. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

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

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

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

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

(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.

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

(h) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient

drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement.

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

Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 13g, is amended to read:

Subd. 13g. **Preferred drug list.** (a) The commissioner shall adopt and implement a preferred drug list by January 1, 2004. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred drug list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall publish the preferred drug list annually in the State Register and shall maintain an accurate and up-to-date list on the agency website.

(b) The commissioner may add to, delete from, and otherwise modify the preferred drug list, after consulting with the Formulary Committee and appropriate medical specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred drug list as part of the administration of the supplemental drug rebate program. Reimbursement for prescription drugs not on the preferred drug list may be subject to prior authorization.

(d) For purposes of this subdivision, "preferred drug list" means a list of prescription drugs within designated therapeutic classes selected by the commissioner, for which prior authorization based on the identity of the drug or class is not required.

(e) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

(f) Notwithstanding paragraph (b), before the commissioner may delete a drug from the preferred drug list or modify the inclusion of a drug on the preferred drug list, the commissioner, in consultation with the commissioner of health, shall consider any implications the deletion or modification may have on state public health policies or initiatives and any impact the deletion or modification may have on increasing health disparities in the state. Prior to deleting a drug or modifying the inclusion of a drug, the commissioner shall also conduct a public hearing. The commissioner shall provide adequate notice to the public prior to the hearing that specifies the drug the commissioner is proposing to delete or modify, any medical or clinical analysis that the commissioner has relied on in proposing the deletion or modification, and evidence that the commissioner has consulted with the commissioner of health and has evaluated the impact of the proposed deletion or modification on public health and health disparities.

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

Sec. 29. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13k. **Eligible providers.** (a) To be eligible to dispense prescription drugs under this section as an enrolled dispensing provider, the dispensing provider must be a:

(1) pharmacy located within the state that is licensed by the Board of Pharmacy under chapter 151;

(2) physician located in a service area where there is no medical assistance enrolled pharmacy; or

(3) physician or advanced practice registered nurse employed by or under contract with a community health board for communicable disease control.

(b) A licensed out-of-state pharmacy may be enrolled as a dispensing provider under paragraph (a) if the pharmacy is:

(1) a retail pharmacy located within 50 miles of the Minnesota border that serves walk-in medical assistance enrollees and whose walk-in customers represent at least 75 percent of the pharmacy's prescription volume;

(2) a retail pharmacy serving foster children enrolled in medical assistance and living outside of Minnesota;

(3) serving enrollees receiving preapproved organ transplants who require medication during after-care while residing outside of Minnesota; or

(4) providing products with limited or exclusive distribution channels for which there is no potential dispensing provider located within the state.

(c) A dispensing provider must attest that they meet the requirements in paragraphs (a) and (b) before enrolling as a dispensing provider in the medical assistance program. If a provider is found to be out of compliance with the requirements in paragraphs (a) and (b), any funds paid to that provider during the time they were out of compliance shall be recovered under section 256B.064.

Sec. 30. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision to read:

Subd. 67. **Pretreatment coordination services.** Effective January 1, 2022, or upon federal approval, whichever is later, medical assistance covers pretreatment coordination services provided according to section 254B.05, subdivision 4a.

EFFECTIVE DATE. This section is effective July 1, 2021. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained or denied.

Sec. 31. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service ~~which~~ that is required because of a recipient's symptoms, diagnosis, or established illness, and ~~which~~ that is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist. Co-payments must not apply to visits that involve tobacco cessation treatments or services;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. ~~No~~ Co-payments ~~shall~~ must not apply to antipsychotic drugs when used for the treatment of mental illness or to drugs used for tobacco cessation;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Sec. 32. Minnesota Statutes 2020, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. **Tobacco abstinence cost-sharing exception.** In addition to the cost-sharing exemptions listed under subdivision 2, the co-payments and deductibles described in subdivision 1 must be waived for nontobacco users, and must only apply to tobacco users. For purposes of this subdivision, "tobacco user" means an individual who uses, four or more times per week within the past six months, any tobacco product. Tobacco products include cigarettes, cigars, pipe tobacco, chewing tobacco, or snuff. Tobacco products do not include the use of tobacco by an American Indian who meets the requirements in Code of Federal Regulations, title 42, sections 447.51 and 447.56, as part of a traditional Native American spiritual or cultural ceremony.

EFFECTIVE DATE. This section is effective July 1, 2022, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 33. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

Subd. 3. **Opioid prescribing work group.** (a) The commissioner of human services, in consultation with the commissioner of health, shall appoint the following voting members to an opioid prescribing work group:

(1) two consumer members who have been impacted by an opioid abuse disorder or opioid dependence disorder, either personally or with family members;

(2) one member who is a licensed physician actively practicing in Minnesota and registered as a practitioner with the DEA;

(3) one member who is a licensed pharmacist actively practicing in Minnesota and registered as a practitioner with the DEA;

(4) one member who is a licensed nurse practitioner actively practicing in Minnesota and registered as a practitioner with the DEA;

(5) one member who is a licensed dentist actively practicing in Minnesota and registered as a practitioner with the DEA;

(6) two members who are nonphysician licensed health care professionals actively engaged in the practice of their profession in Minnesota, and their practice includes treating pain;

(7) one member who is a mental health professional who is licensed or registered in a mental health profession, who is actively engaged in the practice of that profession in Minnesota, and whose practice includes treating patients with chemical dependency or substance abuse;

(8) one member who is a medical examiner for a Minnesota county;

(9) one member of the Health Services Policy Committee established under section 256B.0625, subdivisions 3c to 3e;

(10) one member who is a medical director of a health plan company doing business in Minnesota;

(11) one member who is a pharmacy director of a health plan company doing business in Minnesota; ~~and~~

(12) one member representing Minnesota law enforcement~~.~~; and

(13) two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain.

(b) In addition, the work group shall include the following nonvoting members:

(1) the medical director for the medical assistance program;

(2) a member representing the Department of Human Services pharmacy unit; ~~and~~

(3) the medical director for the Department of Labor and Industry~~.~~; and

(4) a member representing the Department of Health.

(c) An honorarium of $200 per meeting and reimbursement for mileage and parking shall be paid to each voting member in attendance.

Sec. 34. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

Subd. 5. **Program implementation.** (a) The commissioner shall implement the programs within the Minnesota health care program to improve the health of and quality of care provided to Minnesota health care program enrollees. The commissioner shall annually collect and report to provider groups the sentinel measures of data showing individual opioid ~~prescribers data showing the sentinel measures of their~~ prescribers' opioid prescribing patterns compared to their anonymized peers. Provider groups shall distribute data to their affiliated, contracted, or employed opioid prescribers.

(b) The commissioner shall notify an opioid prescriber and all provider groups with which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing

pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber and any provider group that receives a notice under this paragraph shall submit to the commissioner a quality improvement plan for review and approval by the commissioner with the goal of bringing the opioid prescriber's prescribing practices into alignment with community standards. A quality improvement plan must include:

(1) components of the program described in subdivision 4, paragraph (a);

(2) internal practice-based measures to review the prescribing practice of the opioid prescriber and, where appropriate, any other opioid prescribers employed by or affiliated with any of the provider groups with which the opioid prescriber is employed or affiliated; and

(3) appropriate use of the prescription monitoring program under section 152.126.

(c) If, after a year from the commissioner's notice under paragraph (b), the opioid prescriber's prescribing practices do not improve so that they are consistent with community standards, the commissioner shall take one or more of the following steps:

(1) monitor prescribing practices more frequently than annually;

(2) monitor more aspects of the opioid prescriber's prescribing practices than the sentinel measures; or

(3) require the opioid prescriber to participate in additional quality improvement efforts, including but not limited to mandatory use of the prescription monitoring program established under section 152.126.

(d) The commissioner shall terminate from Minnesota health care programs all opioid prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Sec. 35. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber is subject to termination as a medical assistance provider under this section. Notwithstanding this data classification, the commissioner shall share with all of the provider groups with which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an opioid prescriber who is subject to quality improvement activities~~ the data under subdivision 5, paragraph (a), (b), or (c).

(b) Reports and data identifying a provider group are nonpublic data as defined under section 13.02, subdivision 9, until the provider group is subject to termination as a medical assistance provider under this section.

(c) Upon termination under this section, reports and data identifying an opioid prescriber or provider group are public, except that any identifying information of Minnesota health care program enrollees must be redacted by the commissioner.

Sec. 36. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency, meet the definition of qualified professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as a qualified professional after clearing~~ clear a background study, and meet provider training requirements. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

(1) is not disqualified under section 245C.14; or

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the

commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 37. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors, in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to

nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount" means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten

percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated

with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. This section is effective December 31, 2021, or upon federal approval, whichever is later. The commissioner of human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 38. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists, and may include dentists, individually enrolled dental hygienists, and dental therapists.

(c) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

Subd. 2. **Federal approval required.** Each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use a settle-up process no less than annually to adjust health plan payments to comply with this requirement. The commissioner shall apply the uniform adjustment to each submitted claim.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner must ensure that the total annual amount of payments equals at least the sum of the annual value of the voluntary intergovernmental transfers to the commissioner under subdivision 4 and federal financial participation.

(c) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform

adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee schedule requirement must align the state quality goals to Hennepin Healthcare medical assistance patients, including unstably housed individuals, those with higher levels of social and clinical risk, limited English proficiency patients, adults with serious chronic conditions, or individuals of color. The directed payment arrangement will maintain quality and access to a full range of health care delivery mechanisms for these patients, such as behavioral health, emergent care, preventive care, hospitalization, transportation, interpretation, and pharmaceutical. In partnership with the Department of Human Services, the Centers for Medicare and Medicaid Services, and Hennepin Healthcare, mutually agreed upon measures to demonstrate access to care must be identified and measured.

EFFECTIVE DATE. This section is effective January 1, 2022, or upon federal approval, whichever is later, unless the federal approval provides for an effective date after July 1, 2021, but before the date of federal approval, in which case the federally approved effective date applies.

Sec. 39. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

(b) Managed care plans and county-based purchasing plans or the plan's subcontractor if the plan subcontracts with a third party to administer pharmacy services, including a pharmacy benefit manager, must comply with section 256B.0625, subdivision 13k, for purposes of contracting with dispensing providers to provide pharmacy services to medical assistance and MinnesotaCare enrollees.

Sec. 40. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision to read:

Subd. 6f. **Dental fee schedules.** (a) A managed care plan, county-based purchasing plan, or dental benefits administrator as defined under section 256B.0625, subdivision 9c, paragraph (a), must provide individual dental providers, upon request, the applicable fee schedules for covered dental services provided under the contract between the dental provider and the managed care plan, county-based purchasing plan, or dental benefits administrator.

(b) A managed care plan, county-based purchasing plan, or dental benefits administrator may fulfill this requirement by making the applicable fee schedules available through a secure web portal for the contracted dental provider to access.

Sec. 41. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial

soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Sec. 42. Minnesota Statutes 2020, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable

payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics.

(c) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

(d) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

(f) In addition to the reductions in paragraphs (d) and (e), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 43. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

Subd. 5. **Income.** "Income" has the meaning given for modified adjusted gross income, as defined in Code of Federal Regulations, title 26, section 1.36B-1, and means a household's ~~current income, or if income fluctuates month to month, the income for the 12-month eligibility period~~ projected annual income for the applicable tax year.

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

Sec. 44. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits under this section annually ~~each July 1~~ on January 1 as ~~described in section 256B.056, subdivision 1e~~ provided in Code of Federal Regulations, title 26, section 1.36B-1(h).

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

Sec. 45. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be redetermined on an annual basis~~, in accordance with Code of Federal Regulations, title 42, section 435.916 (a). The 12-month eligibility period begins the month of application. Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to implement renewals throughout the year according to guidance from the Centers for Medicare and Medicaid Services~~. The period of eligibility is the entire calendar year following the

year in which eligibility is redetermined. Eligibility redeterminations shall occur during the open enrollment period for qualified health plans as specified in Code of Federal Regulations, title 45, section 155.410(e)(3).

(b) Each new period of eligibility must take into account any changes in circumstances that impact eligibility and premium amount. Coverage begins as provided in section 256L.06.

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

Sec. 46. Minnesota Statutes 2020, section 256L.15, is amended by adding a subdivision to read:

Subd. 5. **Tobacco use premium surcharge.** (a) An enrollee who uses tobacco products as defined in paragraph (e) and is not actively participating in a tobacco cessation program must pay a tobacco premium surcharge in an amount that is equal to ten percent of the enrollee's monthly premium. The tobacco use premium surcharge must be calculated on a monthly basis and paid in accordance with section 256L.06, rounded up to the nearest dollar amount. Nonpayment of the surcharge may result in disenrollment.

(b) Enrollees who initially apply or renew enrollment in the MinnesotaCare program on or after July 1, 2021, must attest as part of the application or renewal process whether the enrollee is using tobacco products and if so, whether the enrollee is actively participating in a tobacco cessation program. Upon request of the commissioner, the enrollee must provide documentation verifying that the enrollee is actively participating in tobacco cessation.

(c) If an enrollee indicates on the initial application or at renewal that the enrollee does not use tobacco or is using tobacco products but is actively participating in a tobacco cessation program, and it is determined that the enrollee was using tobacco products and was not actively participating in a tobacco cessation program during the period of enrollment, the enrollee must pay the total amount of the tobacco use premium surcharge that the enrollee would have been required to pay as a tobacco user during that enrollment period. If the enrollee fails to pay the surcharge amount due, the enrollee may be disenrolled and the unpaid amount may be subject to recovery by the commissioner.

(d) Nonpayment of the surcharge amount owed by the enrollee under paragraph (a) or (c) shall result in disenrollment effective for the calendar month following the month for which the surcharge was due. Disenrollment for nonpayment of the surcharge must meet the requirements in section 256L.06, subdivision 3, paragraphs (d) and (e).

(e) For purposes of this subdivision, the use of tobacco products means the use of a tobacco product four or more times per week within the past six months. Tobacco products include the use of cigarettes, cigars, pipe tobacco, chewing tobacco, or snuff.

EFFECTIVE DATE. This section is effective January 1, 2023, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 47. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

(7) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(8) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(9) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under the MinnesotaCare program or the medical assistance program governed by title XIX of the federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(10) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990. Enrollee deductibles, co-insurance, and co-payments are subject to tax;

(11) payments received under the federal Tricare program, Code of Federal Regulations, title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are subject to tax; and

(12) supplemental ~~or,~~ enhanced, or directed payments authorized under section 256B.196 ~~or,~~ 256B.197, or 256B.1973.

(c) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2020.

Sec. 48. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2023 until July 1, 2023. The payment shall be made no earlier than July 1, 2023, and no later than July 31, 2023.

(b) The commissioner of human services shall delay the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2025 until July 1, 2025. The payment shall be made no earlier than July 1, 2025, and no later than July 31, 2025.

Sec. 49. **DENTAL HOME DEMONSTRATION PROJECT PLAN.**

(a) The commissioner of human services shall develop a plan to implement a dental home demonstration project. The demonstration project must create dental homes to provide incentives to dental providers for the provision of patient-centered, high quality, comprehensive, and coordinated dental care to medical assistance and MinnesotaCare enrollees. The demonstration project must be designed to establish and evaluate alternative models of delivery systems and payment methods that:

(1) emphasize, enhance, and encourage access to primary dental care by using dental teams that include dentists, dental hygienists, dental therapists, advanced dental therapists, and dental assistants;

(2) ensure enrollees with a consistent and ongoing contact with a dental provider or dental team and coordination with the enrollee's medical care;

(3) decrease administrative burdens and create greater transparency and accountability;

(4) incorporate outcome measures on access, quality, cost of care and patient experience; and

(5) establish value-based incentives to:

(i) provide flexibility in enrollment criteria in order to increase the number of dental providers currently serving medical assistance and MinnesotaCare enrollees;

(ii) reduce disparities in access to dental services for high risk and medically and socially complex patients; and

(iii) increase overall access to quality dental services.

(b) The commissioner shall develop outcome measures for the demonstration projects that include measurements for access to preventive care, follow-up care after an oral health evaluation, patient satisfaction, and administrative costs for delivering dental services.

(c) In developing the dental home demonstration project, the commissioner shall consult with interested stakeholders including but not limited to representatives of:

(1) private practice dental clinics for which medical assistance and MinnesotaCare enrollees comprise more than 25 percent of the clinic's patient load;

(2) nonprofit dental clinics with a primary focus on serving Indigenous communities and other communities of color;

(3) nonprofit dental clinics with a primary focus on providing eldercare;

(4) nonprofit dental clinics with a primary focus on serving children;

(5) nonprofit dental clinics providing services in the seven-county metropolitan area;

(6) nonprofit dental clinics providing services outside of the seven-county metropolitan area;

(7) multispecialty hospital-based dental clinics; and

(8) educational institutions operating dental programs.

(d) The commissioner of human services shall submit recommendations for the establishment of a dental home demonstration project to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2022.

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

Sec. 50. **ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGE.**

Notwithstanding Minnesota Statutes, section 256.011, subdivision 3, beginning January 1, 2022, any amount attributable to the enhanced Federal Medical Assistance Percentage (FMAP) under section 6008 of the Families First Coronavirus Response Act shall be deposited in the health care access fund.

Sec. 51. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

The commissioner of human services shall seek all necessary federal waivers and approvals necessary to extend medical assistance postpartum coverage, as provided in Minnesota Statutes, section 256B.055, subdivision 6.

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

Sec. 52. **OVERPAYMENTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, OR SUPPLIES.**

(a) Notwithstanding any other law to the contrary, providers who received payment for durable medical equipment, prosthetics, orthotics, or supplies between January 1, 2018, and June 30, 2019, that were subject to the upper payment limits under United States Code, title 42, section 1396b(i)(27), shall not be required to repay any amount received in excess of the allowable amount to either the state or the Centers for Medicare and Medicaid Services.

(b) The state shall repay with state funds any amount owed to the Centers for Medicare and Medicaid Services for the federal financial participation amount received by the state for payments identified in paragraph (a) in excess of the amount allowed effective January 1, 2018, and the state shall hold harmless the providers who received these payments from recovery of both the state and federal share of the amount determined to have exceeded the Medicare upper payment limit.

(c) Nothing in this section shall be construed to prohibit the commissioner from recouping past overpayments due to false claims or for reasons other than exceeding the Medicare upper payment limits or from recouping future overpayments including the recoupment of payments that exceed the upper Medicare payment limits.

Sec. 53. **PROPOSED FORMULARY COMMITTEE.**

By March 1, 2022, the commissioner of human services, in consultation with relevant professional associations and consumer groups, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a proposed reorganization of the Formulary Committee under Minnesota Statutes, section 256B.0625, subdivision 13c, that includes:

(1) the proposed membership of the committee, including adequate representation of consumers and health care professionals with expertise in clinical prescribing; and

(2) proposed policies and procedures for the operation of the committee that ensures public input, including providing public notice and gathering public comments on the committee's recommendations and proposed actions.

Sec. 54. **OPIATE EPIDEMIC RESPONSE ADVISORY COUNCIL; INITIAL MEMBERSHIP TERMS.**

Notwithstanding Minnesota Statutes, section 256.042, subdivision 2, paragraph (c), the initial term for members of the Opiate Epidemic Response Advisory Council established under Minnesota Statutes, section 256.042, identified in Minnesota Statutes, section 256.042, subdivision 2, paragraph (a), clauses (1), (3), (5), (7), (9), (11), (13), (15), and (17), ends September 30, 2022. The initial term for members identified under Minnesota Statutes, section 256.042, subdivision 2, paragraph (a), clauses (2), (4), (6), (8), (10), (12), (14), and (16), ends September 30, 2023.

Sec. 55. **DIRECTION TO COMMISSIONER; DIRECTED PAYMENT APPLICATION.**

The commissioner of human services, in consultation with Hennepin Healthcare System, shall submit Section 438.6(c) Preprint to the Centers for Medicare and Medicaid Services no later than July 31, 2021. The commissioner shall request from the Centers for Medicare and Medicaid Services an effective date of January 1, 2022.

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

Sec. 56. **DIRECTIONS TO COMMISSIONER; SCREENING TOOL; SUBSTANCE USE DISORDER REFORM EVALUATION; SUBSTANCE USE DISORDER REFORM EDUCATION.**

(a) By July 1, 2022, the commissioner of human services shall develop or authorize a tool for screening individuals for pretreatment coordination services and a template to document an individual's screening result.

(b) By July 1, 2022, the commissioner of human services shall, in consultation with counties and substance use disorder treatment providers, develop a tool to evaluate the effects of substance use disorder treatment reform proposals enacted during the 2019 and 2021 legislative sessions, including access to services, appropriateness of services, and accuracy of billing service units.

(c) By July 1, 2022, the commissioner of human services shall, in consultation with counties and substance use disorder treatment providers, develop educational materials for

county staff, providers, and the general public regarding the content and timing of changes for implementation pursuant to substance use disorder treatment reform proposals enacted during the 2019 and 2021 legislative sessions.

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

Sec. 57. **FUNDING RECOMMENDATIONS FOR PRETREATMENT COORDINATION SERVICES.**

If federal approval is not obtained for pretreatment coordination services under Minnesota Statutes, section 256B.0625, subdivision 67, the commissioner of human services, in consultation with the counties, shall submit recommendations on a funding mechanism for pretreatment coordination services to the chairs and ranking minority members of the legislative committees with jurisdiction over health hand human services policy and finance by March 15, 2022.

Sec. 58. **REVISOR INSTRUCTION.**

The revisor of statutes must change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever the term appears in Minnesota Statutes and may make any necessary changes to grammar or sentence structure to preserve the meaning of the text.

Sec. 59. **REPEALER.**

Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective July 1, 2024.

ARTICLE 2
HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2020, section 62J.495, subdivision 1, is amended to read:

Subdivision 1. **Implementation.** The commissioner of health, in consultation with the e-Health Advisory Committee, shall develop uniform standards to be used for the interoperable electronic health records system for sharing and synchronizing patient data across systems. The standards must be compatible with federal efforts. The uniform standards must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner shall include an update on standards development as part of an annual report to the legislature.~~ Individual health care providers in private practice with no other providers and health care

providers that do not accept reimbursement from a group purchaser, as defined in section 62J.03, subdivision 6, are excluded from the requirements of this section.

Sec. 2. Minnesota Statutes 2020, section 62J.495, subdivision 2, is amended to read:

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) ~~The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending action on policy and necessary resources to continue the promotion of adoption and effective use of health information technology.~~

~~(d)~~ This subdivision expires June 30, 2021.

Sec. 3. Minnesota Statutes 2020, section 62J.495, subdivision 3, is amended to read:

Subd. 3. **Interoperable electronic health record requirements.** (a) Hospitals and health care providers must meet the following criteria when implementing an interoperable electronic health records system within their hospital system or clinical practice setting.

(b) The electronic health record must be a qualified electronic health record.

(c) The electronic health record must be certified by the Office of the National Coordinator pursuant to the HITECH Act. This criterion only applies to hospitals and health care providers if a certified electronic health record product for the provider's particular practice setting is available. This criterion shall be considered met if a hospital or health care provider is using an electronic health records system that has been certified within the last three years, even if a more current version of the system has been certified within the three-year period.

(d) The electronic health record must meet the standards established according to section 3004 of the HITECH Act as applicable.

(e) The electronic health record must have the ability to generate information on clinical quality measures and other measures reported under sections 4101, 4102, and 4201 of the HITECH Act.

(f) The electronic health record system must be connected to a state-certified health information organization either directly or through a connection facilitated by a ~~state-certified~~ health data intermediary as defined in section 62J.498.

(g) A health care provider who is a prescriber or dispenser of legend drugs must have an electronic health record system that meets the requirements of section 62J.497.

Sec. 4. Minnesota Statutes 2020, section 62J.495, subdivision 4, is amended to read:

Subd. 4. **Coordination with national HIT activities.** (a) The commissioner, in consultation with the e-Health Advisory Committee, shall update the statewide implementation plan required under subdivision 2 and released June 2008, to be consistent with the updated federal ~~HIT Strategic Plan released by the Office of the National Coordinator in accordance with section 3001 of the HITECH Act. The statewide plan shall meet the requirements for a plan required under section 3013 of the HITECH Act~~ plans.

(b) The commissioner, in consultation with the e-Health Advisory Committee, shall work to ensure coordination between state, regional, and national efforts to support and accelerate efforts to effectively use health information technology to improve the quality

and coordination of health care and the continuity of patient care among health care providers, to reduce medical errors, to improve population health, to reduce health disparities, and to reduce chronic disease. The commissioner's coordination efforts shall include but not be limited to:

~~(1) assisting in the development and support of health information technology regional extension centers established under section 3012(c) of the HITECH Act to provide technical assistance and disseminate best practices;~~

~~(2) providing supplemental information to the best practices gathered by regional centers to ensure that the information is relayed in a meaningful way to the Minnesota health care community;~~

~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to encourage implementation of admission, discharge and transfer alerts, and care summary document exchange transactions and to evaluate the impact of health information technology on cost and quality of care. Communications about available financial and technical support shall include clear information about the interoperable health record requirements in subdivision 1, including a separate statement in bold-face type clarifying the exceptions to those requirements;

~~(4)~~ (2) providing educational resources and technical assistance to health care providers and patients related to state and national privacy, security, and consent laws governing clinical health information, including the requirements in sections 144.291 to 144.298. In carrying out these activities, the commissioner's technical assistance does not constitute legal advice;

~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health information exchange, including the requirements in sections 144.291 to 144.298, and making recommendations for modifications that would strengthen the ability of Minnesota health care providers to securely exchange data in compliance with patient preferences and in a way that is efficient and financially sustainable; and

~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements related to patient consent for release of health records for the purposes of treatment, payment, and health care operations, as required in section 144.293, subdivision 2. The commissioner shall provide a report to the legislature on the findings of this public input process no later than February 1, 2017.

(c) The commissioner, in consultation with the e-Health Advisory Committee, shall monitor national activity related to health information technology and shall coordinate

statewide input on policy development. The commissioner shall coordinate statewide responses to proposed federal health information technology regulations in order to ensure that the needs of the Minnesota health care community are adequately and efficiently addressed in the proposed regulations. The commissioner's responses may include, but are not limited to:

(1) reviewing and evaluating any standard, implementation specification, or certification criteria proposed by the national HIT standards ~~committee~~ committees;

(2) reviewing and evaluating policy proposed by ~~the~~ national HIT policy ~~committee~~ committees relating to the implementation of a nationwide health information technology infrastructure; and

(3) ~~monitoring and responding to activity related to the development of quality measures and other measures as required by section 4101 of the HITECH Act. Any response related to quality measures shall consider and address the quality efforts required under chapter 62U; and~~

~~(4)~~ monitoring and responding to national activity related to privacy, security, and data stewardship of electronic health information and individually identifiable health information.

(d) To the extent that the state is either required or allowed to apply, or designate an entity to apply for or carry out activities and programs ~~under section 3013 of the HITECH Act~~, the commissioner of health, in consultation with the e-Health Advisory Committee and the commissioner of human services, shall be the lead applicant or sole designating authority. The commissioner shall make such designations consistent with the goals and objectives of sections 62J.495 to 62J.497 and 62J.50 to 62J.61.

(e) The commissioner of human services shall apply for funding necessary to administer the incentive payments to providers authorized under title IV of the American Recovery and Reinvestment Act.

~~(f) The commissioner shall include in the report to the legislature information on the activities of this subdivision and provide recommendations on any relevant policy changes that should be considered in Minnesota.~~

Sec. 5. Minnesota Statutes 2020, section 62J.498, is amended to read:

62J.498 HEALTH INFORMATION EXCHANGE.

Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to 62J.4982:

(b) "Clinical data repository" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include clinical data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

(c) "Clinical transaction" means any meaningful use transaction or other health information exchange transaction that is not covered by section 62J.536.

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

(e) "Health care provider" or "provider" means a health care provider or provider as defined in section 62J.03, subdivision 8.

(f) "Health data intermediary" means an entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This includes but is not limited to health information service providers (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries as defined in section 62J.495.

(g) "Health information exchange" means the electronic transmission of health-related information between organizations according to nationally recognized standards.

(h) "Health information exchange service provider" means a health data intermediary or health information organization.

(i) "Health information organization" means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k), to improve coordination of patient care and the efficiency of health care delivery.

~~(j) "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act as defined in section 62J.495.~~

~~(k)~~ (j) "Major participating entity" means:

(1) a participating entity that receives compensation for services that is greater than 30 percent of the health information organization's gross annual revenues from the health information exchange service provider;

(2) a participating entity providing administrative, financial, or management services to the health information organization, if the total payment for all services provided by the participating entity exceeds three percent of the gross revenue of the health information organization; and

(3) a participating entity that nominates or appoints 30 percent or more of the board of directors or equivalent governing body of the health information organization.

~~(l)~~ (k) "Master patient index" means an electronic database that holds unique identifiers of patients registered at a care facility and is used by a ~~state-certified~~ health information exchange service provider to enable health information exchange among health care providers that are not related health care entities as defined in section 144.291, subdivision 2, paragraph (k). This does not include data that are submitted to the commissioner for public health purposes required or permitted by law, including any rules adopted by the commissioner.

~~(m) "Meaningful use" means use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination and population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(n) "Meaningful use transaction" means an electronic transaction that a health care provider must exchange to receive Medicare or Medicaid incentives or avoid Medicare penalties pursuant to sections 4101, 4102, and 4201 of the HITECH Act.~~

~~(o)~~ (l) "Participating entity" means any of the following persons, health care providers, companies, or other organizations with which a health information organization ~~or health data intermediary~~ has contracts or other agreements for the provision of health information exchange services:

(1) a health care facility licensed under sections 144.50 to 144.56, a nursing home licensed under sections 144A.02 to 144A.10, and any other health care facility otherwise licensed under the laws of this state or registered with the commissioner;

(2) a health care provider, and any other health care professional otherwise licensed under the laws of this state or registered with the commissioner;

(3) a group, professional corporation, or other organization that provides the services of individuals or entities identified in clause (2), including but not limited to a medical clinic,

a medical group, a home health care agency, an urgent care center, and an emergent care center;

(4) a health plan as defined in section 62A.011, subdivision 3; and

(5) a state agency as defined in section 13.02, subdivision 17.

~~(p)~~ (m) "Reciprocal agreement" means an arrangement in which two or more health information exchange service providers agree to share in-kind services and resources to allow for the pass-through of clinical transactions.

~~(q) "State-certified health data intermediary" means a health data intermediary that has been issued a certificate of authority to operate in Minnesota.~~

~~(r)~~ (n) "State-certified health information organization" means a health information organization that has been issued a certificate of authority to operate in Minnesota.

Subd. 2. **Health information exchange oversight.** (a) The commissioner shall protect the public interest on matters pertaining to health information exchange. The commissioner shall:

(1) review and act on applications from ~~health data intermediaries and~~ health information organizations for certificates of authority to operate in Minnesota;

(2) require information to be provided as needed from health information exchange service providers in order to meet requirements established under sections 62J.498 to 62J.4982;

~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under sections 62J.498 to 62J.4982;

~~(3)~~ (4) respond to public complaints related to health information exchange services;

~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines, suspension, or revocation of certificates of authority as outlined in section 62J.4982;

~~(5)~~ (6) provide a biennial report on the status of health information exchange services that includes but is not limited to:

(i) recommendations on actions necessary to ensure that health information exchange services are adequate to meet the needs of Minnesota citizens and providers statewide;

(ii) recommendations on enforcement actions to ensure that health information exchange service providers act in the public interest without causing disruption in health information exchange services;

(iii) recommendations on updates to criteria for obtaining certificates of authority under this section; and

(iv) recommendations on standard operating procedures for health information exchange, including but not limited to the management of consumer preferences; and

~~(6)~~ (7) other duties necessary to protect the public interest.

(b) As part of the application review process for certification under paragraph (a), prior to issuing a certificate of authority, the commissioner shall:

(1) make all portions of the application classified as public data available to the public for at least ten days while an application is under consideration. At the request of the commissioner, the applicant shall participate in a public hearing by presenting an overview of their application and responding to questions from interested parties; and

(2) consult with hospitals, physicians, and other providers prior to issuing a certificate of authority.

(c) When the commissioner is actively considering a suspension or revocation of a certificate of authority as described in section 62J.4982, subdivision 3, all investigatory data that are collected, created, or maintained related to the suspension or revocation are classified as confidential data on individuals and as protected nonpublic data in the case of data not on individuals.

(d) The commissioner may disclose data classified as protected nonpublic or confidential under paragraph (c) if disclosing the data will protect the health or safety of patients.

(e) After the commissioner makes a final determination regarding a suspension or revocation of a certificate of authority, all minutes, orders for hearing, findings of fact, conclusions of law, and the specification of the final disciplinary action, are classified as public data.

Sec. 6. Minnesota Statutes 2020, section 62J.4981, is amended to read:

62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH INFORMATION EXCHANGE SERVICES.

Subdivision 1. **Authority to require organizations to apply.** The commissioner shall require ~~a health data intermediary or~~ a health information organization to apply for a certificate of authority under this section. An applicant may continue to operate until the commissioner acts on the application. If the application is denied, the applicant is considered

a health information exchange service provider whose certificate of authority has been revoked under section 62J.4982, subdivision 2, paragraph (d).

~~Subd. 2. **Certificate of authority for health data intermediaries.** (a) A health data intermediary must be certified by the state and comply with requirements established in this section.~~

~~(b) Notwithstanding any law to the contrary, any corporation organized to do so may apply to the commissioner for a certificate of authority to establish and operate as a health data intermediary in compliance with this section. No person shall establish or operate a health data intermediary in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health data intermediary contract unless the organization has a certificate of authority or has an application under active consideration under this section.~~

~~(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:~~

~~(1) hold reciprocal agreements with at least one state-certified health information organization to access patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements established in subdivision 5; and~~

~~(2) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability between state-certified health information organizations and state-certified health data intermediaries.~~

Subd. 3. **Certificate of authority for health information organizations.** (a) A health information organization must obtain a certificate of authority from the commissioner and demonstrate compliance with the criteria in paragraph (c).

(b) Notwithstanding any law to the contrary, an organization may apply for a certificate of authority to establish and operate a health information organization under this section. No person shall establish or operate a health information organization in this state, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health information organization or health information contract unless the organization has a certificate of authority under this section.

(c) In issuing the certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has demonstrated that the applicant meets the following minimum criteria:

(1) the entity is a legally established organization;

(2) appropriate insurance, including liability insurance, for the operation of the health information organization is in place and sufficient to protect the interest of the public and participating entities;

(3) strategic and operational plans address governance, technical infrastructure, legal and policy issues, finance, and business operations in regard to how the organization will expand to support providers in achieving health information exchange goals over time;

(4) the entity addresses the parameters to be used with participating entities and other health information exchange service providers for clinical transactions, compliance with Minnesota law, and interstate health information exchange trust agreements;

(5) the entity's board of directors or equivalent governing body is composed of members that broadly represent the health information organization's participating entities and consumers;

(6) the entity maintains a professional staff responsible to the board of directors or equivalent governing body with the capacity to ensure accountability to the organization's mission;

(7) the organization is compliant with national certification and accreditation programs designated by the commissioner;

(8) the entity maintains the capability to query for patient information based on national standards. The query capability may utilize a master patient index, clinical data repository, or record locator service as defined in section 144.291, subdivision 2, paragraph (j). The entity must be compliant with the requirements of section 144.293, subdivision 8, when conducting clinical transactions;

(9) the organization demonstrates interoperability with all other state-certified health information organizations using nationally recognized standards;

(10) the organization demonstrates compliance with all privacy and security requirements required by state and federal law; and

(11) the organization uses financial policies and procedures consistent with generally accepted accounting principles and has an independent audit of the organization's financials on an annual basis.

(d) Health information organizations that have obtained a certificate of authority must:

(1) meet the requirements established for connecting to the National eHealth Exchange;

(2) annually submit strategic and operational plans for review by the commissioner that address:

(i) progress in achieving objectives included in previously submitted strategic and operational plans across the following domains: business and technical operations, technical infrastructure, legal and policy issues, finance, and organizational governance;

(ii) plans for ensuring the necessary capacity to support clinical transactions;

(iii) approach for attaining financial sustainability, including public and private financing strategies, and rate structures;

(iv) rates of adoption, utilization, and transaction volume, and mechanisms to support health information exchange; and

(v) an explanation of methods employed to address the needs of community clinics, critical access hospitals, and free clinics in accessing health information exchange services;

(3) enter into reciprocal agreements with all other state-certified health information organizations ~~and state-certified health data intermediaries~~ to enable access to patient data, and for the transmission and receipt of clinical transactions. Reciprocal agreements must meet the requirements in subdivision 5;

(4) participate in statewide shared health information exchange services as defined by the commissioner to support interoperability ~~between state-certified health information organizations and state-certified health data intermediaries~~; and

(5) comply with additional requirements for the certification or recertification of health information organizations that may be established by the commissioner.

Subd. 4. **Application for certificate of authority for health information ~~exchange service providers~~ organizations.** (a) Each application for a certificate of authority shall be in a form prescribed by the commissioner and verified by an officer or authorized representative of the applicant. Each application shall include the following in addition to information described in the criteria in ~~subdivisions 2 and~~ subdivision 3:

(1) ~~for health information organizations only,~~ a copy of the basic organizational document, if any, of the applicant and of each major participating entity, such as the articles of incorporation, or other applicable documents, and all amendments to it;

(2) ~~for health information organizations only,~~ a list of the names, addresses, and official positions of the following:

(i) all members of the board of directors or equivalent governing body, and the principal officers and, if applicable, shareholders of the applicant organization; and

(ii) all members of the board of directors or equivalent governing body, and the principal officers of each major participating entity and, if applicable, each shareholder beneficially owning more than ten percent of any voting stock of the major participating entity;

(3) ~~for health information organizations only,~~ the name and address of each participating entity and the agreed-upon duration of each contract or agreement if applicable;

(4) a copy of each standard agreement or contract intended to bind the participating entities and the health information ~~exchange service provider~~ organization. Contractual provisions shall be consistent with the purposes of this section, in regard to the services to be performed under the standard agreement or contract, the manner in which payment for services is determined, the nature and extent of responsibilities to be retained by the health information organization, and contractual termination provisions;

(5) a statement generally describing the health information ~~exchange service provider~~ organization, its health information exchange contracts, facilities, and personnel, including a statement describing the manner in which the applicant proposes to provide participants with comprehensive health information exchange services;

(6) a statement reasonably describing the geographic area or areas to be served and the type or types of participants to be served;

(7) a description of the complaint procedures to be used as required under this section;

(8) a description of the mechanism by which participating entities will have an opportunity to participate in matters of policy and operation;

(9) a copy of any pertinent agreements between the health information organization and insurers, including liability insurers, demonstrating coverage is in place;

(10) a copy of the conflict of interest policy that applies to all members of the board of directors or equivalent governing body and the principal officers of the health information organization; and

(11) other information as the commissioner may reasonably require to be provided.

(b) Within 45 days after the receipt of the application for a certificate of authority, the commissioner shall determine whether or not the application submitted meets the requirements for completion in paragraph (a), and notify the applicant of any further information required for the application to be processed.

(c) Within 90 days after the receipt of a complete application for a certificate of authority, the commissioner shall issue a certificate of authority to the applicant if the commissioner determines that the applicant meets the minimum criteria requirements of subdivision 2 ~~for health data intermediaries or subdivision 3 for health information organizations~~. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and specify the reasons for disqualification.

(d) Upon being granted a certificate of authority to operate as a state-certified health information organization ~~or state-certified health data intermediary~~, the organization must operate in compliance with the provisions of this section. Noncompliance may result in the imposition of a fine or the suspension or revocation of the certificate of authority according to section 62J.4982.

Subd. 5. **Reciprocal agreements between health information ~~exchange entities~~ organizations.** (a) Reciprocal agreements between two health information organizations ~~or between a health information organization and a health data intermediary~~ must include a fair and equitable model for charges between the entities that:

(1) does not impede the secure transmission of clinical transactions;

(2) does not charge a fee for the exchange of ~~meaningful use~~ transactions transmitted according to nationally recognized standards where no additional value-added service is rendered to the sending or receiving health information organization ~~or health data intermediary~~ either directly or on behalf of the client;

(3) is consistent with fair market value and proportionately reflects the value-added services accessed as a result of the agreement; and

(4) prevents health care stakeholders from being charged multiple times for the same service.

(b) Reciprocal agreements must include comparable quality of service standards that ensure equitable levels of services.

(c) Reciprocal agreements are subject to review and approval by the commissioner.

(d) Nothing in this section precludes a state-certified health information organization ~~or state-certified health data intermediary~~ from entering into contractual agreements for the provision of value-added services ~~beyond meaningful use transactions~~.

Sec. 7. Minnesota Statutes 2020, section 62J.4982, is amended to read:

62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.

Subdivision 1. **Penalties and enforcement.** (a) The commissioner may, for any violation of statute or rule applicable to a health information ~~exchange service provider~~ organization, levy an administrative penalty in an amount up to $25,000 for each violation. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of participating entities affected by the violation;

(2) the effect of the violation on participating entities' access to health information exchange services;

(3) if only one participating entity is affected, the effect of the violation on the patients of that entity;

(4) whether the violation is an isolated incident or part of a pattern of violations;

(5) the economic benefits derived by the health information organization ~~or a health data intermediary~~ by virtue of the violation;

(6) whether the violation hindered or facilitated an individual's ability to obtain health care;

(7) whether the violation was intentional;

(8) whether the violation was beyond the direct control of the health information ~~exchange service provider~~ organization;

(9) any history of prior compliance with the provisions of this section, including violations;

(10) whether and to what extent the health information ~~exchange service provider~~ organization attempted to correct previous violations;

(11) how the health information ~~exchange service provider~~ organization responded to technical assistance from the commissioner provided in the context of a compliance effort; and

(12) the financial condition of the health information ~~exchange service provider~~ organization including~~,~~ but not limited to~~,~~ whether the health information ~~exchange service~~

~~provider~~ organization had financial difficulties that affected its ability to comply or whether the imposition of an administrative monetary penalty would jeopardize the ability of the health information ~~exchange service provider~~ organization to continue to deliver health information exchange services.

The commissioner shall give reasonable notice in writing to the health information ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for it. A health information ~~exchange service provider~~ organization may have 15 days within which to contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982, according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(b) If the commissioner has reason to believe that a violation of section 62J.4981 or 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved before commencing action under subdivision 2. The commissioner may notify the health information ~~exchange service provider~~ organization and the representatives, or other persons who appear to be involved in the suspected violation, to arrange a voluntary conference with the alleged violators or their authorized representatives. The purpose of the conference is to attempt to learn the facts about the suspected violation and, if it appears that a violation has occurred or is threatened, to find a way to correct or prevent it. The conference is not governed by any formal procedural requirements, and may be conducted as the commissioner considers appropriate.

(c) The commissioner may issue an order directing a health information ~~exchange service provider~~ organization or a representative of a health information ~~exchange service provider~~ organization to cease and desist from engaging in any act or practice in violation of sections 62J.4981 and 62J.4982.

(d) Within 20 days after service of the order to cease and desist, a health information ~~exchange service provider~~ organization may contest whether the facts found constitute a violation of sections 62J.4981 and 62J.4982 according to the contested case and judicial review provisions of sections 14.57 to 14.69.

(e) In the event of noncompliance with a cease and desist order issued under this subdivision, the commissioner may institute a proceeding to obtain injunctive relief or other appropriate relief in Ramsey County District Court.

Subd. 2. **Suspension or revocation of certificates of authority.** (a) The commissioner may suspend or revoke a certificate of authority issued to a ~~health data intermediary or~~ health information organization under section 62J.4981 if the commissioner finds that:

(1) the health information ~~exchange service provider~~ organization is operating significantly in contravention of its basic organizational document, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 62J.4981, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) the health information ~~exchange service provider~~ organization is unable to fulfill its obligations to furnish comprehensive health information exchange services as required under its health information exchange contract;

(3) the health information ~~exchange service provider~~ organization is no longer financially solvent or may not reasonably be expected to meet its obligations to participating entities;

(4) the health information ~~exchange service provider~~ organization has failed to implement the complaint system in a manner designed to reasonably resolve valid complaints;

(5) the health information ~~exchange service provider~~ organization, or any person acting with its sanction, has advertised or merchandised its services in an untrue, misleading, deceptive, or unfair manner;

(6) the continued operation of the health information ~~exchange service provider~~ organization would be hazardous to its participating entities or the patients served by the participating entities; or

(7) the health information ~~exchange service provider~~ organization has otherwise failed to substantially comply with section 62J.4981 or with any other statute or administrative rule applicable to health information exchange service providers, or has submitted false information in any report required under sections 62J.498 to 62J.4982.

(b) A certificate of authority shall be suspended or revoked only after meeting the requirements of subdivision 3.

(c) If the certificate of authority of a health information ~~exchange service provider~~ organization is suspended, the health information ~~exchange service provider~~ organization shall not, during the period of suspension, enroll any additional participating entities, and shall not engage in any advertising or solicitation.

(d) If the certificate of authority of a health information ~~exchange service provider~~ organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as necessary to the orderly conclusion of the affairs of the organization. The organization shall engage in no further advertising or solicitation. The commissioner may,

by written order, permit further operation of the organization as the commissioner finds to be in the best interest of participating entities, to the end that participating entities will be given the greatest practical opportunity to access continuing health information exchange services.

Subd. 3. **Denial, suspension, and revocation; administrative procedures.** (a) When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health information ~~exchange service provider~~ organization in writing stating the grounds for denial, suspension, or revocation and setting a time within 20 days for a hearing on the matter.

(b) After a hearing before the commissioner at which the health information ~~exchange service provider~~ organization may respond to the grounds for denial, suspension, or revocation, or upon the failure of the health information ~~exchange service provider~~ organization to appear at the hearing, the commissioner shall take action as deemed necessary and shall issue written findings and mail them to the health information ~~exchange service provider~~ organization.

(c) If suspension, revocation, or administrative penalty is proposed according to this section, the commissioner must deliver, or send by certified mail with return receipt requested, to the health information ~~exchange service provider~~ organization written notice of the commissioner's intent to impose a penalty. This notice of proposed determination must include:

(1) a reference to the statutory basis for the penalty;

(2) a description of the findings of fact regarding the violations with respect to which the penalty is proposed;

(3) the nature and amount of the proposed penalty;

(4) any circumstances described in subdivision 1, paragraph (a), that were considered in determining the amount of the proposed penalty;

(5) instructions for responding to the notice, including a statement of the health information ~~exchange service provider's~~ organization's right to a contested case proceeding and a statement that failure to request a contested case proceeding within 30 calendar days permits the imposition of the proposed penalty; and

(6) the address to which the contested case proceeding request must be sent.

Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the

certification and recertification of health information ~~exchange service providers~~ organizations when implementing sections 62J.498 to 62J.4982.

Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every health information ~~exchange service provider~~ organization subject to sections 62J.4981 and 62J.4982 as follows:

(1) filing an application for certificate of authority to operate as a health information organization, $7,000; and

(2) ~~filing an application for certificate of authority to operate as a health data intermediary, $7,000;~~

~~(3)~~ annual health information organization certificate fee, $7,000~~; and~~.

~~(4) annual health data intermediary certificate fee, $7,000.~~

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

(c) Administrative monetary penalties imposed under this subdivision shall be credited to an account in the special revenue fund and are appropriated to the commissioner for the purposes of sections 62J.498 to 62J.4982.

Sec. 8. Minnesota Statutes 2020, section 62J.84, subdivision 6, is amended to read:

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

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

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

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

(c) The commissioner shall not post to the department's website or a private entity contracting with the commissioner shall not post any information described in this section if the information is not public data under section 13.02, subdivision 8a; or is trade secret information under section 13.37, subdivision 1, paragraph (b); or is trade secret information

pursuant to the Defend Trade Secrets Act of 2016, United States Code, title 18, section 1836, as amended. If a manufacturer believes information should be withheld from public disclosure pursuant to this paragraph, the manufacturer must clearly and specifically identify that information and describe the legal basis in writing when the manufacturer submits the information under this section. If the commissioner disagrees with the manufacturer's request to withhold information from public disclosure, the commissioner shall provide the manufacturer written notice that the information will be publicly posted 30 days after the date of the notice.

(d) If the commissioner withholds any information from public disclosure pursuant to this subdivision, the commissioner shall post to the department's website a report describing the nature of the information and the commissioner's basis for withholding the information from disclosure.

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

Sec. 9. Minnesota Statutes 2020, section 144.05, is amended by adding a subdivision to read:

Subd. 7. **Expiration of report mandates.** (a) If the submission of a report by the commissioner of health to the legislature is mandated by statute and the enabling legislation does not include a date for the submission of a final report, the mandate to submit the report shall expire in accordance with this section.

(b) If the mandate requires the submission of an annual report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1,2023. If the mandate requires the submission of a biennial or less frequent report and the mandate was enacted before January 1, 2021, the mandate shall expire on January 1, 2024.

(c) Any reporting mandate enacted on or after January 1, 2021 shall expire three years after the date of enactment if the mandate requires the submission of an annual report and shall expire five years after the date of enactment if the mandate requires the submission of a biennial or less frequent report, unless the enacting legislation provides for a difference expiration date.

(d) The commissioner shall submit a list to the chairs and ranking minority members of the legislative committee with jurisdiction over health by February 15 of each year, beginning February 15, 2022, of all reports set to expire during the following calendar year in accordance with this section.

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

Sec. 10. **[144.064] THE VIVIAN ACT.**

Subdivision 1. **Short title.** This section shall be known and may be cited as the "Vivian Act."

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(1) "commissioner" means the commissioner of health;

(2) "health care practitioner" means a medical professional that provides prenatal or postnatal care;

(3) "CMV" means the human herpesvirus cytomegalovirus, also called HCMV, human herpesvirus 5, and HHV-5; and

(4) "congenital CMV" means the transmission of a CMV infection from a pregnant mother to her fetus.

Subd. 3. **Commissioner duties.** (a) The commissioner shall make available to health care practitioners, women who may become pregnant, expectant parents, and parents of infants up-to-date and evidence-based information about congenital CMV that has been reviewed by experts with knowledge of the disease. The information shall include the following:

(1) the recommendation to consider testing for congenital CMV if the parent or legal guardian of the infant elected not to have newborn screening performed under section 144.125, and the infant failed a newborn hearing screening or pregnancy history suggests increased risk for congenital CMV infection;

(2) the incidence of CMV;

(3) the transmission of CMV to pregnant women and women who may become pregnant;

(4) birth defects caused by congenital CMV;

(5) available preventative measures to avoid the infection of women who are pregnant or may become pregnant; and

(6) resources available for families of children born with congenital CMV.

(b) The commissioner shall follow existing department practice, inclusive of community engagement, to ensure that the information in paragraph (a) is culturally and linguistically appropriate for all recipients.

(c) The department shall establish an outreach program to:

(1) educate women who may become pregnant, expectant parents, and parents of infants about CMV; and

(2) raise awareness for CMV among health care providers who provide care to expectant mothers or infants.

Sec. 11. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

Subd. 2. **Initial and annual fee.** (a) A licensee must pay an initial fee that is equivalent to the annual fee upon issuance of the initial license.

(b) A licensee must pay an annual fee at least 60 days before the anniversary date of the issuance of the license. The annual fee is as follows:

TYPE	~~ANNUAL~~ LICENSE FEE
	~~$19,920~~
Academic broad scope - type A, B, or C	$25,896
~~Academic broad scope - type B~~	~~19,920~~
~~Academic broad scope - type C~~	~~19,920~~
Academic broad scope - type A, B, or C (4-8 locations)	$31,075
Academic broad scope - type A, B, or C (9 or more locations)	$36,254
	~~19,920~~
Medical broad scope - type A	$25,896
Medical broad scope- type A (4-8 locations)	$31,075
Medical broad scope- type A (9 or more locations)	$36,254
~~Medical institution - diagnostic and therapeutic~~	~~3,680~~
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$4,784
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (4-8 locations)	$5,740
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies (9 or more locations)	$6,697
~~Medical institution - diagnostic (no written directives)~~	~~3,680~~

~~Medical private practice - diagnostic and therapeutic~~	~~3,680~~
~~Medical private practice - diagnostic (no written directives)~~	~~3,680~~
~~Eye applicators~~	~~3,680~~
~~Nuclear medical vans~~	~~3,680~~
~~High dose rate afterloader~~	~~3,680~~
~~Mobile high dose rate afterloader~~	~~3,680~~
~~Medical therapy - other emerging technology~~	~~3,680~~
Teletherapy	~~8,960~~ $11,648
Gamma knife	~~8,960~~ $11,648
Veterinary medicine	~~2,000~~ $2,600
In vitro testing lab	~~2,000~~ $2,600
Nuclear pharmacy	~~8,800~~ $11,440
Nuclear pharmacy (5 or more locations)	$13,728
Radiopharmaceutical distribution (10 CFR 32.72)	~~3,840~~ $4,992
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~8,800~~ $11,440
Radiopharmaceutical processing and distribution (10 CFR 32.72) (5 or more locations)	$13,728
Medical sealed sources - distribution (10 CFR 32.74)	~~3,840~~ $4,992
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~8,800~~ $11,440
Medical sealed sources - processing and distribution (10 CFR 32.74) (5 or more locations)	$13,728
Well logging - sealed sources	~~3,760~~ $4,888
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~2,000~~ $2,600
~~Measuring systems - portable gauge~~	~~2,000~~
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (4-8 locations)	$3,120
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other) (9 or more locations)	$3,640
X-ray fluorescent analyzer	~~1,520~~ $1,976
~~Measuring systems - gas chromatograph~~	~~2,000~~
~~Measuring systems - other~~	~~2,000~~
~~Broad scope~~ Manufacturing and distribution - type A broad scope	~~19,920~~ $25,896
Manufacturing and distribution - type A broad scope (4-8 locations)	$31,075

Manufacturing and distribution - type A broad scope (9 or more locations)	$36,254
~~Broad scope~~ Manufacturing and distribution - type B or C broad scope	~~17,600~~ $22,880
~~Broad scope Manufacturing and distribution - type C~~	~~17,600~~
Manufacturing and distribution - type B or C broad scope (4-8 locations)	$27,456
Manufacturing and distribution - type B or C broad scope (9 or more locations)	$32,032
Manufacturing and distribution - other	~~5,280~~ $6,864
Manufacturing and distribution - other (4-8 locations)	$8,236
Manufacturing and distribution - other (9 or more locations)	$9,609
Nuclear laundry	~~18,640~~ $24,232
Decontamination services	~~4,960~~ $6,448
Leak test services only	~~2,000~~ $2,600
Instrument calibration service only~~, less than 100 curies~~	~~2,000~~ $2,600
~~Instrument calibration service only, 100 curies or more~~	~~2,000~~
Service, maintenance, installation, source changes, etc.	~~4,960~~ $6,448
Waste disposal service, prepackaged only	~~6,000~~ $7,800
Waste disposal	~~8,320~~ $10,816
Distribution - general licensed devices (sealed sources)	~~1,760~~ $2,288
Distribution - general licensed material (unsealed sources)	~~1,120~~ $1,456
Industrial radiography - fixed or temporary location	~~9,840~~ $12,792
~~Industrial radiography - temporary job sites~~	~~9,840~~
Industrial radiography - fixed or temporary location (5 or more locations)	$16,629
Irradiators, self-shielding~~, less than 10,000 curies~~	~~2,880~~ $3,744
Irradiators, other, less than 10,000 curies	~~5,360~~ $6,968
~~Irradiators, self-shielding, 10,000 curies or more~~	~~2,880~~
Research and development - type A, B, or C broad scope	~~9,520~~ $12,376
~~Research and development - type B broad scope~~	~~9,520~~
~~Research and development - type C broad scope~~	~~9,520~~
Research and development - type A, B, or C broad scope (4-8 locations)	$14,851
Research and development - type A, B, or C broad scope (9 or more locations)	$17,326
Research and development - other	~~4,480~~ $5,824
Storage - no operations	~~2,000~~ $2,600

Source material - shielding	~~584~~ $759
Special nuclear material plutonium - neutron source in device	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - medical (institution)	~~3,680~~ $4,784
Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~5,280~~ $6,864
Accelerator-produced radioactive material	~~3,840~~ $4,992
Nonprofit educational institutions	~~300~~ $500
~~General license registration~~	~~150~~

Sec. 12. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

Subd. 4. **Initial and renewal application fee.** A licensee must pay an initial and a renewal application fee ~~as follows:~~ according to this subdivision.

TYPE	APPLICATION FEE
	~~$ 5,920~~
Academic broad scope - type A, B, or C	$6,808
~~Academic broad scope - type B~~	~~5,920~~
~~Academic broad scope - type C~~	~~5,920~~
Medical broad scope - type A	~~3,920~~ $4,508
Medical - diagnostic, diagnostic and therapeutic, mobile nuclear medicine, eye applicators, high dose rate afterloaders, and medical therapy emerging technologies	$1,748
~~Medical institution - diagnostic and therapeutic~~	~~1,520~~
~~Medical institution - diagnostic (no written directives)~~	~~1,520~~
~~Medical private practice - diagnostic and therapeutic~~	~~1,520~~
~~Medical private practice - diagnostic (no written directives)~~	~~1,520~~
~~Eye applicators~~	~~1,520~~
~~Nuclear medical vans~~	~~1,520~~
~~High dose rate afterloader~~	~~1,520~~
~~Mobile high dose rate afterloader~~	~~1,520~~
~~Medical therapy - other emerging technology~~	~~1,520~~
Teletherapy	~~5,520~~ $6,348
Gamma knife	~~5,520~~ $6,348
Veterinary medicine	~~960~~ $1,104
In vitro testing lab	~~960~~ $1,104
Nuclear pharmacy	~~4,880~~ $5,612
Radiopharmaceutical distribution (10 CFR 32.72)	~~2,160~~ $2,484
Radiopharmaceutical processing and distribution (10 CFR 32.72)	~~4,880~~ $5,612

Medical sealed sources - distribution (10 CFR 32.74)	~~2,160~~ $2,484
Medical sealed sources - processing and distribution (10 CFR 32.74)	~~4,880~~ $5,612
Well logging - sealed sources	~~1,600~~ $1,840
Measuring systems - (fixed gauge, portable gauge, gas chromatograph, other)	~~960~~ $1,104
~~Measuring systems - portable gauge~~	~~960~~
X-ray fluorescent analyzer	~~584~~ $671
~~Measuring systems - gas chromatograph~~	~~960~~
~~Measuring systems - other~~	~~960~~
~~Broad scope~~ Manufacturing and distribution - type A, B, and C broad scope	~~5,920~~ $6,854
~~Broad scope manufacturing and distribution - type B~~	~~5,920~~
~~Broad scope manufacturing and distribution - type C~~	~~5,920~~
Manufacturing and distribution - other	~~2,320~~ $2,668
Nuclear laundry	~~10,080~~ $11,592
Decontamination services	~~2,640~~ $3,036
Leak test services only	~~960~~ $1,104
Instrument calibration service only~~, less than 100 curies~~	~~960~~ $1,104
~~Instrument calibration service only, 100 curies or more~~	~~960~~
Service, maintenance, installation, source changes, etc.	~~2,640~~ $3,036
Waste disposal service, prepackaged only	~~2,240~~ $2,576
Waste disposal	~~1,520~~ $1,748
Distribution - general licensed devices (sealed sources)	~~880~~ $1,012
Distribution - general licensed material (unsealed sources)	~~520~~ $598
Industrial radiography - fixed or temporary location	~~2,640~~ $3,036
~~Industrial radiography - temporary job sites~~	~~2,640~~
Irradiators, self-shielding~~, less than 10,000 curies~~	~~1,440~~ $1,656
Irradiators, other, less than 10,000 curies	~~2,960~~ $3,404
~~Irradiators, self-shielding, 10,000 curies or more~~	~~1,440~~
Research and development - type A, B, or C broad scope	~~4,960~~ $5,704
~~Research and development - type B broad scope~~	~~4,960~~
~~Research and development - type C broad scope~~	~~4,960~~
Research and development - other	~~2,400~~ $2,760
Storage - no operations	~~960~~ $1,104
Source material - shielding	~~136~~ $156
Special nuclear material plutonium - neutron source in device	~~1,200~~ $1,380
Pacemaker by-product and/or special nuclear material - medical (institution)	~~1,200~~ $1,380

Pacemaker by-product and/or special nuclear material - manufacturing and distribution	~~2,320~~ $2,668
Accelerator-produced radioactive material	~~4,100~~ $4,715
Nonprofit educational institutions	~~300~~ $345
~~General license registration~~	~~0~~
~~Industrial radiographer certification~~	~~150~~

Sec. 13. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition of a materials license issued by another agreement state or the United States Nuclear Regulatory Commission for a period of 180 days or less during a calendar year must pay ~~$1,200~~ $2,400. For a period of 181 days or more, the licensee must obtain a license under subdivision 4.

Sec. 14. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

Subd. 9. **Fees for license amendments.** A licensee must pay a fee of ~~$300~~ $600 to amend a license as follows:

(1) to amend a license requiring review including, but not limited to, addition of isotopes, procedure changes, new authorized users, or a new radiation safety officer; and

(2) to amend a license requiring review and a site visit including, but not limited to, facility move or addition of processes.

Sec. 15. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision to read:

Subd. 10. **Fees for general license registrations.** A person required to register generally licensed devices according to Minnesota Rules, part 4731.3215, must pay an annual registration fee of $450.

Sec. 16. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$135~~ $177 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 17. Minnesota Statutes 2020, section 144.125, subdivision 2, is amended to read:

Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

(b) Notwithstanding paragraph (a), a test to detect congenital human herpesvirus cytomegalovirus shall be added to the list of tests to be administered under this section.

Sec. 18. **[144.1461] PREGNANCY AND CHILDBIRTH; MIDWIFE AND DOULA CARE.**

In order to improve maternal and infant health as well as improving birth outcomes in groups with the most significant disparities that include Black, Indigenous, and other communities of color; rural communities; and people with low incomes, the commissioner of health in partnership with patient groups and culturally based community organizations shall, within existing appropriations:

(1) develop procedures and services designed for making midwife and doula services available to groups with the most maternal and infant mortality and morbidity disparities;

(2) promote racial, ethnic, and language diversity in the midwife and doula workforce that better aligns with the childbearing population in groups with the most significant maternal and infant mortality and morbidity disparities; and

(3) ensure that midwife and doula training and education is tailored to the specific needs of groups with the most significant maternal and infant mortality and morbidity disparities, including trauma-informed care, maternal mood disorders, intimate partner violence, and systemic racism.

Sec. 19. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

Subdivision 1. **Establishment; membership.** The commissioner of health shall establish a ~~15-member~~ 16-member Rural Health Advisory Committee. The committee shall consist of the following members, all of whom must reside outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2:

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

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

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

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

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

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

(7) a dentist licensed under chapter 150A;

(8) a midlevel practitioner;

~~(8)~~ (9) a registered nurse or licensed practical nurse;

~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented on the committee;

~~(10)~~ (11) a representative of an institution of higher education located outside the seven-county metropolitan area that provides training for rural health care providers; and

~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who are mentally ill or developmentally disabled.

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

Sec. 20. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision to read:

Subd. 3. **Reporting safe place newborn births.** A hospital that receives a safe place newborn under section 145.902 shall report the birth of the newborn to the Office of Vital Records within five days after receiving the newborn. The state registrar must register information about the safe place newborn according to Minnesota Rules, part 4601.0600, subpart 4, item C.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 21. Minnesota Statutes 2020, section 144.216, is amended by adding a subdivision to read:

Subd. 4. **Status of safe place birth registrations.** (a) Information about the safe place newborn registered under subdivision 3 shall constitute the record of birth for the child. The birth record for the child is confidential data on individuals as defined in section 13.02, subdivision 3. Information about the child's birth record or a child's birth certificate issued from the child's birth record shall be disclosed only to the responsible social services agency as defined in section 260C.007, subdivision 27a, or pursuant to court order.

(b) Pursuant to section 144.218, subdivision 6, if the safe place newborn was born in a hospital and it is known that the child's record of birth was registered, the Office of Vital Records shall replace the original birth record registered under section 144.215.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 22. Minnesota Statutes 2020, section 144.218, is amended by adding a subdivision to read:

Subd. 6. **Safe place newborns.** If a hospital receives a safe place newborn under section 145.902 and it is known that the child's record of birth was registered, the hospital shall report the newborn to the Office of Vital Records and identify the child's birth record. The state registrar shall issue a replacement birth record for the child that is free of information that identifies a parent. The prior vital record is confidential data on individuals as defined in section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 23. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner and payment of the required fee:

(1) to a person who ~~has a tangible interest in the requested vital record. A person who has a tangible interest~~ is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vii) the party responsible for filing the vital record;~~

~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;

~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, tribal, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties;

(3) to an attorney representing the subject of the vital record or another person listed in clause (1), upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state registrar or local issuance office shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

Sec. 24. Minnesota Statutes 2020, section 144.226, subdivision 1, is amended to read:

Subdivision 1. **Which services are for fee.** (a) The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(b) The fee for the administrative review and processing of a request for a certified vital record or a certification that the vital record cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

(c) The fee for processing a request for the replacement of a birth record for all events, except for safe place newborns pursuant to section 144.218, subdivision 6, and when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is $40. The fee is payable at the time of application and is nonrefundable.

(d) The fee for administrative review and processing of a request for the filing of a delayed registration of birth, stillbirth, or death is $40. The fee is payable at the time of application and is nonrefundable.

(e) The fee for administrative review and processing of a request for the amendment of any vital record is $40. The fee is payable at the time of application and is nonrefundable.

(f) The fee for administrative review and processing of a request for the verification of information from vital records is $9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is $20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the subject of the record. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(g) The fee for administrative review and processing of a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is $9. The fee is payable at the time of application and is nonrefundable.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 25. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

Subdivision 1. **Restricted construction or modification.** (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of

construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds in an existing hospital in Carver County serving the southwest suburban metropolitan area;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility;

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause;

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city of Maple Grove, exclusively for patients who are under 21 years of age on the date of admission, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete;

(ii) this project shall serve patients in the continuing care benefit program under section 256.9693. The project may also serve patients not in the continuing care benefit program; and

(iii) if the project ceases to participate in the continuing care benefit program, the commissioner must complete a subsequent public interest review under section 144.552. If the project is found not to be in the public interest, the license must be terminated six months from the date of that finding. If the commissioner of human services terminates the contract without cause or reduces per diem payment rates for patients under the continuing care benefit program below the rates in effect for services provided on December 31, 2015, the

project may cease to participate in the continuing care benefit program and continue to operate without a subsequent public interest review;

(27) a project involving the addition of 21 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission; ~~or~~

(28) a project to add 55 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which 15 beds are to be used for inpatient mental health and 40 are to be used for other services. In addition, five unlicensed observation mental health beds shall be added~~.~~; or

(29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing safety net, level I trauma center hospital in Ramsey County as designated under section 383A.91, subdivision 5. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project under this clause.

Sec. 26. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES WITH YOUNG CHILDREN.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section and have the meanings given them.

(b) "Evidence-based home visiting program" means a program that:

(1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;

(2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;

(3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;

(4) has demonstrated significant, sustained positive outcomes; and

(5) either:

(i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or

(ii) is based on quasi-experimental research using two or more separate, comparable client samples.

(c) "Evidence-informed home visiting program" means a program that:

(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women and young children; and

(2) either:

(i) has an active evaluation of the program; or

(ii) has a plan and timeline for an active evaluation of the program to be conducted.

(d) "Health equity" means every individual has a fair opportunity to attain the individual's full health potential and no individual is disadvantaged from achieving this potential.

(e) "Promising practice home visiting program" means a program that has shown improvement toward achieving positive outcomes for pregnant women or young children.

Subd. 2. **Grants for home visiting programs.** (a) The commissioner of health shall award grants to community health boards, nonprofit organizations, and Tribal nations to start up or expand voluntary home visiting programs serving pregnant women and families with young children. Home visiting programs supported under this section shall provide voluntary home visits by early childhood professionals or health professionals, including but not limited to nurses, social workers, early childhood educators, and trained paraprofessionals. Grant money shall be used to:

(1) establish or expand evidence-based, evidence-informed, or promising practice home visiting programs that address health equity and utilize community-driven health strategies;

(2) serve families with young children or pregnant women who have high needs or are high-risk, including but not limited to a family with low income, a parent or pregnant woman with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing housing instability or domestic abuse; and

(3) improve program outcomes in two or more of the following areas:

(i) maternal and newborn health;

(ii) school readiness and achievement;

(iii) family economic self-sufficiency;

(iv) coordination and referral for other community resources and supports;

(v) reduction in child injuries, abuse, or neglect; or

(vi) reduction in crime or domestic violence.

(b) Grants awarded to evidence-informed and promising practice home visiting programs must include money to evaluate program outcomes for up to four of the areas listed in paragraph (a), clause (3).

Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give priority to community health boards, nonprofit organizations, and Tribal nations seeking to expand home visiting services with community or regional partnerships.

(b) The commissioner shall allocate at least 75 percent of the grant money awarded each grant cycle to evidence-based home visiting programs that address health equity and up to 25 percent of the grant money awarded each grant cycle to evidence-informed or promising practice home visiting programs that address health equity and utilize community-driven health strategies.

Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the annual appropriation under this section to provide training and technical assistance and to administer and evaluate the program. The commissioner may contract for training, capacity-building support for grantees or potential grantees, technical assistance, and evaluation support.

Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to establishing or expanding evidence-based home visiting programs shall, for grants awarded on or after July 1, 2021, be awarded according to this section. This section shall not govern grant awards of federal funds for home visiting programs and shall not govern grant awards using state general fund appropriations dedicated to establishing or expanding nurse-family partnership home visiting programs.

Sec. 27. Minnesota Statutes 2020, section 145.902, is amended to read:

145.902 GIVE LIFE A CHANCE; SAFE PLACE FOR NEWBORNS DUTIES; IMMUNITY.

Subdivision 1. **General.** (a) For purposes of this section, a "safe place" means a hospital licensed under sections 144.50 to 144.56, including the hospital where the newborn was born, a health care provider who provides urgent care medical services, or an ambulance service licensed under chapter 144E dispatched in response to a 911 call from a mother or a person with the mother's permission to relinquish a newborn infant.

(b) A safe place shall receive a newborn left with an employee on the premises of the safe place during its hours of operation, provided that:

(1) the newborn was born within seven days of being left at the safe place, as determined within a reasonable degree of medical certainty; and

(2) the newborn is left in an unharmed condition.

(c) The safe place must not inquire as to the identity of the mother or the person leaving the newborn or call the police, provided the newborn is unharmed when presented to the hospital. The safe place may ask the mother or the person leaving the newborn about the medical history of the mother or newborn and if the newborn may have lineage to an Indian Tribe and, if known, the name of the Tribe but the mother or the person leaving the newborn is not required to provide any information. The safe place may provide the mother or the person leaving the newborn with information about how to contact relevant social service agencies.

(d) A safe place that is a health care provider who provides urgent care medical services shall dial 911, advise the dispatcher that the call is being made from a safe place for newborns, and ask the dispatcher to send an ambulance or take other appropriate action to transport the newborn to a hospital. An ambulance with whom a newborn is left shall transport the newborn to a hospital for care. Hospitals must receive a newborn left with a safe place and make the report as required in subdivision 2.

Subd. 2. **Reporting.** (a) Within 24 hours of receiving a newborn under this section, the hospital must inform the responsible social service agency that a newborn has been left at the hospital, but must not do so in the presence of the mother or the person leaving the newborn. The hospital must provide necessary care to the newborn pending assumption of legal responsibility by the responsible social service agency pursuant to section 260C.139, subdivision 5.

(b) Within five days of receiving a newborn under this section, a hospital shall report the newborn to the Office of Vital Records pursuant to section 144.216, subdivision 3. If a hospital receives a safe place newborn under section 145.902 and it is known that the child's record of birth was registered because the newborn was born at that hospital, the hospital shall report the newborn to the Office of Vital Records and identify the child's birth record. The state registrar shall issue a replacement birth record for the child pursuant to section 144.218, subdivision 6.

Subd. 3. **Immunity.** (a) A safe place with responsibility for performing duties under this section, and any employee, doctor, ambulance personnel, or other medical professional working at the safe place, are immune from any criminal liability that otherwise might result

from their actions, if they are acting in good faith in receiving a newborn, and are immune from any civil liability that otherwise might result from merely receiving a newborn.

(b) A safe place performing duties under this section, or an employee, doctor, ambulance personnel, or other medical professional working at the safe place who is a mandated reporter under chapter 260E, is immune from any criminal or civil liability that otherwise might result from the failure to make a report under that section if the person is acting in good faith in complying with this section.

EFFECTIVE DATE. This section is effective August 1, 2021.

Sec. 28. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal, or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. In the case of single or multifamily residences, "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater than six but less than 160 square feet of friable asbestos-containing material on other facility components, or, if linear feet or square feet cannot be measured, greater than one cubic foot but less than 35 cubic feet of friable asbestos-containing material on or off all facility components in one facility. ~~This provision excludes asbestos-containing floor tiles and sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in single family residences and buildings with no more than four dwelling units.~~ Asbestos-related work includes asbestos abatement area preparation; enclosure, removal, or encapsulation operations; and an air quality monitoring specified in rule to assure that the abatement and adjacent areas are not contaminated with asbestos fibers during the project and after completion.

For purposes of this subdivision, the quantity of ~~asbestos containing~~ material applies separately for every project.

Sec. 29. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72 shall, before receipt of the license and before causing asbestos-related work to be performed, pay the commissioner an annual license fee of ~~$100~~ $105.

Sec. 30. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner a certification fee of ~~$50~~ $52.50 before the issuance of the certificate. ~~The commissioner may establish by rule fees required before the issuance of~~ An individual required to be certified as an asbestos inspector, asbestos management planner, and asbestos project designer ~~certificates required~~ under section 326.73, subdivisions 2, 3, and 4, shall pay the commissioner a certification fee of $105 before the issuance of the certificate.

Sec. 31. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs of the asbestos-related work. For asbestos-related work performed in single or multifamily residences, of greater than ten but less than 260 linear feet of asbestos-containing material on pipes, or greater than six but less than 160 square feet of asbestos-containing material on other facility components, a person shall pay a project permit fee of $35 to the commissioner.

Sec. 32. **DEVELOPMENT OF CURRICULUM.**

Of the appropriation in fiscal year 2022 to the commissioner of health for health disparities grants under Minnesota Statutes, section 145.928, $275,000 shall be allocated for a grant to the University of Minnesota School of Public Health's Center for Antiracism Research for Health Equity, to develop a model curriculum on antiracism and implicit bias for hospitals with obstetric care and birth centers to use to provide continuing education to staff who care for pregnant or postpartum patients. The model curriculum must be evidence-based. This is a onetime allocation.

ARTICLE 3
HEALTH OCCUPATION AND HEALTH RELATED LICENSING BOARDS

Section 1. Minnesota Statutes 2020, section 144E.001, is amended by adding a subdivision to read:

Subd. 16. **Education program primary instructor or primary instructor.** "Education program primary instructor" or "primary instructor" means an individual, as approved by the board, who serves as the lead instructor of an emergency medical care initial certification course and who is responsible for planning or conducting the course according to the most

current version of the National EMS Education Standards by the NHTSA, United States Department of Transportation.

Sec. 2. Minnesota Statutes 2020, section 144E.27, is amended to read:

144E.27 ~~EDUCATION PROGRAMS; BOARD APPROVAL~~ REGISTRATION OF EMR.

Subdivision 1. **Education program instructor.** An education program instructor must be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.

Subd. 1a. **Approval required.** (a) All education programs for an emergency medical responder must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

(iii) admission criteria for students; and

(iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to Emergency Medical Responder registration education;

(3) have a program medical director and a program coordinator;

(4) have at least one instructor for every ten students at the practical skill stations;

(5) retain documentation of program approval by the board, course outline, and student information; and

(6) submit the appropriate fee as required under section 144E.29.

(c) The National EMS Education Standards by the NHTSA, United States Department of Transportation contains the minimal entry level of knowledge and skills for emergency medical responders. Medical directors of emergency medical responder groups may expand the knowledge and skill set.

Subd. 2. **Registration requirements.** To be eligible for registration with the board as an emergency medical responder, an individual shall complete a board-approved application form and:

(1) successfully complete a board-approved initial emergency medical responder education program. Registration under this clause is valid for two years and expires on October 31; or

(2) be credentialed as an emergency medical responder by the National Registry of Emergency Medical Technicians. Registration under this clause expires the same day as the National Registry credential.

Subd. 2a. **Registration expiration dates.** Emergency medical responder registration expiration dates are as follows:

(1) for initial registration granted between January 1 and June 30 of an even-numbered year, the expiration date is October 31 of the next even-numbered year;

(2) for initial registration granted between July 1 and December 31 of an even-numbered year, the expiration date is October 31 of the second odd-numbered year;

(3) for initial registration granted between January 1 and June 30 of an odd-numbered year, the expiration date is October 31 of the next odd-numbered year; and

(4) for initial registration granted between July 1 and December 31 of an odd-numbered year, the expiration date is October 31 of the second even-numbered year.

Subd. 3. **Renewal.** (a) The board may renew the registration of an emergency medical responder who:

(1) successfully completes a board-approved refresher course; ~~and~~

(2) successfully completes a course in cardiopulmonary resuscitation approved by the board or the licensee's medical director; and

(3) submits a completed renewal application to the board before the registration expiration date.

(b) The board may renew the lapsed registration of an emergency medical responder who:

(1) successfully completes a board-approved refresher course; ~~and~~

(2) successfully completes a course in cardiopulmonary resuscitation approved by the board or the licensee's medical director; and

(3) submits a completed renewal application to the board within 12 months after the registration expiration date.

Subd. 5. **Denial, suspension, revocation.** (a) The board may deny, suspend, revoke, place conditions on, or refuse to renew the registration as an emergency medical responder of an individual who the board determines:

(1) violates sections 144E.001 to 144E.33 or the rules adopted under those sections, an agreement for corrective action, or an order that the board issued or is otherwise empowered to enforce;

(2) misrepresents or falsifies information on an application form for registration;

(3) is convicted or pleads guilty or nolo contendere to any felony; any gross misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol; or any misdemeanor relating to assault, sexual misconduct, theft, or the illegal use of drugs or alcohol;

(4) is actually or potentially unable to provide emergency medical services with reasonable skill and safety to patients by reason of illness, use of alcohol, drugs, chemicals, or any other material, or as a result of any mental or physical condition;

(5) engages in unethical conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of the public;

(6) maltreats or abandons a patient;

(7) violates any state or federal controlled substance law;

(8) engages in unprofessional conduct or any other conduct which has the potential for causing harm to the public, including any departure from or failure to conform to the minimum standards of acceptable and prevailing practice without actual injury having to be established;

(9) provides emergency medical services under lapsed or nonrenewed credentials;

(10) is subject to a denial, corrective, disciplinary, or other similar action in another jurisdiction or by another regulatory authority;

(11) engages in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient; or

(12) makes a false statement or knowingly provides false information to the board, or fails to cooperate with an investigation of the board as required by section 144E.30.

(b) Before taking action under paragraph (a), the board shall give notice to an individual of the right to a contested case hearing under chapter 14. If an individual requests a contested case hearing within 30 days after receiving notice, the board shall initiate a contested case hearing according to chapter 14.

(c) The administrative law judge shall issue a report and recommendation within 30 days after closing the contested case hearing record. The board shall issue a final order within 30 days after receipt of the administrative law judge's report.

(d) After six months from the board's decision to deny, revoke, place conditions on, or refuse renewal of an individual's registration for disciplinary action, the individual shall have the opportunity to apply to the board for reinstatement.

Subd. 6. **Temporary suspension.** (a) In addition to any other remedy provided by law, the board may temporarily suspend the registration of an individual as an emergency responder after conducting a preliminary inquiry to determine whether the board believes that the individual has violated a statute or rule that the board is empowered to enforce and determining that the continued provision of service by the individual would create an imminent risk to public health or harm to others.

(b) A temporary suspension order prohibiting an individual from providing emergency medical care shall give notice of the right to a preliminary hearing according to paragraph (d) and shall state the reasons for the entry of the temporary suspension order.

(c) Service of a temporary suspension order is effective when the order is served on the individual personally or by certified mail, which is complete upon receipt, refusal, or return for nondelivery to the most recent address provided to the board for the individual.

(d) At the time the board issues a temporary suspension order, the board shall schedule a hearing, to be held before a group of its members designated by the board, that shall begin within 60 days after issuance of the temporary suspension order or within 15 working days of the date of the board's receipt of a request for a hearing from the individual, whichever is sooner. The hearing shall be on the sole issue of whether there is a reasonable basis to continue, modify, or lift the temporary suspension. A hearing under this paragraph is not subject to chapter 14.

(e) Evidence presented by the board or the individual may be in the form of an affidavit. The individual or the individual's designee may appear for oral argument.

(f) Within five working days of the hearing, the board shall issue its order and, if the suspension is continued, notify the individual of the right to a contested case hearing under chapter 14.

(g) If an individual requests a contested case hearing within 30 days after receiving notice under paragraph (f), the board shall initiate a contested case hearing according to chapter 14. The administrative law judge shall issue a report and recommendation within 30 days after the closing of the contested case hearing record. The board shall issue a final order within 30 days after receipt of the administrative law judge's report.

Sec. 3. Minnesota Statutes 2020, section 144E.27, subdivision 2, is amended to read:

Subd. 2. **Registration.** To be eligible for registration with the board as an emergency medical responder, an individual shall ~~complete a board-approved application form and~~:

(1) successfully complete ~~a board-approved initial emergency medical responder education program. Registration under this clause is valid for two years and expires on October 31~~ the United States Department of Transportation course, or its equivalent as approved by the board, specific to the emergency medical responder classification; ~~or~~

(2) be credentialed as an emergency medical responder by the National Registry of Emergency Medical Technicians~~. Registration under this clause expires the same day as the National Registry credential.~~; and

(3) complete a board-approved application form.

Sec. 4. Minnesota Statutes 2020, section 144E.28, subdivision 1, is amended to read:

Subdivision 1. **Requirements.** To be eligible for certification by the board as an EMT, AEMT, or paramedic, an individual shall:

(1) successfully complete the United States Department of Transportation course, or its equivalent as approved by the board, specific to the EMT, AEMT, or paramedic classification;

(2) ~~pass the written and practical examinations approved by the board and administered by the board or its designee,~~ obtain National Registry of Emergency Medical Technicians certification specific to the EMT, AEMT, or paramedic classification; and

(3) complete a board-approved application form.

Sec. 5. Minnesota Statutes 2020, section 144E.28, subdivision 3, is amended to read:

Subd. 3. **Reciprocity.** The board may certify an individual who possesses a current National Registry of Emergency Medical Technicians ~~registration~~ certification from another jurisdiction if the individual submits a board-approved application form. The board certification classification shall be the same as the National Registry's classification. Certification shall be for the duration of the applicant's ~~registration~~ certification period in another jurisdiction, not to exceed two years.

Sec. 6. Minnesota Statutes 2020, section 144E.28, subdivision 7, is amended to read:

Subd. 7. **Renewal.** (a) Before the expiration date of certification, an applicant for renewal of certification as an EMT shall:

(1) successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director;

(2) ~~take the United States Department of Transportation EMT refresher course and successfully pass the practical skills test portion of the course, or successfully complete 48 hours of continuing education in EMT programs that are consistent with the United States Department of Transportation National EMS Education Standards or its equivalent as approved by the board or as approved by the licensee's medical director and pass a practical skills test approved by the board and administered by an education program approved by the board. The cardiopulmonary resuscitation course and practical skills test may be included as part of the refresher course or continuing education renewal requirements; and~~ satisfy one of the following requirements:

(i) maintain National Registry of Emergency Medical Technicians certification following the requirements of the National Continued Competency Program, or its equivalent as approved by the board. The cardiopulmonary resuscitation course required under clause (1) shall count toward the continuing education requirements for renewal; or

(ii) for an individual who only holds Minnesota EMT certification and held the certification prior to April 1, 2021, maintain Minnesota certification by completing the required hours of continuing education as determined in the National Continued Competency Program of the National Registry of Emergency Medical Technicians, or its equivalent as approved by the board. The cardiopulmonary resuscitation course required under clause (1) shall count toward the continuing education requirements for renewal. This item expires April 1, 2036; and

(3) complete a board-approved application form.

(b) Before the expiration date of certification, an applicant for renewal of certification as an AEMT or paramedic shall:

(1) for an AEMT, successfully complete a course in cardiopulmonary resuscitation that is approved by the board or the licensee's medical director, and for a paramedic, successfully complete a course in advanced cardiac life support that is approved by the board or the licensee's medical director;

(2) ~~successfully complete 48 hours of continuing education in emergency medical training programs, appropriate to the level of the applicant's AEMT or paramedic certification, that are consistent with the United States Department of Transportation National EMS Education Standards or its equivalent as approved by the board or as approved by the licensee's medical director. An applicant may take the United States Department of Transportation Emergency Medical Technician refresher course or its equivalent without the written or practical test as approved by the board, and as appropriate to the applicant's level of certification, as part of the 48 hours of continuing education. Each hour of the refresher course, the cardiopulmonary resuscitation course, and the advanced cardiac life-support course counts toward the 48-hour continuing education requirement; and~~ satisfy one of the following requirements:

(i) maintain National Registry of Emergency Medical Technicians certification following the requirements of the National Continued Competency Program, or its equivalent as approved by the board. The cardiopulmonary resuscitation course or advanced cardiac life support course required under clause (1) shall count toward the continuing education requirements for renewal; or

(ii) for an individual who only holds Minnesota AEMT or paramedic certification and held the certification prior to April 1, 2021, maintain Minnesota certification by completing the required hours of continuing education as determined in the National Continued Competency Program of the National Registry of Emergency Medical Technicians, or its equivalent as approved by the board. The cardiopulmonary resuscitation course or advanced cardiac life support course required under clause (1) shall count toward the continuing education requirements for renewal. This item expires April 1, 2036; and

(3) complete a board-approved application form.

(c) Certification shall be renewed every two years.

(d) If the applicant does not meet the renewal requirements under this subdivision, the applicant's certification expires.

Sec. 7. Minnesota Statutes 2020, section 144E.28, subdivision 8, is amended to read:

Subd. 8. **Reinstatement.** (a) Within ~~four~~ two years of a certification expiration date, a person whose certification has expired under subdivision 7, paragraph (d), may have the certification reinstated upon submission of:

(1) evidence to the board of training equivalent to the continuing education requirements of subdivision 7; and

(2) a board-approved application form.

(b) If more than ~~four~~ two years have passed since a certificate expiration date, an applicant must complete the initial certification process required under subdivision 1.

Sec. 8. Minnesota Statutes 2020, section 144E.283, is amended to read:

144E.283 PRIMARY INSTRUCTOR QUALIFICATIONS.

~~(a)~~ An ~~emergency medical technician~~ education program primary instructor must:

(1) possess ~~valid~~ current Minnesota certification, registration, or licensure as one of the following, at a level that is equivalent to or higher than the level of certification or registration being taught:

(i) an EMR, EMT, AEMT, or paramedic~~,~~;

(ii) a physician~~,~~ with certification in adult or pediatric emergency medicine from the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine, with certification in an emergency medical services subspecialty, or serving as a medical director of a licensed ambulance service;

(iii) a physician assistant~~,~~ with experience in emergency medicine; or

(iv) a registered nurse with certification in adult or pediatric prehospital nursing from (A) the Board of Certification for Emergency Nursing, including certified flight registered nurse or certified transport registered nurse, or (B) the National Certification Corporation, including certified in neonatal pediatric transport;

(2) ~~have two years of active emergency medical practical experience~~ if required under this chapter for Minnesota certification or registration, possess National Registry of Emergency Medical Technicians certification or registration as an EMR, EMT, AEMT, or paramedic, at a level that is equivalent to or higher than the level of certification or registration being taught;

(3) satisfy one of the following requirements:

(i) hold at least an associate's degree and have been certified for at least three years at a level that is equivalent to or higher than the level of certification or registration being taught; or

(ii) have been certified for at least five years at a level that is equivalent to or higher than the level of certification or registration being taught;

~~(3)~~ (4) be recommended by a medical director of a licensed hospital, ambulance service, or education program approved by the board;

~~(4)~~ (5) satisfy one of the following requirements:

(i) successfully complete the United States Department of Transportation Emergency Medical Services Instructor ~~Education Program or its equivalent as approved by the board~~ course; ~~and~~

(ii) successfully complete the National Association of EMS Educators Instructor level 1 course;

(iii) successfully complete the Fire Instructor I course;

(iv) hold at least a bachelor's degree in education;

(v) hold at least a master's degree in a related field of study;

(vi) have been vetted through the Minnesota State faculty credentialing process; or

(vii) successfully complete an equivalent course or hold an equivalent degree as approved by the board;

~~(5)~~ (6) complete eight hours of continuing education in educational topics every two years, with documentation filed with the education program coordinator~~.~~;

(7) complete a board-approved application form; and

(8) receive board approval as a primary instructor.

~~(b) An emergency medical responder instructor must possess valid registration, certification, or licensure as an EMR, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.~~

Sec. 9. Minnesota Statutes 2020, section 144E.285, subdivision 1, is amended to read:

Subdivision 1. **Approval required.** (a) All education programs for an EMR, EMT, AEMT, or paramedic must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type ~~and length~~ of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

~~(iii) names and addresses of clinical sites, including a contact person and telephone number;~~

~~(iv)~~ (iii) admission criteria for students; and

~~(v)~~ (iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to EMR, EMT, AEMT, or paramedic education;

(3) have a program medical director and a program coordinator;

(4) utilize primary instructors who meet the requirements of section 144E.283 for teaching at least 50 percent of the course content. The remaining 50 percent of the course may be taught by guest lecturers approved by the education program coordinator or medical director;

~~(5) have at least one instructor for every ten students at the practical skill stations;~~

~~(6) maintain a written agreement with a licensed hospital or licensed ambulance service designating a clinical training site;~~

~~(7)~~ (5) retain documentation of program approval by the board, course outline, and student information;

~~(8)~~ (6) notify the board of the starting date of a course prior to the beginning of a course; and

~~(9)~~ (7) submit the appropriate fee as required under section 144E.29~~; and~~.

~~(10) maintain a minimum average yearly pass rate as set by the board on an annual basis. The pass rate will be determined by the percent of candidates who pass the exam on the first attempt. An education program not meeting this yearly standard shall be placed on probation and shall be on a performance improvement plan approved by the board until meeting the pass rate standard. While on probation, the education program may continue providing classes if meeting the terms of the performance improvement plan as determined by the board. If an education program having probation status fails to meet the pass rate~~

~~standard after two years in which an EMT initial course has been taught, the board may take disciplinary action under subdivision 5.~~

Sec. 10. Minnesota Statutes 2020, section 144E.285, is amended by adding a subdivision to read:

Subd. 1a. **EMR requirements.** The National EMS Education Standards established by the NHTSA, United States Department of Transportation, specifies the minimum requirements for knowledge and skills for emergency medical responders. A medical director of an emergency medical responder education group may establish additional knowledge and skill requirements for EMRs.

Sec. 11. Minnesota Statutes 2020, section 144E.285, is amended by adding a subdivision to read:

Subd. 1b. **EMT requirements.** In addition to the requirements under subdivision 1, paragraph (b), an education program applying for approval to teach EMTs must:

(1) in the application prescribed by the board, include names and addresses of clinical sites, including a contact person and telephone number;

(2) maintain a written agreement with a licensed hospital or licensed ambulance service designating a clinical training site; and

(3) maintain a minimum average yearly pass rate as set by the board. An education program not meeting the standard in this subdivision shall be placed on probation and must comply with a performance improvement plan approved by the board until the program meets the pass-rate standard. While on probation, the education program may continue to provide classes if the program meets the terms of the performance improvement plan, as determined by the board. If an education program that is on probation status fails to meet the pass-rate standard after two years in which an EMT initial course has been taught, the board may take disciplinary action under subdivision 5.

Sec. 12. Minnesota Statutes 2020, section 144E.285, subdivision 2, is amended to read:

Subd. 2. **AEMT and paramedic requirements.** (a) In addition to the requirements under subdivision 1, paragraph (b), an education program applying for approval to teach AEMTs and paramedics must:

(1) be administered by an educational institution accredited by the Commission of Accreditation of Allied Health Education Programs (CAAHEP)~~.~~;

(2) in the application prescribed by the board, include names and addresses of clinical sites, including a contact person and telephone number; and

(3) maintain a written agreement with a licensed hospital or licensed ambulance service designating a clinical training site.

(b) An AEMT and paramedic education program that is administered by an educational institution not accredited by CAAHEP, but that is in the process of completing the accreditation process, may be granted provisional approval by the board upon verification of submission of its self-study report and the appropriate review fee to CAAHEP.

(c) An educational institution that discontinues its participation in the accreditation process must notify the board immediately and provisional approval shall be withdrawn.

~~(d) This subdivision does not apply to a paramedic education program when the program is operated by an advanced life-support ambulance service licensed by the Emergency Medical Services Regulatory Board under this chapter, and the ambulance service meets the following criteria:~~

~~(1) covers a rural primary service area that does not contain a hospital within the primary service area or contains a hospital within the primary service area that has been designated as a critical access hospital under section 144.1483, clause (9);~~

~~(2) has tax-exempt status in accordance with the Internal Revenue Code, section 501(c)(3);~~

~~(3) received approval before 1991 from the commissioner of health to operate a paramedic education program;~~

~~(4) operates an AEMT and paramedic education program exclusively to train paramedics for the local ambulance service; and~~

~~(5) limits enrollment in the AEMT and paramedic program to five candidates per biennium.~~

Sec. 13. Minnesota Statutes 2020, section 144E.285, subdivision 4, is amended to read:

Subd. 4. **Reapproval.** An education program shall apply to the board for reapproval at least three months prior to the expiration date of its approval and must:

(1) submit an application prescribed by the board specifying any changes from the information provided for prior approval and any other information requested by the board to clarify incomplete or ambiguous information presented in the application; ~~and~~

(2) comply with the requirements under subdivision 1, paragraph (b), clauses (2) to ~~(10).~~ (7);

(3) be subject to a site visit;

(4) for education programs that teach EMTs, comply with the requirements in subdivision 1b; and

(5) for education programs that teach AEMTs and paramedics, comply with the requirements in subdivision 2 and maintain accreditation with the CAAHEP.

Sec. 14. Minnesota Statutes 2020, section 148.995, subdivision 2, is amended to read:

Subd. 2. **Certified doula.** "Certified doula" means an individual who has received a certification to perform doula services from the International Childbirth Education Association, the Doulas of North America (DONA), the Association of Labor Assistants and Childbirth Educators (ALACE), Birthworks, the Childbirth and Postpartum Professional Association (CAPPA), Childbirth International, the International Center for Traditional Childbearing, ~~or~~ Commonsense Childbirth, Inc., Modern Doula Education (MDE), or an organization designated by the commissioner under section 148.9965.

Sec. 15. Minnesota Statutes 2020, section 148.996, subdivision 2, is amended to read:

Subd. 2. **Qualifications.** The commissioner shall include on the registry any individual who:

(1) submits an application on a form provided by the commissioner. The form must include the applicant's name, address, and contact information;

(2) ~~maintains~~ submits evidence of maintaining a current certification from one of the organizations listed in section 148.995, subdivision 2, or from an organization designated by the commissioner under section 148.9965; and

(3) pays the fees required under section 148.997.

Sec. 16. Minnesota Statutes 2020, section 148.996, subdivision 4, is amended to read:

Subd. 4. **Renewal.** Inclusion on the registry maintained by the commissioner is valid for three years, provided the doula meets the requirement in subdivision 2, clause (2), during the entire period. At the end of the three-year period, the certified doula may submit a new application to remain on the doula registry by meeting the requirements described in subdivision 2.

Sec. 17. Minnesota Statutes 2020, section 148.996, is amended by adding a subdivision to read:

Subd. 6. **Removal from registry.** (a) If the commissioner determines that a doula included on the registry does not meet the requirement in subdivision 2, clause (2), the commissioner shall notify the affected doula that the doula no longer meets the requirement in subdivision 2, clause (2), specify steps the doula must take to maintain inclusion on the registry, and specify the effect of failing to take such steps. The commissioner must provide this notice by first class mail to the address on file with the commissioner for the affected doula.

(b) Following the provision of notice under paragraph (a), the commissioner shall remove from the registry any doula who no longer meets the requirement in subdivision 2, clause (2), and who does not take the steps specified by the commissioner to maintain inclusion on the registry.

Sec. 18. **[148.9965] DESIGNATION OF DOULA CERTIFICATION ORGANIZATIONS BY COMMISSIONER.**

Subdivision 1. **Review and designation by commissioner.** The commissioner shall periodically review the doula certification organizations listed in section 148.995, subdivision 2, or designated by the commissioner under this section. The commissioner may: (1) designate additional organizations from which individuals, if maintaining current doula certification from such an organization, are eligible for inclusion on the registry of certified doulas; and (2) remove the designation of a doula certification organization previously designated by the commissioner.

Subd. 2. **Designation.** A doula certification organization seeking designation under this section shall provide the commissioner with evidence that the organization satisfies designation criteria established by the commissioner. If the commissioner designates a doula certification organization under this section, the commissioner shall provide notice of the designation by publication in the State Register and on the Department of Health website for the registry of certified doulas and shall specify the date after which a certification by the organization authorizes a doula certified by the organization to be included on the registry.

Subd. 3. **Removal of designation.** (a) The commissioner may remove the designation of a doula certification organization previously designated by the commissioner under this section upon a determination by the commissioner that the organization does not meet the commissioner's criteria for designation. If the commissioner removes a designation, the

commissioner shall provide notice of the removal by publication in the State Register and shall specify the date after which a certification by the organization no longer authorizes a doula certified by the organization to be included on the registry.

(b) Following removal of a designation, the Department of Health website for the registry of certified doulas shall be modified to reflect the removal.

Sec. 19. Minnesota Statutes 2020, section 151.01, subdivision 29, is amended to read:

Subd. 29. **~~Legend~~ Medical gas.** "~~Legend~~ Medical gas" means ~~a liquid or gaseous substance used for medical purposes and that is required by federal law to be dispensed only pursuant to the prescription of a licensed practitioner~~ any gas or liquid manufactured or stored in a liquefied, nonliquefied, or cryogenic state that:

(1) has a chemical or physical action in or on the human body or animals or is used in conjunction with medical gas equipment; and

(2) is intended to be used for the diagnosis, cure, mitigation, treatment, or prevention of disease.

Sec. 20. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 29a. **Medical gas manufacturer.** "Medical gas manufacturer" means any person:

(1) originally manufacturing a medical gas by chemical reaction, physical separation, compression of atmospheric air, purification, or other means;

(2) filling a medical gas into a dispensing container via gas to gas, liquid to gas, or liquid to liquid processes;

(3) combining two or more medical gases into a container to form a medically appropriate mixture; or

(4) filling a medical gas via liquid to liquid into a final use container at the point of use.

Sec. 21. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 29b. **Medical gas wholesaler.** "Medical gas wholesaler" means any person who sells a medical gas to another business or entity for the purpose of reselling or providing that medical gas to the ultimate consumer or patient.

Sec. 22. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to read:

Subd. 29c. **Medical gas dispenser.** "Medical gas dispenser" means any person, other than a licensed practitioner or pharmacy, who sells or provides a medical gas directly to the ultimate consumer or patient via a valid prescription.

Sec. 23. **[151.191] LICENSING MEDICAL GAS FACILITIES; FEES; PROHIBITIONS.**

Subdivision 1. **Medical gas manufacturers; requirements.** (a) No person shall act as a medical gas manufacturer without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a medical gas manufacturer license under this section must be made in a manner specified by the board.

(c) A license must not be issued or renewed for a medical gas manufacturer unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) A license must not be issued or renewed for a medical gas manufacturer that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish standards for the licensure of a medical gas manufacturer that is not required to be licensed or registered by the state in which it is physically located.

(e) The board must require a separate license for each facility located within the state at which medical gas manufacturing occurs and for each facility located outside of the state at which medical gases that are shipped into the state are manufactured.

(f) Prior to the issuance of an initial or renewed license for a medical gas manufacturing facility, the board may require the facility to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas manufacturing facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) A duly licensed medical gas manufacturing facility may also wholesale or dispense any medical gas that is manufactured by the licensed facility, or manufactured or wholesaled by another properly licensed medical gas facility, without also obtaining a medical gas wholesaler license or medical gas dispenser registration.

(h) The filling of a medical gas into a final use container, at the point of use and by liquid to liquid transfer, is permitted as long as the facility used as the base of operations is duly licensed as a medical gas manufacturer.

Subd. 2. **Medical gas wholesalers; requirements.** (a) No person shall act as a medical gas wholesaler without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for a medical gas wholesaler license under this section must be made in a manner specified by the board.

(c) A license must not be issued or renewed for a medical gas wholesaler unless the applicant agrees to operate in a manner prescribed by federal and state law and according to Minnesota Rules.

(d) A license must not be issued or renewed for a medical gas wholesaler that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of licensure or registration. The board may establish standards for the licensure of a medical gas wholesaler that is not required to be licensed or registered by the state in which it is physically located.

(e) The board must require a separate license for each facility located within the state at which medical gas wholesaling occurs and for each facility located outside of the state from which medical gases that are shipped into the state are wholesaled.

(f) Prior to the issuance of an initial or renewed license for a medical gas wholesaling facility, the board may require the facility to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas wholesaling facility located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) A duly licensed medical gas wholesaling facility may also dispense any medical gas that is manufactured or wholesaled by another properly licensed medical gas facility.

Subd. 3. **Medical gas dispensers; requirements.** (a) A person or establishment not licensed as a pharmacy, practitioner, medical gas manufacturer, or medical gas dispenser must not engage in the dispensing of medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration must be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board.

(b) Application for a medical gas dispenser registration under this section must be made in a manner specified by the board.

(c) A registration must not be issued or renewed for a medical gas dispenser located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. A license must not be issued for a medical gas dispenser located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when dispensing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) A registration must not be issued or renewed for a medical gas dispenser that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may establish standards for the registration of a medical gas dispenser that is not required to be licensed or registered by the state in which it is physically located.

(e) The board must require a separate registration for each medical gas dispenser located within the state and for each facility located outside of the state from which medical gases are dispensed to residents of this state.

(f) Prior to the issuance of an initial or renewed registration for a medical gas dispenser, the board may require the medical gas dispenser to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas dispenser located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.

(g) A facility holding a medical gas dispenser registration must not engage in the manufacturing or wholesaling of medical gases, except that a medical gas dispenser may transfer medical gases from one of its duly registered facilities to other duly registered medical gas manufacturing, wholesaling, or dispensing facilities owned or operated by that same company, without requiring a medical gas wholesaler license.

Sec. 24. **REVISOR INSTRUCTION.**

In Minnesota Statutes, the revisor of statutes shall recode as Minnesota Statutes, section 144E.28, subdivision 8a, the community emergency medical technician certification requirements that are currently coded as Minnesota Statutes, section 144E.275, subdivision 7, and shall revise any necessary cross-references consistent with that recoding.

Sec. 25. **REPEALER.**

Minnesota Statutes 2020, sections 144E.27, subdivisions 1 and 1a; and 151.19, subdivision 3, are repealed.

ARTICLE 4
PRESCRIPTION DRUGS AND OPIATES

Section 1. Minnesota Statutes 2020, section 16A.151, subdivision 2, is amended to read:

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

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

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

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

account and are appropriated to the commissioner of the agency for the purpose as directed by the federal court.

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

(f) Any money received by the state resulting from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state, or a court order in litigation brought by the attorney general of the state, on behalf of the state or a state agency, against one or more opioid manufacturers or opioid wholesale drug distributors or consulting firms working for an opioid manufacturer or opioid wholesale drug distributor related to alleged violations of consumer fraud laws in the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids, must be deposited in a separate account in the state treasury and the commissioner shall notify the chairs and ranking minority members of the Finance Committee in the senate and the Ways and Means Committee in the house of representatives that an account has been created. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of this account shall be credited to the account. This paragraph does not apply to attorney fees and costs awarded to the state or the Attorney General's Office, to contract attorneys hired by the state or Attorney General's Office, or to other state agency attorneys. If the licensing fees under section 151.065, subdivision 1, clause (16), and subdivision 3, clause (14), are reduced and the registration fee under section 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, then the commissioner shall transfer from the separate account created in this paragraph to the opiate epidemic response fund under section 256.043 an amount that ensures that $20,940,000 each fiscal year is available for distribution in accordance with section 256.043, ~~subdivisions 2 and~~ subdivision 3.

(g) Notwithstanding paragraph (f), if money is received from a settlement agreement or an assurance of discontinuance entered into by the attorney general of the state or a court order in litigation brought by the attorney general of the state on behalf of the state or a state agency against a consulting firm working for an opioid manufacturer or opioid wholesale drug distributor and deposited into the separate account created under paragraph (f), the commissioner shall annually transfer from the separate account to the opiate epidemic response fund under section 256.043 an amount equal to the estimated amount submitted to the commissioner by the Board of Pharmacy in accordance with section 151.066, subdivision 3, paragraph (b). The amount transferred shall be included in the amount available for distribution in accordance with section 256.043, subdivision 3. This transfer shall occur

each year until the registration fee under section 151.066, subdivision 3, is repealed in accordance with section 256.043, subdivision 4, or the money deposited in the account in accordance with this paragraph has been transferred, whichever occurs first.

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

Sec. 2. **[62J.85] PRESCRIPTION DRUG MANUFACTURER IMPORTATION PATHWAY PLAN.**

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

(b) "Drug product" or "drug" means a prescription drug or biological product that is intended for human use and regulated as a drug except where specific reference is made to a drug approved under section 505 of the federal Food, Drug, and Cosmetic Act, United States Code, title 21, section 355, or biological product approved under section 351 of the federal Public Health Act, United States Code, title 42, section 262. Drug product or drug does not include biological products that are intended for transfusions, including blood or blood products; or allogeneic-, cellular-, or tissue-based products.

(c) "FD&C Act" means the federal Food, Drug, and Cosmetic Act, United States Code, title 21, section 301, et seq.

(d) "Importation guidance" means the draft guidance released by the federal Food and Drug Administration (FDA) titled "Importation of Certain FDA-Approved Human Prescription Drugs, Including Biological Products, Under Section 801(d)(1)(B) of the Federal Food, Drug, and Cosmetic Act; Draft Guidance for the Industry," which if finalized allows for the importation of MMA products.

(e) "Manufacturer" means the entity that is the holder of the New Drug Application or Biologics License Application for the drug product.

(f) "Multimarket-approved product" or "MMA product" means a FDA-approved drug product that:

(1) was manufactured outside the United States and authorized for marketing by another country's regulatory authority;

(2) is subject to a new drug application or biologics license application;

(3) is imported into the United States and is authorized by the manufacturer to be marketed in the United States; and

(4) continues to meet the quality standards for marketing in its originally intended foreign market.

Subd. 2. **Application.** This section applies to any MMA product in which the manufacturer of the product has obtained a new National Drug Code (NDC) for the MMA product and has imported the MMA product in compliance with the FD&C Act and any importation guidance finalized by the FDA.

Subd. 3. **Incentives.** (a) In order to facilitate importation of drugs pursuant to importation guidance finalized by the FDA, any MMA product offered for sale in Minnesota at a cost that is at least 23 percent lower than the wholesale acquisition cost for the FDA-approved product manufactured in the United States shall be:

(1) included on the uniform preferred drug list and covered under the medical assistance and MinnesotaCare programs; and

(2) a covered drug under the state employee group insurance program pursuant to chapter 43A.

(b) A health plan company must provide coverage for each MMA product that meets the requirements in paragraph (a) if the manufacturer's FDA-approved drug product manufactured in the United States is covered by the health plan company and the health plan company must not impose any enrollee cost-sharing requirements for the covered MMA product.

(c) This subdivision shall not become effective for MMA products that are offered for sale in Minnesota in accordance with paragraph (a) unless affirmative action is taken by the legislature.

Sec. 3. Minnesota Statutes 2020, section 62W.11, is amended to read:

62W.11 GAG CLAUSE PROHIBITION.

(a) No contract between a pharmacy benefit manager or health carrier and a pharmacy or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing to an enrollee any health care information that the pharmacy or pharmacist deems appropriate regarding the nature of treatment; the risks or alternatives; the availability of alternative therapies, consultations, or tests; the decision of utilization reviewers or similar persons to authorize or deny services; the process that is used to authorize or deny health care services or benefits; or information on financial incentives and structures used by the health carrier or pharmacy benefit manager.

(b) A pharmacy or pharmacist must provide to an enrollee information regarding the enrollee's total cost for each prescription drug dispensed where part or all of the cost of the prescription is being paid or reimbursed by the employer-sponsored plan or by a health carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

(c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing information regarding the total cost for pharmacy services for a prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual and customary price ~~of~~ for the prescription drug, the pharmacy's acquisition cost for the prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit manager or health carrier for the prescription drug.

(d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for a prescription drug.

~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or pharmacy from discussing the availability of any therapeutically equivalent alternative prescription drugs or alternative methods for purchasing the prescription drug, including but not limited to paying out-of-pocket the pharmacy's usual and customary price when that amount is less expensive to the enrollee than the amount the enrollee is required to pay for the prescription drug under the enrollee's health plan.

Sec. 4. Minnesota Statutes 2020, section 151.065, subdivision 1, is amended to read:

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

(1) pharmacist licensed by examination, $175;

(2) pharmacist licensed by reciprocity, $275;

(3) pharmacy intern, $50;

(4) pharmacy technician, $50;

(5) pharmacy, $260;

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

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

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

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

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

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

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

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

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

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, $5,260;

(16) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, $55,260;

(17) medical gas dispenser, $260;

(18) controlled substance researcher, $75; and

(19) pharmacy professional corporation, $150.

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

Sec. 5. Minnesota Statutes 2020, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, $175;

(2) pharmacy technician, $50;

(3) pharmacy, $260;

(4) drug wholesaler, legend drugs only, $5,260;

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

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, $5,260;

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

(8) third-party logistics provider, $260;

(9) drug manufacturer, nonopiate legend drugs only, $5,260;

(10) drug manufacturer, nonopiate legend and nonlegend drugs, $5,260;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, $5,260;

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

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, $5,260;

(14) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, $55,260;

(15) medical gas dispenser, $260;

(16) controlled substance researcher, $75; and

(17) pharmacy professional corporation, $100.

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

Sec. 6. Minnesota Statutes 2020, section 151.065, subdivision 7, is amended to read:

Subd. 7. **Deposit of fees.** (a) The license fees collected under this section, with the exception of the fees identified in paragraphs (b) and (c), shall be deposited in the state government special revenue fund.

(b) $5,000 of each fee collected under subdivision 1, clauses (6) to ~~(9)~~ (8), ~~and~~ (11) to (13), and (15), and subdivision 3, clauses (4) to ~~(7)~~ (6), ~~and~~ (9) to (11), and (13), and $55,000 of each fee collected under subdivision 1, clause (16), and subdivision 3, clause (14), shall be deposited in the opiate epidemic response fund established in section 256.043.

(c) If the fees collected under subdivision 1, clause (16), or subdivision 3, clause (14), are reduced under section 256.043, $5,000 of the reduced fee shall be deposited in the opiate epidemic response fund in section 256.043.

Sec. 7. Minnesota Statutes 2020, section 151.066, subdivision 3, is amended to read:

Subd. 3. **Determination of an opiate product registration fee.** (a) The board shall annually assess an opiate product registration fee on any manufacturer of an opiate that annually sells, delivers, or distributes an opiate within or into the state 2,000,000 or more units as reported to the board under subdivision 2.

(b) For purposes of assessing the annual registration fee under this section and determining the number of opiate units a manufacturer sold, delivered, or distributed within or into the state, the board shall not consider any opiate that is used for medication-assisted

therapy for substance use disorders. If there is money deposited into the separate account as described in section 16A.151, subdivision 2, paragraph (g), the board shall submit to the commissioner of management and budget an estimate of the difference in the annual fee revenue collected under this section due to this exception.

(c) The annual registration fee for each manufacturer meeting the requirement under paragraph (a) is $250,000.

~~(c)~~ (d) In conjunction with the data reported under this section, and notwithstanding section 152.126, subdivision 6, the board may use the data reported under section 152.126, subdivision 4, to determine which manufacturers meet the requirement under paragraph (a) and are required to pay the registration fees under this subdivision.

~~(d)~~ (e) By April 1 of each year, beginning April 1, 2020, the board shall notify a manufacturer that the manufacturer meets the requirement in paragraph (a) and is required to pay the annual registration fee in accordance with section 151.252, subdivision 1, paragraph (b).

~~(e)~~ (f) A manufacturer may dispute the board's determination that the manufacturer must pay the registration fee no later than 30 days after the date of notification. However, the manufacturer must still remit the fee as required by section 151.252, subdivision 1, paragraph (b). The dispute must be filed with the board in the manner and using the forms specified by the board. A manufacturer must submit, with the required forms, data satisfactory to the board that demonstrates that the assessment of the registration fee was incorrect. The board must make a decision concerning a dispute no later than 60 days after receiving the required dispute forms. If the board determines that the manufacturer has satisfactorily demonstrated that the fee was incorrectly assessed, the board must refund the amount paid in error.

~~(f)~~ (g) For purposes of this subdivision, a unit means the individual dosage form of the particular drug product that is prescribed to the patient. One unit equals one tablet, capsule, patch, syringe, milliliter, or gram.

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

Sec. 8. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

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

(b) "Central repository" means a wholesale distributor that meets the requirements under subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this section.

(c) "Distribute" means to deliver, other than by administering or dispensing.

(d) "Donor" means:

(1) a health care facility as defined in this subdivision;

(2) a skilled nursing facility licensed under chapter 144A;

(3) an assisted living facility registered under chapter 144D where there is centralized storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

(4) a pharmacy licensed under section 151.19, and located either in the state or outside the state;

(5) a drug wholesaler licensed under section 151.47;

(6) a drug manufacturer licensed under section 151.252; or

(7) an individual at least 18 years of age, provided that the drug or medical supply that is donated was obtained legally and meets the requirements of this section for donation.

(e) "Drug" means any prescription drug that has been approved for medical use in the United States, is listed in the United States Pharmacopoeia or National Formulary, and meets the criteria established under this section for donation; or any over-the-counter medication that meets the criteria established under this section for donation. This definition includes cancer drugs and antirejection drugs, but does not include controlled substances, as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed to a patient registered with the drug's manufacturer in accordance with federal Food and Drug Administration requirements.

(f) "Health care facility" means:

(1) a physician's office or health care clinic where licensed practitioners provide health care to patients;

(2) a hospital licensed under section 144.50;

(3) a pharmacy licensed under section 151.19 and located in Minnesota; or

(4) a nonprofit community clinic, including a federally qualified health center; a rural health clinic; public health clinic; or other community clinic that provides health care utilizing a sliding fee scale to patients who are low-income, uninsured, or underinsured.

(g) "Local repository" means a health care facility that elects to accept donated drugs and medical supplies and meets the requirements of subdivision 4.

(h) "Medical supplies" or "supplies" means any prescription and nonprescription medical supplies needed to administer a prescription drug.

(i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules, part 6800.3750.

(j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that it does not include a veterinarian.

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

Sec. 9. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

Subd. 7. **Standards and procedures for inspecting and storing donated prescription drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or under contract with the central repository or a local repository shall inspect all donated prescription drugs and supplies before the drug or supply is dispensed to determine, to the extent reasonably possible in the professional judgment of the pharmacist or practitioner, that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe and suitable for dispensing, has not been subject to a recall, and meets the requirements for donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an inspection record stating that the requirements for donation have been met. If a local repository receives drugs and supplies from the central repository, the local repository does not need to reinspect the drugs and supplies.

(b) The central repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drug or supply being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If donated drugs or supplies are not inspected immediately upon receipt, a repository must quarantine the donated drugs or supplies separately from all dispensing stock until the donated drugs or supplies have been inspected and (1) approved for dispensing under the program; (2) disposed of pursuant to paragraph (c); or (3) returned to the donor pursuant to paragraph (d).~~

(c) The central repository and local repositories shall dispose of all prescription drugs and medical supplies that are not suitable for donation in compliance with applicable federal and state statutes, regulations, and rules concerning hazardous waste.

(d) In the event that controlled substances or prescription drugs that can only be dispensed to a patient registered with the drug's manufacturer are shipped or delivered to a central or local repository for donation, the shipment delivery must be documented by the repository and returned immediately to the donor or the donor's representative that provided the drugs.

(e) Each repository must develop drug and medical supply recall policies and procedures. If a repository receives a recall notification, the repository shall destroy all of the drug or medical supply in its inventory that is the subject of the recall and complete a record of destruction form in accordance with paragraph (f). If a drug or medical supply that is the subject of a Class I or Class II recall has been dispensed, the repository shall immediately notify the recipient of the recalled drug or medical supply. A drug that potentially is subject to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

(f) A record of destruction of donated drugs and supplies that are not dispensed under subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation shall be maintained by the repository for at least ~~five~~ two years. For each drug or supply destroyed, the record shall include the following information:

(1) the date of destruction;

(2) the name, strength, and quantity of the drug destroyed; and

(3) the name of the person or firm that destroyed the drug.

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

Sec. 10. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed for the administration of this program shall be utilized by the participants of the program and shall be available on the board's website:

(1) intake application form described under subdivision 5;

(2) local repository participation form described under subdivision 4;

(3) local repository withdrawal form described under subdivision 4;

(4) drug repository donor form described under subdivision 6;

(5) record of destruction form described under subdivision 7; and

(6) drug repository recipient form described under subdivision 8.

(b) All records, including drug inventory, inspection, and disposal of donated prescription drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two years. Records required as part of this program must be maintained pursuant to all applicable practice acts.

(c) Data collected by the drug repository program from all local repositories shall be submitted quarterly or upon request to the central repository. Data collected may consist of the information, records, and forms required to be collected under this section.

(d) The central repository shall submit reports to the board as required by the contract or upon request of the board.

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

Sec. 11. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision to read:

Subd. 14. **Cooperation.** The central repository, as approved by the Board of Pharmacy, may enter into an agreement with another state that has an established drug repository or drug donation program if the other state's program includes regulations to ensure the purity, integrity, and safety of the drugs and supplies donated, to permit the central repository to offer to another state program inventory that is not needed by a Minnesota resident and to accept inventory from another state program to be distributed to local repositories and dispensed to Minnesota residents in accordance with this program.

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

Sec. 12. **OPIATE REGISTRATION FEE REDUCTION.**

(a) For purposes of assessing the opiate registration fee under Minnesota Statutes, section 151.066, subdivision 3, that is required to be paid on June 1, 2021, in accordance with Minnesota Statutes, section 151.252, subdivision 1, paragraph (b), the Board of Pharmacy shall not consider any injectable opiate product distributed to a hospital or hospital pharmacy. If there is money deposited into the separate account as described in Minnesota Statutes, section 16A.151, subdivision 2, paragraph (g), the board shall submit to the commissioner of management and budget an estimate of the difference in the annual opiate registration fee revenue collected under Minnesota Statutes, section 151.066, due to the exception described in this paragraph.

(b) Any estimated loss to the opiate registration fee revenue attributable to paragraph (a) must be included in any transfer that occurs under Minnesota Statutes, section 16A.151, subdivision 2, paragraph (g), in calendar year 2021.

(c) If a manufacturer has already paid the opiate registration fee due on June 1, 2021, the Board of Pharmacy shall return the amount of the fee to the manufacturer if the manufacturer would not have been required to pay the fee after the calculations described in paragraph (a) were made.

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

ARTICLE 5
HEALTH COVERAGE AND TRANSPARENCY

Section 1. Minnesota Statutes 2020, section 62J.701, is amended to read:

62J.701 GOVERNMENTAL PROGRAMS.

~~(a) Beginning January 1, 1999, the provisions in paragraphs (b) to (e) apply.~~

~~(b)~~ (a) For purposes of sections 62J.695 to 62J.80, the requirements and other provisions that apply to health plan companies also apply to governmental programs.

~~(c)~~ (b) For purposes of this section, "governmental programs" means the medical assistance program, the MinnesotaCare program, the state employee group insurance program, the public employees insurance program under section 43A.316, and coverage provided by political subdivisions under section 471.617.

~~(d)~~ (c) Notwithstanding paragraph ~~(b)~~ (a), section 62J.72 does not apply to the fee-for-service programs under medical assistance and MinnesotaCare and section 62J.72, subdivision 3, paragraph (b), does not apply to the prepaid medical assistance program or MinnesotaCare.

~~(e)~~ (d) If a state commissioner or local unit of government contracts with a health plan company or a third-party administrator, the contract may assign any obligations under paragraph ~~(b)~~ (a) to the health plan company or third-party administrator. Nothing in this paragraph shall be construed to remove or diminish any enforcement responsibilities of the commissioners of health or commerce provided in sections 62J.695 to 62J.80.

Sec. 2. Minnesota Statutes 2020, section 62J.72, subdivision 3, is amended to read:

Subd. 3. **Information on patients' medical bills.** (a) A health plan company and health care provider shall provide patients and enrollees with a copy of an explicit and intelligible

bill ~~whenever the patient or enrollee is sent a bill and is responsible for paying any portion of that bill~~. The ~~bills~~ bill must contain descriptive language sufficient to be understood by the average patient or enrollee. This subdivision does not apply to a flat co-pay paid by the patient or enrollee at the time the service is required.

(b) In addition to the requirements in paragraph (a), when a health care provider transmits a bill to a patient, the bill must specify the following for the health care services provided:

(1) the Medicare-allowable fee-for-service payment rate if the service is covered by Medicare; and

(2) the provider's Medicare percent, as defined in section 62J.825, subdivision 1.

Sec. 3. **[62J.825] HEALTH CARE PRICE TRANSPARENCY; NOTICE AND DISCLOSURE OF MEDICARE PERCENT.**

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

(b) "Health plan" has the meaning given in section 62A.011, subdivision 3, and does not include coverage provided under medical assistance, MinnesotaCare, or Medicare Part A, Part B, or Part C.

(c) "Medicare percent" means the percentage of the Medicare allowable payment rate that a health care provider accepts as payment in full for health care services provided by the provider that are covered by Medicare, and for services not covered by Medicare, a dollar amount the provider is willing to accept as payment in full.

Subd. 2. **Required notice.** (a) A health care provider must establish a Medicare percent that the provider will accept as payment in full for health care services provided by that provider. For services that are not covered by a patient's health plan or for patients who are not insured, a provider must provide notice to patients and the public of the provider's Medicare percent by:

(1) posting information describing the Medicare percent and specifying the provider's Medicare percent in a prominent, clearly visible location at or near the provider's reception desk, registration desk, or patient check-in area;

(2) posting information describing the Medicare percent and specifying the provider's Medicare percent on the provider's public website; and

(3) including information describing the Medicare percent and specifying the provider's Medicare percent on any document related to provider payments that the provider requires a patient or patient's representative to sign.

(b) The notices required in paragraph (a) must include the following statement: "The Medicare percent means the reimbursement that this provider will accept as payment in full for services provided to patients. The Medicare percent can be used by a patient to compare the cost of care between providers."

Sec. 4. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER CREDENTIALING.**

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

(b) "Clean application for provider credentialing" or "clean application" means an application for provider credentialing submitted by a health care provider to a health plan company that is complete, is in the format required by the health plan company, and includes all information and substantiation required by the health plan company and does not require evaluation of any identified potential quality or safety concern.

(c) "Provider credentialing" means the process undertaken by a health plan company to evaluate and approve a health care provider's education, training, residency, licenses, certifications, and history of significant quality or safety concerns in order to approve the health care provider to provide health care services to patients at a clinic or facility.

Subd. 2. **Time limit for credentialing determination.** A health plan company that receives an application for provider credentialing must:

(1) if the application is determined to be a clean application for provider credentialing and if the health care provider submitting the application or the clinic or facility at which the health care provider provides services requests the information, affirm that the health care provider's application is a clean application and notify the health care provider or clinic or facility of the date by which the health plan company will make a determination on the health care provider's application;

(2) if the application is determined not to be a clean application, inform the health care provider of the application's deficiencies or missing information or substantiation within three business days after the health plan company determines the application is not a clean application; and

(3) make a determination on the health care provider's clean application within 45 days after receiving the clean application unless the health plan company identifies a substantive quality or safety concern in the course of provider credentialing that requires further

investigation. Upon notice to the health care provider, clinic, or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

EFFECTIVE DATE. This section applies to applications for provider credentialing submitted to a health plan company on or after January 1, 2022.

Sec. 5. **[62Q.524] DISCLOSURE OF APPLICATION OF FUNDS FROM A PATIENT ASSISTANCE PROGRAM TO A DEDUCTIBLE.**

A health plan company must include in the summary of benefits and coverage a statement indicating whether funds from a patient assistance program, as defined in section 62J.84, subdivision 2, paragraph (h), are applied by the health plan company to an enrollee's deductible.

EFFECTIVE DATE. This section is effective January 1, 2022, and applies to health plans offered, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2020, section 62W.13, is amended to read:

62W.13 RETROACTIVE ADJUSTMENTS.

No pharmacy benefit manager shall directly or indirectly retroactively ~~adjust~~ deny or reduce a claim or aggregate of claims for reimbursement submitted by a pharmacy for a prescription drug, more than 30 days after the original claim was submitted, unless the adjustment is a result of a~~:~~

~~(1)~~ pharmacy audit conducted in accordance with section 62W.09 and it was determined that:

(1) the original claim was submitted fraudulently; or

(2) the original claim payment was incorrect because the pharmacy was already paid for the prescription drug or service~~; or~~.

~~(2) technical billing error.~~

ARTICLE 6
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2020, section 144.057, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** (a) Except as specified in paragraph (b), the commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services that have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; and

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70.

(b) The commissioner of human services is not required to conduct a background study on any individual identified in paragraph (a) if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075.

(c) If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department

of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

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

Sec. 2. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection vendor" means ~~a~~ one of up to three qualified ~~organization~~ organizations under ~~a~~ written contract with the commissioner to provide services in accordance with section 245C.05, subdivision 5, paragraph (b).

Sec. 3. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each background study, the entity initiating the study must provide the commissioner's privacy notice to the background study subject required under section 13.04, subdivision 2. The notice must be available through the commissioner's electronic NETStudy and NETStudy 2.0 systems and shall include the information in paragraphs (b) and (c).

(b) The background study subject shall be informed that any previous background studies that received a set-aside will be reviewed, and without further contact with the background study subject, the commissioner may notify the agency that initiated the subsequent background study:

(1) that the individual has a disqualification that has been set aside for the program or agency that initiated the study;

(2) the reason for the disqualification; and

(3) that information about the decision to set aside the disqualification will be available to the license holder upon request without the consent of the background study subject.

(c) The background study subject must also be informed that:

(1) the subject's fingerprints collected for purposes of completing the background study under this chapter must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will only retain fingerprints of subjects with a criminal history;

(2) effective upon implementation of NETStudy 2.0, the subject's photographic image will be retained by the commissioner, and if the subject has provided the subject's Social Security number for purposes of the background study, the photographic image will be

available to prospective employers and agencies initiating background studies under this chapter to verify the identity of the subject of the background study;

(3) ~~the commissioner's~~ an authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. ~~The~~ An authorized fingerprint collection vendor shall retain no more than the subject's name and the date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities;

(4) the commissioner shall provide the subject notice, as required in section 245C.17, subdivision 1, paragraph (a), when an entity initiates a background study on the individual;

(5) the subject may request in writing a report listing the entities that initiated a background study on the individual as provided in section 245C.17, subdivision 1, paragraph (b);

(6) the subject may request in writing that information used to complete the individual's background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051, paragraph (a), are met; and

(7) notwithstanding clause (6), the commissioner shall destroy:

(i) the subject's photograph after a period of two years when the requirements of section 245C.051, paragraph (c), are met; and

(ii) any data collected on a subject under this chapter after a period of two years following the individual's death as provided in section 245C.051, paragraph (d).

Sec. 4. Minnesota Statutes 2020, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (b), for background studies conducted by the commissioner for child foster care, children's residential facilities, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(b) For background studies initiated on or after the implementation of NETStudy 2.0, except as provided under subdivision 5a, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and

photograph. The photograph and fingerprints must be recorded at the same time by ~~the commissioner's~~ an authorized fingerprint collection vendor and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b).

(c) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(d) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(e) ~~The commissioner's~~ An authorized fingerprint collection vendor shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. ~~The~~ An authorized fingerprint collection vendor shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(f) For any background study conducted under this chapter, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

Sec. 5. Minnesota Statutes 2020, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, paragraph (a), clause (2);

(6) for a background study related to a child foster family setting application for licensure, foster residence settings, children's residential facilities, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 119B, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years;

(ii) when the background study subject is 18 years of age or older, or a minor under section 245C.05, subdivision 5a, paragraph (c), information received following submission of fingerprints for a national criminal history record check; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry; and

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under chapter 119B, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 6. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test the NETStudy 2.0 system and implement it no later than September 1, 2015.

(b) The NETStudy 2.0 system developed and implemented by the commissioner shall incorporate and meet all applicable data security standards and policies required by the Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal Apprehension, and the Office of MN.IT Services. The system shall meet all required standards for encryption of data at the database level as well as encryption of data that travels electronically among agencies initiating background studies, ~~the commissioner's~~ authorized fingerprint collection ~~vendor~~ vendors, the commissioner, the Bureau of Criminal Apprehension, and in cases involving national criminal record checks, the FBI.

(c) The data system developed and implemented by the commissioner shall incorporate a system of data security that allows the commissioner to control access to the data field level by the commissioner's employees. The commissioner shall establish that employees have access to the minimum amount of private data on any individual as is necessary to perform their duties under this chapter.

(d) The commissioner shall oversee regular quality and compliance audits of ~~the~~ authorized fingerprint collection ~~vendor~~ vendors.

Sec. 7. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ON-SITE BACKGROUND STUDY FINGERPRINTING.**

(a) The commissioner of human services shall contract with a qualified contractor to conduct on-site fingerprinting beginning August 1, 2021, at locations of employers with 50 or more staff with outstanding background studies, including studies that have been delayed pursuant to the commissioner's modifications to background study requirements issued in response to the COVID-19 outbreak. The commissioner shall develop a list of employers with 50 or more staff who need fingerprints taken in order to complete a background study. The commissioner and the contractor shall coordinate to develop a plan to identify which employer locations the contractor shall serve and inform those employers and staff of the timing and nature of the contractor's services.

(b) The commissioner may contract with the qualified contractor to provide services under paragraph (a) up to the date of the expiration of the modification in CV23: modifying certain background study requirements, issued by the commissioner of human services pursuant to Executive Orders 20-11 and 20-12.

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

ARTICLE 7
MISCELLANEOUS

Section 1. **[62A.082] NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

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

(b) "Disability" has the meaning given in section 363A.03, subdivision 12.

(c) "Enrollee" means a natural person covered by a health plan or group health plan and includes an insured, policy holder, subscriber, covered person, member, contract holder, or certificate holder.

(d) "Organ transplant" means the transplantation or transfusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition.

Subd. 2. **Transplant discrimination prohibited.** A health plan or group health plan that provides coverage for anatomical gifts, organ transplants, or related treatment and services shall not:

(1) deny coverage to an enrollee based on the enrollee's disability;

(2) deny eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the health plan or group health plan solely for the purpose of avoiding the requirements of this section;

(3) penalize or otherwise reduce or limit the reimbursement of a health care provider, or provide monetary or nonmonetary incentives to a health care provider, to induce the provider to provide care to a patient in a manner inconsistent with this section; or

(4) reduce or limit an enrollee's coverage benefits because of the enrollee's disability for medical services and other services related to organ transplantation performed pursuant to this section as determined in consultation with the enrollee's treating health care provider and the enrollee.

Subd. 3. **Collective bargaining.** In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed pursuant to this section shall not be treated as a termination of the collective bargaining agreement.

Subd. 4. **Coverage limitation.** Nothing in this section shall be deemed to require a health plan or group health plan to provide coverage for a medically inappropriate organ transplant.

Sec. 2. Minnesota Statutes 2020, section 260E.31, subdivision 1, is amended to read:

Subdivision 1. **Reports required.** (a) Except as provided in paragraph (b), a person mandated to report under this chapter shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(b) A health care professional or a social service professional who is mandated to report under this chapter is exempt from reporting under paragraph (a) ~~a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy~~ if the professional is providing or collaborating with other professionals to provide the woman with prenatal care, postpartum care, or other health care services, including care of the woman's infant. If the woman does not continue to receive regular prenatal or postpartum care, after the woman's health care professional has made attempts to contact the woman, then the professional is required to report under paragraph (a).

(c) Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including but not limited to tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.

(d) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter. The local welfare agency shall accept a report made under paragraph (c) notwithstanding refusal by a voluntary reporter to provide the reporter's name or address as long as the report is otherwise sufficient.

(e) For purposes of this section, "prenatal care" means the comprehensive package of medical and psychological support provided throughout the pregnancy.

Sec. 3. **[363A.50] NONDISCRIMINATION IN ACCESS TO TRANSPLANTS.**

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

(b) "Anatomical gift" has the meaning given in section 525A.02, subdivision 4.

(c) "Auxiliary aids and services" include, but are not limited to:

(1) qualified interpreters or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

(2) qualified readers, taped texts, texts in accessible electronic format, or other effective methods of making visually delivered materials available to individuals with visual impairments;

(3) the provision of information in a format that is accessible for individuals with cognitive, neurological, developmental, intellectual, or physical disabilities;

(4) the provision of supported decision-making services; and

(5) the acquisition or modification of equipment or devices.

(d) "Covered entity" means:

(1) any licensed provider of health care services, including licensed health care practitioners, hospitals, nursing facilities, laboratories, intermediate care facilities, psychiatric

residential treatment facilities, institutions for individuals with intellectual or developmental disabilities, and prison health centers; or

(2) any entity responsible for matching anatomical gift donors to potential recipients.

(e) "Disability" has the meaning given in section 363A.03, subdivision 12.

(f) "Organ transplant" means the transplantation or infusion of a part of a human body into the body of another for the purpose of treating or curing a medical condition.

(g) "Qualified individual" means an individual who, with or without available support networks, the provision of auxiliary aids and services, or reasonable modifications to policies or practices, meets the essential eligibility requirements for the receipt of an anatomical gift.

(h) "Reasonable modifications" include, but are not limited to:

(1) communication with individuals responsible for supporting an individual with postsurgical and post-transplantation care, including medication; and

(2) consideration of support networks available to the individual, including family, friends, and home and community-based services, including home and community-based services funded through Medicaid, Medicare, another health plan in which the individual is enrolled, or any program or source of funding available to the individual, in determining whether the individual is able to comply with post-transplant medical requirements.

(i) "Supported decision making" has the meaning given in section 524.5-102, subdivision 16a.

Subd. 2. **Prohibition of discrimination.** (a) A covered entity may not on the basis of a qualified individual's mental or physical disability:

(1) deem an individual ineligible to receive an anatomical gift or organ transplant;

(2) deny medical or related organ transplantation services, including evaluation, surgery, counseling, and postoperative treatment and care;

(3) refuse to refer the individual to a transplant center or other related specialist for the purpose of evaluation or receipt of an anatomical gift or organ transplant;

(4) refuse to place an individual on an organ transplant waiting list or place the individual at a lower-priority position on the list than the position at which the individual would have been placed if not for the individual's disability; or

(5) decline insurance coverage for any procedure associated with the receipt of the anatomical gift or organ transplant, including post-transplantation and postinfusion care.

(b) Notwithstanding paragraph (a), a covered entity may take an individual's disability into account when making treatment or coverage recommendations or decisions, solely to the extent that the physical or mental disability has been found by a physician, following an individualized evaluation of the potential recipient to be medically significant to the provision of the anatomical gift or organ transplant. The provisions of this section may not be deemed to require referrals or recommendations for, or the performance of, medically inappropriate organ transplants.

(c) If an individual has the necessary support system to assist the individual in complying with post-transplant medical requirements, an individual's inability to independently comply with those requirements may not be deemed to be medically significant for the purposes of paragraph (b).

(d) A covered entity must make reasonable modifications to policies, practices, or procedures, when such modifications are necessary to make services such as transplantation-related counseling, information, coverage, or treatment available to qualified individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such services.

(e) A covered entity must take such steps as may be necessary to ensure that no qualified individual with a disability is denied services such as transplantation-related counseling, information, coverage, or treatment because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the services being offered or result in an undue burden.

(f) A covered entity must otherwise comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990, the Americans with Disabilities Act Amendments Act of 2008, and the Minnesota Human Rights Act.

(g) The provisions of this section apply to each part of the organ transplant process.

Subd. 3. **Remedies.** In addition to all other remedies available under this chapter, any individual who has been subjected to discrimination in violation of this section may initiate a civil action in a court of competent jurisdiction to enjoin violations of this section.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed $48,000,000, the amount in fiscal year 2017 shall not exceed $122,000,000, and the amount in any fiscal biennium thereafter shall not exceed $244,000,000. The purpose of this transfer is to meet the rate increase required under section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

144E.27 EDUCATION PROGRAMS; BOARD APPROVAL.

Subdivision 1. **Education program instructor.** An education program instructor must be an emergency medical responder, EMT, AEMT, paramedic, physician, physician assistant, or registered nurse.

Subd. 1a. **Approval required.** (a) All education programs for an emergency medical responder must be approved by the board.

(b) To be approved by the board, an education program must:

(1) submit an application prescribed by the board that includes:

(i) type and length of course to be offered;

(ii) names, addresses, and qualifications of the program medical director, program education coordinator, and instructors;

(iii) admission criteria for students; and

(iv) materials and equipment to be used;

(2) for each course, implement the most current version of the United States Department of Transportation EMS Education Standards, or its equivalent as determined by the board applicable to Emergency Medical Responder registration education;

(3) have a program medical director and a program coordinator;

(4) have at least one instructor for every ten students at the practical skill stations;

(5) retain documentation of program approval by the board, course outline, and student information; and

(6) submit the appropriate fee as required under section 144E.29.

(c) The National EMS Education Standards by the NHTSA, United States Department of Transportation contains the minimal entry level of knowledge and skills for emergency medical responders. Medical directors of emergency medical responder groups may expand the knowledge and skill set.

151.19 REGISTRATION; FEES.

Subd. 3. **Sale of federally restricted medical gases.** (a) A person or establishment not licensed as a pharmacy or a practitioner must not engage in the retail sale or dispensing of federally restricted medical gases without first obtaining a registration from the board and paying the applicable fee specified in section 151.065. The registration must be displayed in a conspicuous place in the business for which it is issued and expires on the date set by the board. It is unlawful for a person to sell or dispense federally restricted medical gases unless a certificate has been issued to that person by the board.

(b) Application for a medical gas dispenser registration under this section must be made in a manner specified by the board.

(c) A registration must not be issued or renewed for a medical gas dispenser located within the state unless the applicant agrees to operate in a manner prescribed by federal and state law and according to the rules adopted by the board. A license must not be issued for a medical gas dispenser

located outside of the state unless the applicant agrees to operate in a manner prescribed by federal law and, when dispensing medical gases for residents of this state, the laws of this state and Minnesota Rules.

(d) A registration must not be issued or renewed for a medical gas dispenser that is required to be licensed or registered by the state in which it is physically located unless the applicant supplies the board with proof of the licensure or registration. The board may, by rule, establish standards for the registration of a medical gas dispenser that is not required to be licensed or registered by the state in which it is physically located.

(e) The board must require a separate registration for each medical gas dispenser located within the state and for each facility located outside of the state from which medical gases are dispensed to residents of this state.

(f) Prior to the issuance of an initial or renewed registration for a medical gas dispenser, the board may require the medical gas dispenser to pass an inspection conducted by an authorized representative of the board. In the case of a medical gas dispenser located outside of the state, the board may require the applicant to pay the cost of the inspection, in addition to the license fee in section 151.065, unless the applicant furnishes the board with a report, issued by the appropriate regulatory agency of the state in which the facility is located, of an inspection that has occurred within the 24 months immediately preceding receipt of the license application by the board. The board may deny licensure unless the applicant submits documentation satisfactory to the board that any deficiencies noted in an inspection report have been corrected.