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Senate

State of Minnesota

S.F. No. 2995 – Omnibus Health and Human Services Appropriations (2nd Engrossment)

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ARTICLE 1
HEALTH CARE

Section 1 **(256.01, subdivision 43 – Education on contraceptive options)** requires the commissioner to establish requirements for hospitals to convey to medical assistance and MinnesotaCare enrollees certain information regarding contraception options.

Section 2 **(256.0471, subdivision 1– Qualifying overpayment)** clarifies that recoveries of medical assistance and MinnesotaCare overpayments due to client error apply only to the benefits the client received while a client continued to receive benefits while appealing an adverse eligibility determination that was ultimately unsuccessful.

Section 3 **(256.969, subdivision 2b - Hospital payment rates)** requires the commissioner to rebase hospital payment rates for hospitals and critical access hospitals.

Section 4 **(256.969, subdivision 9 - Disproportionate numbers of low-income patients served)**

> **Paragraph (d)** modifies the disproportionate share hospital payments factor for certain hospitals with level one trauma centers.
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> **Paragraph (g)** modifies the existing supplemental payments to certain hospitals that administer large quantities of high cost drugs to enrollees in fee-for-service medical

assistance by (1) requiring the commissioner to pay the non-federal share of any payments that exceed the hospital specific disproportionate share hospital limit for a children's hospital that qualifies for an alternative DSH payment, and (2) by increasing the pool from which the supplemental drug payments may be made from $1,500,000 to $10,000,000.

Section 5 **(256.969, subdivision 25 - Long-term hospital rates)** modifies the methodology for determining the rates for long-term hospitals by requiring the rates to equal the higher of the rates determined under the existing methodology or the cost-based methodology that currently applies to critical access hospitals.

Section 6 **(256.969, subdivision 31 - Long-acting reversible contraceptives)** requires the commissioner and managed care plans to provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the inpatient hospital setting.

Section 7 **(256B.055, subdivision 17 - Adults who were in foster care at the age of 18)** expands an existing medical assistance eligibility category for people under 26 who were in foster care when they turned 18 by allowing a person who was in foster care in another state to qualify.

Section 8 **(256B.0625, subdivision 9 - Dental services)** restores the comprehensive medical assistance adult dental benefit.

Section 9 **(256B.0625, subdivision 13 – Drugs)** provides an exception to the 34-day supply limit on prescription drugs by requiring medical assistance to cover up to a 12-month supply of a prescription contraceptive and defines "prescription contraceptive."

Section 10 **(256B.0625, subdivision 13c - Formulary Committee)** further specifies the qualifications for certain members of the medical assistance drug formulary committee, clarifies that the committee is subject to the Open Meeting Law, and extends the sunset of the committee to June 30, 2027.

Section 11 **(256B.0625, subdivision 13f - Prior authorization)** prohibits medical assistance from requiring prior authorization for (1) liquid medications if the patient utilizes tube feeding and (2) liquid methadone.

Section 12 **(256B.0625, subdivision 13g - Preferred drug list)** modifies provisions related to the medical assistance preferred drug list by (1) requiring the commissioner to make public contracts between the commissioner and any vendor participating in the preferred drug list and supplementary rebate program, (2) requiring the commissioner to consult patient advocacy groups and the Minnesota Rare Disease Advisory Council before modifying the preferred drug list, and (3) specifying that the commissioner must give 30-days' notice prior to any required public hearing and disclose specific information about the proposed changes to the preferred drug list that are the topic of the public hearing.

Section 13 **(256B.0625, subdivision 28b - Doula services)** requires the commissioner to enroll doula agencies and individual doulas in medical assistance to allow for direct reimbursement for doula services.

Section 14 **(256B.0625, subdivision 30 – Other clinic services)**

> **Paragraph (k)** permits federally qualified health clinics that are also urban Indian organizations to elect from among three reimbursement options, one of which is a rate equivalent to the all-inclusive rate payment established by the Indian Health Service.
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> **Paragraph (m)** permits an Indian health service facility or a Tribal health center operating under a 638 contract or compact to elect to enroll in medical assistance as a Tribal FQHC and requires the commissioner to establish an alternative payment method for a facility or center that makes this election that is equivalent to the method and rate for those that do not make such an election.

Section 15 **(256B.0625, subdivision 31 - Medical supplies and equipment)** specifies that medical assistance covers both seizure detections devices and their monitoring.

Section 16 **(256B.0625, subdivision 34 - Indian health services facilities)** strikes language that is no longer necessary given the amendment to section 256B.0625, subdivision 30 establishing the all-inclusive rate payment.

Section 17 **(256B.0625, subdivision 68 – Biomarker testing)** creates a medical assistance benefit for biomarking testing equivalent to the mandated commercial market benefit.

Section 18 **(256B.0625, subdivision 69 – Recuperative care)** creates a medical assistance benefit for recuperative care.

Section 19 **(256B.0625, subdivision 70 – Coverage of services for the diagnosis, monitoring, and treatment of rare diseases)** requires that medical assistance coverage for services related to the diagnosis, monitoring, and treatment of a rare disease or condition meets the requirements set forth in section 62Q.451. Prohibits denial of coverage solely on the basis that the service was provided, referred for, or ordered by an out-of-network provider. Establishes limits on prior authorization requirements for services of out-of-network providers.

Section 20 **(256B.0625, Subdivision 71 - Coverage and payment for pharmacy services)** requires medical assistance to provide the same coverage for pharmacists' services as for physicians' services for services within pharmacists' scope of practice.

Section 21 **(256B.0631, subdivision 2 – Exceptions)** creates two new exceptions to the medical assistance co-pay requirement: (1) no co-payment is required under medical assistance for the placement or removal of long-acting reversable contraception; and (2) no co-payment is required under medical assistance for additional diagnostic services and testing following a mammogram.

Section 22 **[256B.0701 – RECUPERATIVE CARE SERVICES]** defines recuperative care services and specifies the settings in which recuperative care services may be provided, who is eligible to receive recuperative care services, and the reimbursement rate for the services, and requires a legislative report on the roll out of the new benefit.

Section 23 **(256B.196, subdivision 2 – Commissioner's duties)** requires recipients of certain supplemental payments related to intergovernmental transfers to submit data requested by the commissioner within 24 months of the request in order to remain eligible for the supplemental payments.

Section 24 **(256B.69, subdivision 4 - Limitation of choice; opportunity to opt out)** establishes a managed care opt-out for all medical assistance enrollees.

Section 25 **(256B.69, subdivision 5a – Managed care contracts)** repeals the managed care withhold requirements that managed care contracts for medical assistance and MinnesotaCare include performance measures related to reducing a health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, reducing a plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, and reducing a plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees.

Section 26 **(256B.69, subdivision 6d - Prescription drugs)** effective January 1, 2026, requires the commissioner to carve-out outpatient prescription drugs dispensed by a pharmacy from managed care contracts for medical assistance enrollees but retains the commissioner's authority to continue to include prescription drugs administered to a medical assistance enrollee, and meanwhile, effective January 1, 2024, specifies the outpatient prescription drug rates managed care organizations must pay.

Section 27 **(256B.69, subdivision 19a – Limitation on reimbursement; rare disease services provided in Minnesota by out-of-network providers)** requires a provider to accept the established contractual payment for a service as payment in full if a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in Minnesota related to the diagnosis, monitoring, and treatment of a rare disease or condition. Establishes payment terms for out-of-network providers in the absence of an established contractual payment under medical assistance.

Section 28 **(256B.69, subdivision 19b – Limitation on reimbursement; rare disease services provided outside of Minnesota by an out-of-network provider)** requires a plan to pay the established contractual payment for a service if a managed care or county-based purchasing plan has an established contractual payment under medical assistance with an out-of-network provider for a service provided in another state related to diagnosis, monitoring, and treatment of a rare disease or condition. Establishes payment terms for out-of-network providers in the absence of an established contractual payment under medical assistance.

Section 29 **(256B.69, subdivision 28 - Medicare special needs plans; medical assistance basic health care)** is a conforming change related to the managed care opt-out provision.

Section 30 **(256B.69, subdivision 36 - Enrollee support system)** requires the commissioner to modify the medical assistance enrollee system to provide prospective medical assistance enrollees with access to counseling on choosing to opt-out of managed care.

Section 31 **(256B.692, subdivision 1 – In general)** clarifies that the medical assistance managed care opt-out provisions also apply to county-based purchasing plans.

Section 32 **(256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT)** effective January 1, 2026, establishes a supplemental payment for critical access hospitals that provide high volumes of 340B drugs, and creates a pool of $3,000,000 for this purpose.

Section 33 **(256B.758 REIMBURSEMENT FOR DOULA SERVICES)** increases doula services reimbursement rates by 113 percent to $100 per prenatal or postpartum visit and by 187 percent to $1,400 for attending and providing doula services at birth.

Section 34 **(256B.76 – PHYSICIAN, PROFESSIONAL SERVICES, AND DENTAL REIMBURSEMENT)**

> **Subdivision 1** authorizes the commissioner to reimburse physicians and licensed professionals for costs incurred when the physician or licensed professional pays the fee for required metabolic disorder testing of newborns.
>
> **Subdivision 2** rebases payment rates for dental services provided on or after January 1, 2024, other than for those provided by federally qualified health centers, rural health centers, state-operated dental clinics, or Indian health centers, by using 2018 charges, and requires rebasing to occur every 3 years beginning January 1, 2027.
>
> **Subdivision 4** strikes obsolete language related to reimbursement rates for critical access dental providers.

Section 35 **(256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES)** increases by 8 percent the payment rates for all outpatient behavioral health services effective January 1, 2024, and requires an annual inflation adjustment thereafter until implementation of a new rate methodology for these services. Specifies that if the rates paid under this section exceed the upper payment limit, the difference must be paid with state-only funds. These increases do not apply to federally qualified health centers, rural health centers, Indian health services, certified community behavioral health clinics, cost-based rates, or rates negotiated with a county.

Section 36 **(256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES)** increases by 10 percent the medical assistance reimbursement rates for family planning and abortion services except for those services provided by federally qualified health centers, rural health centers, or Indian health services.

Section 37 **(256L.03, subdivision 5 - Cost-sharing)** excludes from MinnesotaCare cost-sharing requirements any cost-sharing for (1) pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV) and (2) additional diagnostic services or testing following a mammogram.

Section 38 **(Laws 2021, First Special Session chapter 7, article 6, section 26 - EXTENSION OF COVID-19 HUMAN SERVICES PROGRAM MODIFICATIONS)** extends the temporary permissible use of audio-only telehealth to June 30, 2025.

Section 39 **(MODIFY WITHHOLD PROVISIONS)** requires the commissioner to submit a report to the legislature describing and analyzing the implications to removing the mandatory performance measures related to emergency department utilization rates, hospitalization admission rates, and hospital readmission rates.

ARTICLE 2

HEALTH INSURANCE

Section 1 (**62A.02, subdivision 1 – Filing)** Requires a health plan to file its prescription drug formulary with the commissioner. Requires proposed changes to a drug formulary to be made by a filing prior to August 1 of the application year.

Section 2 **(62A.0412 - COVERAGE FOR INFERTILITY TREATMENT)** requires all large group health plans that provide maternity benefits to Minnesota residents to provide comprehensive coverage for the diagnosis of infertility, treatment for infertility, and certain standard fertility preservation services. Establishes limits on cost-sharing requirements. Defines key terms for the purposes of this section including "infertility," "diagnosis of and treatment for infertility," and "standard fertility preservation services."

Section 3 **(62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS)** adds to the conditions for a health insurer to do business in Minnesota federal requirements related to the third-party liability.

Section 4 **(62A.15, subdivision 3d – Pharmacist)** requires certain group policies and subscriber contracts to include coverage for medical treatment or services provided by a licensed pharmacist if such medical treatment or services are covered if provided by a licensed physician.

Section 5 **(62A.15, subdivision 4 – Denial of benefits)** prohibits certain health carriers from denying benefits payable for services covered if the services are lawfully performed by a licensed pharmacist.

Section 6 **(62A.30, subdivision 5 – Mammogram; diagnostic services and testing)** requires health plans to cover additional diagnostic services and testing following a mammogram without cost-sharing requirements.

Section 7 **(62A.30, subdivision 6 – Application)** provides an exception to subdivision 5 if an enrollee in a health savings plan or catastrophic health plan has not met the enrollee's deductible.

Section 8 **(62A.673, subdivision 2 – Definitions)** extends the use of audio-only telehealth to June 30, 2025.

Section 9 **(62D.1071 - COVERAGE OF LICENSED PHARMACIST SERVICES)** provides that all benefits provided by a health maintenance contract relating to expenses incurred for medical treatment or services provided by a licensed physician must include services provided by a licensed pharmacist to the extent a licensed pharmacist's services are within the pharmacist's

scope of practice. Prohibits a health maintenance organization from denying payment for medical services covered by an enrollee's health maintenance contract if the services are lawfully performed by a licensed pharmacist.

Section 10 **(62J.497, subdivision 1 – Definitions)** Defines key terms for the purposes of this section including "dispense," "electronic media," "NCDPD," and "real-time prescription benefit tool."

Section 11 **(62J.497, subdivision 3 – Standards for electronic prescribing)** requires group purchasers and pharmacy benefit managers to use a real-time prescription benefit tool that complies with the NCPDP Real-Time Prescription Benefit Standard and that notifies a prescriber of certain enumerated items, including but not limited to if a prescribed drug is covered by the patient's group purchaser or pharmacy benefit manager, if a prescribed drug is included on the formulary or preferred drug list of the patient's group purchaser or pharmacy benefit manager, and if prior authorization is required for the prescribed drug.

Section 12 **(65J.811 - PROVIDER BALANCE BILLING REQUIREMENTS)** requires health care providers and health facilities to comply with the federal "No Surprises Act." Provides a complaint process for violations of the No Surprises Act. Classifies data. Authorizes a civil penalty.

Section 13 **(62J.824 - FACILITY FEE DISCLOSURE)** clarifies that a provider-based clinic that charges a facility fee must, prior to the delivery of nonemergency services, provide notice to patients served by telehealth that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

Section 14 **(62J.826 - MEDICAL AND DENTAL PRACTICES; CURRENT STANDARD CHARGES; COMPARISON TOOL)** defines key terms for the purposes of the section including "chargemaster," "medical or dental practices," and "standard charge." Requires enumerated medical and dental practices to make available to the public a list of their current standard charges for all items and services, as reflected in the medical or dental practice's chargemaster, provided by the medical or dental practice. Specifies a required file format and mandatory contents.

Section 15 **(62J.84, subdivision 2 – Definitions)** Defines key terms for the purposes of this section and section 62J.841 including "biosimilar," "generic drug," "manufacturer," and "patient assistance program."

Section 16 **(62J.84, subdivision 3 – Prescription drug price increases reporting)** adds references to biosimilar drugs. Specifies information that a manufacturer must submit to the commissioner after a drug price increase is effective.

Section 17 (**62J.84, subdivision 4 – New prescription drug price reporting)** adds reporting requirements for courses of treatment lasting less than 30 days. Specifies information that a manufacturer must submit to a commissioner for certain new prescription drugs.

Section 18 **(62J.84, subdivision 6 – Public posting of prescription drug price information)** Requires the commissioner to post information reported to the commissioner under section

62J.841, subdivision 2, on its website, or to contract with a private entity for the same. Updates cross-references to refer to new subdivisions created in subsequent sections of the bill.
Section 19 **(62J.84, subdivision 7 – Consultation)** Permits the commissioner to consult with a private entity or consortium, the University of Minnesota, or the commissioner of commerce, as appropriate, in issuing the form and format of the information reported under this section and section 62J.841; in posting information pursuant to subdivision 6; and in taking any other action for the purpose of implementing this section and section 62J.841. Further permits the commissioner to consult with representatives of the manufacturers to establish a standard format for reporting information under this section and section 62J.841. Replaces "manufacturers" with "reporting entities." This means the commissioner may consult with additional entities when establishing the formatting requirements for the required reports.

Section 20 **(62J.84, subdivision 8 – Enforcement and penalties)** Subjects a manufacturer to civil penalties for failure to comply with section 62J.841. Subjects pharmacies, pharmacy benefits managers, wholesale drug distributors, and other entities required to submit reports subject to civil penalties for failing to register, submit reports, or prove information.
Section 21 **(62J.84, subdivision 9 – Legislative report)** Requires the commissioner to, no later than May 15, 2024, and by January 15 of each year thereafter, report to the legislative committees with jurisdiction over commerce and health and human services policy and finance on the implementation of this section and section 62J.841, including but not limited to the effectiveness in addressing the following goals: (1) promoting transparency in pharmaceutical pricing for the state, health carriers, and other payers; (2) enhancing the understanding on pharmaceutical spending trends; and (3) assisting the state, health carriers, and other payers in the management of pharmaceutical costs and limiting formulary changes due to prescription drug cost increases during a coverage year. The report must include a summary of the information submitted to the commissioner under subdivisions 3, 4, and 5, and section 62J.841. Updates cross-references to refer to new subdivisions created in subsequent sections pf the bill.

Section 22 **(62J.84, subdivision 10 – Notice of prescription drugs of substantial public interest)** requires the commissioner to create and post on the department's website a list of prescription drugs that the commissioner determines to represent a substantial public interest for which the commissioner intends to request data. The list must be updated quarterly.

Section 23 to 26 **(62J.84, subdivisions 11, 12, 13, and 14)** requires drug manufacturers, pharmacies, prescription benefits managers, and drug wholesalers to submit specified information to the commissioner for certain types of drugs.
Section 27 **(62J.84, subdivision 15 – Registration requirements)** requires drug manufacturers, pharmacies, prescription benefit managers, and drug wholesalers to submit specified information on certain types of drugs to the commissioner.

Section 28 **(62J.84, subdivision 16 – Rulemaking)** allows the commissioner of health to use the expedited rulemaking process to adopt rules to implement the changes to the prescription drug price transparency act.

Section 29 **(62J.841 - REPORTING PRESCRIPTION DRUG PRICES; FORMULARY DEVELOPMENT AND PRICE STABILITY)** Defines key terms for purposes of this section

including “average wholesale price,” “national drug code,” and “wholesale acquisition cost.” Requires manufacturers to, beginning July 31, 2024, and by July 31 of each year thereafter, report to the commissioner certain information for every drug with a wholesale acquisition cost of $100 or more for a 30-day supply or for a course of treatment lasting less than 30 days, as applicable to the next calendar year. Such reported information includes a drug's national drug code, labeler code, and the manufacturer name associated with the labeler code; brand or generic name, and wholesale acquisition cost for one unit. Classifies information reported under this subdivision is classified as public data not on individuals.

Section 30 **(62K.10, subdivision 4 – Network adequacy)** clarifies that the commissioner must consider the availability of psychiatric residential treatment facilities in determining network adequacy. Provides that the commissioner may establish the sufficiency of the number and types of providers by referencing any reasonable criteria, including but not limited to, certain provider and enrollee ratios, hours of operation, geographic accessibility, and waiting times for an appointment with participating providers.

Section 31 **(62Q.451 - UNRESTRICTED ACCESS TO SERVICES FOR THE DIAGNOSIS, MONITORING, AND TREATMENT OF RARE DISEASES)** defines “rare disease or condition” for the purposes of this section. Prohibits a health plan company from restricting the choice of an enrollee as to where the enrollee receives services from a licensed health care provider related to the diagnosis, monitoring, and treatment of a rare disease or condition, including but not limited to restrictions through any prior authorization, preauthorization, prior approval, precertification process, increased fees, or other methods. Imposes cost-sharing limitations and information requirements on health plan companies. Prohibits denial of coverage for a service based solely on the service being provided, referred for, or ordered by an out-of-network provider. Establishes payment limitations and procedures for out-of-network providers located in Minnesota as well as for out-of-network providers located out of the state. Excludes the State Employee Group Insurance Program and retail pharmacies from the provisions of the section.

Section 32 **(62Q.473 - BIOMARKER TESTING)** defines key terms for the purposes of the section including “biomarker,” “biomarker testing,” and “clinical utility.” Requires health plans to provide coverage for biomarker testing to diagnose, treat, manage, and monitor illness or disease if the test provides clinical utility.

Section 33 **(62Q.522 - COVERAGE OF CONTRACEPTIVE METHODS AND SERVICES)** defines key terms for the purposes of the section including “contraceptive method,” “contraceptive service,” “exempt organization” and “medical necessity.” Requires a health plan to provide coverage for contraceptive methods and services. Prohibits health plan companies from imposing cost-sharing requirements nor referral requirements for contraceptive methods or services. Exempts certain organizations from the coverage requirements of this section based on religious objections.

Section 34 **(62Q.523 - COVERAGE FOR PRESCRIPTION CONTRACEPTIVES; SUPPLY REQUIREMENTS)** defines “prescription contraceptive” for the purpose of this section. Requires a health plan to cover a 12-month supply for any prescription contraceptive if a

12-month supply is prescribed by the prescribing health care provider. The prescribing health care provider must determine the appropriate duration to prescribe the prescription contraceptives for up to 12 months.

Section 35 **(62Q.83 - PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT)** defines key terms for the purposes of this section including “drug,” “formulary,” and “prescription.” Requires a health plan company that provides prescription drug benefit coverage and uses a formulary to make the plan's formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates. Permits a health plan company, once a formulary has been established, to expand its formulary, remove certain drugs, and change utilization review requirements in accordance with the specifications of this section. Excludes SEGIP from the requirements of this section.

Section 36 **(62U.04, subdivision 4 – Encounter data)** requires dental plan companies to submit encounter data to the MN APCD and requires encounter data reporting to include enrollee race and ethnicity.

Section 37 **(62U.04, subdivision 5 – Pricing data)** requires dental plan companies to submit pricing data and requires pricing data reported to include data on supplemental contractual value-based payments paid to health care providers.

Section 38 **(62U.04, subdivision 5a – Self-insurers)** requires a third-party administrator to annually notify self-insurers that they may elect to have the third-party administrator submit encounter and price data.

Section 39 **(62U.04, subdivision 5b – Nonclaims-based payments)** requires health plan companies and third-party administrators to submit all nonclaims-based payments to the MN APCD. Defines “nonclaims-based payments.” Classifies the data as nonpublic data.

Section 40 **(62U.04, subdivision 11 – Restricted uses of the all-payer claims data)** makes conforming changes for data submitted related to self-insurers and nonclaims-based payments so that the data may be used for purposes identified under current law. Strikes obsolete language. Removes time limitations for certain uses of the data.

Section 41 **(62U.04, subdivision 13 – Expanded access to and use of the all-payer claims data)** requires MDH to provide MN APCD data to organizations engaged in efforts to research or affect transformation in health care provided that the use of the data serves a public benefit and is not used to create an unfair market advantage, reidentify an individual, or publicly report details regarding a contract between a health care company and a provider. This section requires MDH to provide safeguards, develop a fee schedule, and create a research advisory group.

Section 42 **(62U.10, subdivision 7 – Outcomes reporting; savings determination)** strikes obsolete language and authorizes MDH to use nonclaims-based payment data to determine actual total private and public health care and long-term care spending for certain health indicators for the most recent calendar year available.

Section 43 **(151.071, subdivision 2 – Grounds for disciplinary action)** Provides that a drug manufacturer's failure to comply with section 62J.841 is prohibited and grounds for disciplinary action.

Section 44 **(REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS)** defines "commissioner," "nonclaims-based payments," "nonpublic data," and "primary care services." Requires MDH to report to the legislature by February 15, 2024, on the volume and distribution of health care spending across payment models used by health plan companies and third-party administrators. Requires health plan companies and third-party administrators to comply with data requests from the commissioner within 60 days. Classifies data collected under this section as nonpublic data.

Section 45 **(COMMISSIONER OF COMMERCE)** requires the commissioner of commerce to consult with health plan companies, pharmacies, and pharmacy benefit managers to develop guidance to implement coverage for the pharmacy services required by Minnesota Statutes, sections 62A.15, subdivisions 3d and 4; and 62D.1071.

ARTICLE 3

KEEPING NURSES AT THE BEDSIDE

Section 1 **(144.1501 Subd 1 – Definitions)** creates definitions for "hospital nurse" and "PSLF program" for the purposes of the health professional education loan forgiveness program.

Section 2 **(144.1501 Subd 2 - Creation of account)** adds forgiving the loans of participants in the federal Public Service Loan Forgiveness program who agree to work in non-profit hospitals providing direct care to the allowable purposes under the health professional education loan forgiveness program.

Section 3 **(144.1501 Subd 3 – Eligibility)** creates an additional eligibility category for the health professional education loan forgiveness program for nurses who are participants in the PSLF program and agrees to be hospital nurses; clarifies that nurses who agree to teach are required to agree to teach for two years.

Section 4 **(144.1501 Subd 4 - Loan forgiveness)** specifies the terms of the loan forgiveness for hospital nurses participating in the PSLF program and for nurses who agree to teach.

Section 5 **(144.1501 Subd 5 - Penalty for nonfulfillment)** specifies the conditions under which a hospital nurse participating in the PSLF program and receiving loan forgiveness under this section could fail to fulfill the nurse's obligations under this section.

Section 6 **(144.566) VIOLENCE AGAINST HEALTH CARE WORKERS**

Subd 1 **Definitions.** Adds a definition of "Workplace violence hazard."

Subd 2 **Action plans and action plan reviews required.** Modifies an existing requirement that hospitals have preparedness and incident response action plans to acts of violence (action plans) by requiring that the hospital update the plans at least annually, that the plan be in writing, and that the plan be made available to health care workers at all times.

Subd 3 **Action plan committees.** Makes conforming changes.

Subd 4 **Required elements of action plans; generally.** Specifies the general requirements of all action plans with respect to development, implementation, and compliance measures.

Subd 5 **Required elements of action plans; evaluation of risk factors.** Specifies that action plans must incorporate an evaluation of workplace violence hazards.

Subd 6 **Required elements of action plans; review of workplace violence incidents.** Requires action plans to include procedures for evaluating instances of workplace violence.

Subd 7 **Required elements of action plans; reporting workplace violence.** Requires actions plans to contain policies and procedures related to reporting and investigating incidents of workplace violence, and to protecting employees from retaliation or other punitive actions that could create a disincentive to report workplace violence.

Subd 8 **Required elements of action plans; coordination with other employers.** Requires action plans to include policies and procedures for coordination between the hospital and other employers and their employees who work in the hospital, including coordination regarding required training.

Subd 9 **Required elements of action plans; white supremacist affiliation and support prohibited.** Requires hospitals to adopt policies that prohibit security personnel employed by the hospital or assigned to the hospital by a contractor from affiliating with white supremacist groups.

Subd 10 **Required elements of action plans; training.** Requires action plans to include policies and procedures regarding the development and provision of training with regards to workplace violence prevention and response.

Subd 11 **Training required.** Modifies existing duties of hospitals to provide training to health care employees regarding safety during and responses to workplace violence.

Subd 12 **Annual review and update of action plans.** Modifies existing requirements that hospitals review action plans annually by expanding the topics that must be reviewed to include, for example, security risks and workplace violence hazards in particular units or areas of the hospital, staffing patterns that may contribute to increased risk of workplace violence, and instances of discrimination by security personnel.

Subd 13 **Action plan updates.** Requires hospitals to update action plans based on the annual review to reflect corrective actions the hospital will take to mitigate hazards identified in the review.

Subd 14 **Requests for additional staffing.** Requires hospitals to create and implement a procedure for health care workers to officially request additional staffing; requires the hospital to document all such requests; requires the hospital to provide a written explanation for all denied requests; requires the hospital to make the staffing request documentation available to the commission of health; and authorizes the commissioner of health to use the documentation while enforcing the requirements of this section.

Subd 15 D**isclosure of action plans.** Modifies an existing requirement that hospitals make their action plans available to certain parties by removing the requirement that the plan be provided to law enforcement but adding that the plans be made available directly to health care workers, and not merely through the workers' exclusive bargaining representatives. Also requires the hospital to submit its action plan and most recent annual review to the commissioner of health.

Subd 16 **Legislative report required.** Requires the commissioner of health to compile the information contained in each hospital's action plan and most recent annual review into a report to the legislature.

Subd 17 **Interference prohibited.** Makes a technical change to an existing requirement.

Subd 18 **Penalties.** Modifies existing authority of the commissioner of health to enforce this section by increasing the upper limit of the fine from $250 to $10,000.

Section 7 **(144.608 Subd 1 - Trauma Advisory Council established)** makes conforming changes related to the addition of definitions to the health professional education loan forgiveness statute.

Section 8 **(144.653, subdivision 5 - Correction orders**) modifies the existing authority of the commissioner of health to enforce hospital regulations by adding the authority to enforce hospital staffing committee requirements established under this article.

Section 9 **[144.7051 DEFINTIONS]** Defines "concern for safe staffing form," Commissioner," "Daily staffing schedule," "Direct-care registered nurse," "Emergency" and "Hospital."

Section 10 **[144.7053 HOSPITAL NURSE STAFFING COMMITTEE]**

Subd 1 **Hospital nurse staffing committee required.** Requires each licensed hospital to create a hospital nurse staffing committee.

Subd 2 **Staffing committee membership.** Specifies that 35% of the membership of the hospital nurse staffing committee must be direct care registered nurses, 15% must be other direct care staff, and 50% must be appointed by the hospital.

Subd 3 **Staffing committee compensation**. Requires hospitals to count employee time spent on committee business as work time and compensate all members at their normal wage rate.

Subd 4 **Staffing committee meeting frequency.** Requires the committee to meet at least quarterly.

Subd 5 **Staffing committee duties.** Specifies the duties of the committee, which include creating a written core staffing plans to guide the creation of daily staffing schedules for each inpatient care unit of the hospital.

Section 11 **[144.7054 HOSPITAL NURSE WORKLOAD COMMITTEE]**

Subd 1 **Hospital nurse workload committee required.** Requires each hospital to establish a nurse workload committee for each inpatient care unit of the hospital.

Subd 2 **Workload committee membership.** Specifies that 35% of the membership of each nurse workforce committee must be direct care registered nurses who are typically assigned to the unit, 15% must be other direct care staff typically assigned to the unit, and 50% must be appointed by the hospital.

Subd 3 **Workload committee compensation.** Requires hospitals to count employee time spent on committee business as work time and compensate all members at their normal wage rate.

Subd 4 **Workload committee meeting frequency.** Requires each nurse workforce committee to meet at least monthly whenever the committee is in possession of an unresolved concern for safe staffing form.

Subd 5 **Workload committee duties.** Specifies the duties of nurse workforce committees, which include resolving staffing issues on the unit that arise from violations of the hospital's core staffing plan and creating a dispute resolution process that includes an option for arbitration.

Section 12 **(144.7055 HOSPITAL CORE STAFFING PLAN)**

Subd 1 **Definitions.** modifies the definition of "core staffing plan" and "inpatient care unit" and deletes an unused term.

Subd 2 **Hospital core staffing plans.** Modifies the existing requirement that every hospital develop a core staffing plan by transferring responsibility for creating the staffing plan from the chief nursing executive to the hospital nurse staffing committee and specifies the required content of the staffing plan, which includes defining the maximum number of patients on each unit for whom a nurse can typically care for safely.

Subd 2a **Development of hospital core staffing plans.** Specifies the criteria the hospital nurse staffing committee must consider when developing the hospital's core staffing plan, which include unit-specific patient acuity, unit specific demands on direct care staff's time, design features of the unit, and procedures for identifying additional staffing as required.

Subd 2b **Failure to develop hospital core staffing plans.** Requires the hospital staffing committee to enter into expedited arbitration if the committee cannot agree on a core staffing plan and requires that the arbitrator understand patient care needs.

Subd 2c **Objections to hospital core staffing plans.** Permits a hospital that objects to a core staffing plan adopted by a hospital nurse staffing committee to elect to attempt to amend the plan through arbitration.

Subd 2d **Mandatory submission of core staffing plan to commissioner.** Requires each hospital to submit to the commissioner of health the core staffing plan approved by the nurse staffing committee.

Subd 3 **Standard electronic reporting developed.** Deletes obsolete language and maintains the requirement that the Minnesota Hospital Association continue to post on its website the actual direct patient care hours per patient and per unit.

Section 13 **[144.7056] IMPLEMENTATION OF HOSPITAL CORE STAFFING PLANS**.

Subd 1 **Plan implementation required.** Requires each hospital to implement the hospital core staffing plan adopted by its hospital nurse staffing committee; and clarifies that the requirements of a core staffing plan do not apply during an emergency.

Subd 2 **Public posting of core staffing plans.** Requires each hospital to publicly post in each unit the core staffing plan for that unit.

Subd 3 **Public posting of compliance with plan.** Requires hospitals to publicly post in each unit whether the unit is currently in compliance with its core staffing plan for that unit.

Subd. 4 **Public posting of emergency department wait times.** Requires each hospital to post on its website and in its emergency department the approximate waiting time for patients who are not in critical need of emergency care.

Subd 5 **Public distribution of core staffing plan and notice of compliance.** Requires hospitals to make written copies of its core staffing plan available upon request.

Subd 6 **Reporting noncompliance.** Permits any employee, patient, or family member of a patient to submit a concern for safe staffing form; prohibits the hospital from retaliating against an employee who submits a concern for safe staffing form; and authorizes the commissioner of labor and industry to impose fines on any hospital the commissioner determines has retaliated against an employee for submitting a concern for safe staffing form.

Subd 7 **Documentation of compliance.** Requires hospitals to maintain documentation of compliance with the hospital's core staffing plan, retain it for five years, and permit the hospital's nurse staffing committee to access the documentation.

Section 14 **[144.7057] HOSPITAL NURSE STAFFING REPORTS**.

Subd 1 **Nurse staffing report required.** Requires each hospital to submit to the commissioner a quarterly staffing report.

Subd 2 **Nurse staffing report.** Specifies the required elements of the quarterly staffing report, including the hospital's compliance with its staffing plan, an analysis of compliance trends at the hospital, and action plans to address instances of noncompliance.

Subd 3 **Public posting of nurse staffing reports.** Requires each hospital to post on its website a copy of the staffing report submitted to the commissioner.

Subd 4 **Standardized reporting.** Requires the commissioner of health to develop a standard format for the staffing report.

Subd 5 **Penalties.** Authorizes the commissioner to exercise the commissioner's existing authority to regulate hospitals to impose immediate fines on a hospital that fails to report any instance of the hospital accepting an elective surgery at a time when the unit performing the surgery is out of compliance with its core staffing plan.

Section 15 **[144.7058] GRADING OF COMPLIANCE WITH CORE STAFFING PLANS**.

Subdivision 1. **Grading compliance with core staffing plans.** Requires the commissioner of health to develop a uniform annual grading system that evaluates each hospital's compliance with its own core staffing plan.

Subd. 2. **Grading factors.** Specifies the criteria the commissioner must consider when developing the grading system, including the prevalence of violent incidents in the hospital; prevalence of infections, pressure ulcers, and falls; wait times in emergency departments; prevalence of overtime; and frequency and extent of noncompliance with a staffing plan.

Subd. 3. **Public disclosure of compliance grades.** The commissioner of health must publish on the Department of Health website a compliance grade for each hospital.

Section 16 **[144.7059] RETALIATION AGAINST NURSES PROHIBITED**.

Subd 1 **Definitions.** Defines "Emergency," "Nurse," and "Taking action against."

Subd 2 **Prohibited actions.** Prohibits hospitals and certain other health care facilities from discharging, disciplining, or threatening a nurse, or reporting a nurse to the Board of Nursing solely on the ground that the nurse fails to accept an assignment of one or more additional patients because the nurse determines that accepting an additional patient assignment, in the nurse's judgment, may create an unnecessary danger to a patient's life, health, or safety or may otherwise constitute a ground for disciplinary action by the Board of Nursing.

Subd 3 **State nurses.** Specifies that this section applies to all nurses employed by the state no matter the setting in which the nurse works.

Subd 4 **Collective bargaining rights.** Protects a nurse's rights under any collective bargaining agreement.

Subd 5 **Emergency.** Creates an exception under this section for situations when replacement staff are not able to report for duty for the next shift, or a period of increased patient need because of unusual, unpredictable, or unforeseen circumstances, including but not limited to an act of terrorism, a disease outbreak, adverse weather conditions, or a natural disaster, that impacts continuity of patient care.

Subd 6 **Enforcement.** Authorizes the commissioner of labor and industry to impose fines on a hospital the commissioner determines has violated this section.

Section 17 **(144.7067, subdivision 1 - Establishment of reporting system)** modifies the existing adverse events reporting system by adding a requirement that hospitals report whether

the unit in which an adverse event took place was in compliance with the hospital's core staffing plan at the time of the adverse event.

Section 18 **(147A.08 – EXEMPTIONS)** makes conforming changes related to the addition of definitions to the health professional education loan forgiveness statute.

Section 19 **(BEST PRACTICES TOOLKIT DEVELOPMENT)** requires the commissioner of health to develop a best practices toolkit for implementation of workload and hospital staffing committees, including recommendations related to mediation and dispute resolution.

Section 20 **DIRECTION TO COMMISSIONER OF HEALTH; NURSING WORKFORCE REPORT.** Requires the commissioner of health to publish a report on the current status of the state's nursing workforce employed by hospitals.

Section 21 **DIRECTION TO COMMISSIONER OF HEALTH; NURSING WORKFORCE REPORT.** Requires the commissioner of health to publish a report on the current status of the state's nursing workforce employed by hospitals.

Section 22 **DIRECTION TO COMMISSIONER OF HEALTH; KEEPING NURSES AT THE BEDSIDE ACT IMPACT EVALUATION.** Requires the commissioner of health to contract with the Impact Evaluation Unit at MMB to conduct a causal impact study of the implementation of the Keeping Nurses at the Bedside Act.

Section 23 **DIRECTION TO COMMISSIONER OF HUMAN SERVICES.** Clarifies that child care expenses incurred by a nursing facility scholarship recipient while earning a wage working at the facility are allowable costs.

Section 24 **INITIAL IMPLEMENTATION OF THE KEEPING NURSES AT THE BEDSIDE ACT.** Requires hospitals to form hospital nurse staffing committees by October 1, 2024, to implement core staffing plans by October 1, 2025, and begin submitting nurse staffing reports to the commissioner of health by January 1, 2026.

Section 25 **REVISOR INSTRUCTION** requires the revisor of statutes to renumber definitions related to hospital core staffing plans.

ARTICLE 4

DEPARTMENT OF HEALTH

Section 1 and 2 **(13.10, subdivision 5; 13.465, subdivision 8 – Adoption records)** update cross references to provisions relating to adoption records.

Section 3 **(16A.151, subdivision 2 – Exceptions)** requires money received by the state as a result from a lawsuit related to electronic nicotine delivery systems to be deposited in the tobacco use prevention account.

Section 4 to 6 **(103I.005, subdivisions 17a, 17b, and 20a)** defines "submerged closed-loop heat exchanger, moves the definition of "temporary boring," and amends the definition of "water supply well."

Section 7 **(103I.208, subdivision 2 – Permit fee)** establishes a $275 permit fee for a submerged closed loop heat exchanger.

Section 8 **(103I.209 – SUBMERGED CLOSED LOOP HEAT EXCHANGER SYSTEM; REQUIREMENTS)** requires a permit issued by the commissioner of health to install a submerged closed loop heat exchanger in a water supply well. Provides requirements for setbacks, construction, and heat transfer fluids.

Section 9 **(103I.210 – SUBMERGED CLOSED LOOP HEAT EXCHANGER SYSTEM; PERMITS)** requires the commissioner of health to issue permits for the installation of submerged closed loop heat exchanger systems if the requirements of this section are satisfied.

Section 10 **(121A.335, subdivision 3 – Frequency of testing)** strikes requirements for schools when lead is found at a specific location providing cooking or drinking water. These requirements are replaced with new language in a subsequent section.

Section 11 **(121A.335, subdivision 5 – Reporting)** requires school districts and charter schools to directly notify parents annually of the results of lead testing in its buildings if tests were conducted. Strikes remediation or notification requirements related to elevated lead levels. Requires test results and planned remediation to be reported to the school board and made available within 30 days of receiving the results. Requires annual reporting of test results and remediation activities to the commissioner of health.

Section 12 **(121A.335, subdivision 6 – Remediation)** requires a school that finds lead above five parts per billion in a specific location that provides cooking or drinking water to formulate and implement a remediation plan. The plan must be made publicly available.

Section 13 **(144.05, subdivision 8 – Grant program reporting)** requires the commissioner of health to submit an annual report to the legislature including information about the department's grant programs and grants awarded.

Section 14 **(144.0526 – MINNESOTA ONE HEALTH ANTIMICROBIAL STEWARDSHIP COLLABORATIVE)** requires the commissioner of health to establish the Minnesota One Health Antimicrobial Stewardship Collaborative to lead stewardship initiatives across human, animal, and environmental health.

Section 15 **(144.0701 – Special guerilla unit veterans grant program)** requires the commissioner of health to establish a grant program to offer culturally specific and specialized assistance to support the health and well-being of special guerilla unit veterans.

Section 16 **(144.0752 – CULTURAL COMMUNICATIONS)** requires the commissioner of health to establish a cultural communications program to advance culturally and linguistically appropriate communication services for communities most impacted by health disparities. Requires the commissioner ensure that the department follows the National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards.

Section 17 **(144.0754 - OFFICE OF AFRICAN AMERICAN HEALTH; DUTIES)** requires the commissioner of health to establish the Office of African American Health to address the unique needs of African American Minnesotans. The Office must work closely with the African American Health State Advisory Council and coordinate engagement across various systems and communities. The Office must award grants.

Section 18 **(144.0755 - AFRICAN AMERICAN HEALTH STATE ADVISORY COUNCIL)** establishes the African American Health State Advisory Council to advise the commissioner on how to reduce health inequities and disparities that particularly affect African American Minnesotans.

Section 19 **(144.0756 - AFRICAN AMERICAN HEALTH SPECIAL EMPHASIS GRANT PROGRAM)** requires the commissioner of health to establish the African American health special emphasis grant program, which is administered by the Office of African American Health. The program is to identify disparities impacting African American health and develop community-based solutions.

Section 20 **(144.0757 – OFFICE OF AMERICAN INDIAN HEALTH)** establishes the Office of American Indian Health. The Office must address the unique needs of American Indian Tribal communities in Minnesota.

Section 21 **(144.0758 – AMERICAN INDIAN SPECIAL EMPHASIS GRANTS)** requires the commissioner of health to establish the American Indian health special emphasis grant program. The purpose of the program is to develop programs that address health disparities of Minnesota's American Indian population, identify disparities in American Indian health, and develop community-based solutions.

Section 22 **(144.0759 – PUBLIC HEALTH AMERICORPS)** authorizes the commissioner of health to award a grant to a statewide, nonprofit organization to support Public Health AmeriCorps members.

Section 23 **(144.122 – License, permit, and survey fees)** requires the commissioner of health to charge hospitals an annual licensing fee and a per bed or bassinet fee. The revenue is credited toward trauma hospital designations.

Section 24 **(144.1462 – COMMUNITY HEALTH WORKERS)** requires the commissioner of health to work with state and community partners to develop and expand the community health workers profession in Minnesota. The commissioner must award grants or enter into contracts to accomplish this.

Section 25 and 26 **(144.218, subdivisions 1 and 2)** make conforming changes to terminology and across references related to birth certificates and adoption.

Section 27 **(144.225, subdivision 2 – Data about births)** makes conforming changes related to what data on birth records and adoption records is available.

Section 28 **(144.252 – Access to original birth records after adoption)** amends provisions related to obtaining original birth records for a person who has been adopted. Requires the state registrar to provide a copy of the person's original birth record to the person who was adopted or

a relative of the adopted person. If a contact preference form is attached to the original birth record, the contact form must also be provided. The adopted person or adopted person's relative may obtain copies of the adoption order, certificate of adoption, and related documents. A person who is adopted as an adult may access the person's birth record that existed before adoption.

Section 29 **(144.2253 – BIRTH PARENT CONTACT PREFERENCE FORM)** requires the commissioner of health to make available a contact preference form that a birth parent may complete at the birth of the child to indicate whether the parent would like to be contacted by the child. The commissioner must retain the form with the person's original birth record.

Section 30 **(144.2254 – PREVISOULY FILED CONSENTS TO DISCLOSURE AND AFFIDAVITS OF NONDISCLOSURE)** requires the commissioner of health to inform a person applying for an original birth record of any unrevoked consent to disclosure or affidavits of nondisclosure on file with the department. A birth parent's consent to disclosure or affidavit of nondisclosure filed with the commissioner expires on June 30, 2024.

Section 31 and 32 **(144.226, subdivisions 3 and 4)** require the state registrar or local issuance office to forward birth record and vital record surcharges to the commissioner of management and budget on a monthly basis.

Section 33 **(144.3832 – PUBLIC WATER SYSTEM INFRASTRUCTURE STRENGTHENING GRANTS)** requires the commissioner of health to establish a grant program to ensure the uninterrupted delivery of safe water; mitigating potential threats from climate change; providing resiliency to maintain drinking water supplies in case of a loss of power; providing redundancy in water sources; and preventing contamination by cross connections.

Section 34 **(144.3885 – LABOR TRAFFICKING SERVICES GRANT PROGRAM)** requires the commissioner of health to establish a labor trafficking services grant program to provide services for victims of labor trafficking or labor exploitation. Nonprofit organizations and non-governmental organizations serving victims of labor trafficking or labor exploitation are eligible for grants.

Section 35 **(144.398 – TOBACCO USE PREVENTION ACCOUNT; ESTABLISHMENT AND USES)** creates the tobacco use prevention account in the special revenue fund. Funds received as a result of litigation as described in section 3 must be deposited into this account. Money in the account must be used for tobacco use prevention purposes.

Section 36 **(144.4962 – LOCAL AND TRIBAL PUBLIC HEALTH EMERGENCY PREPARADNESS RESPONSE GRANT PROGRAM)** requires the commissioner of health to establish a grant program for local and tribal public health organizations. Grant proceeds must align with the Centers for Disease Control and Prevention's issued report: Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health.

Section 37 **144.557 – REQUIREMENTS FOR CERTAIN HEALTH CARE ENTITY TRANSACTIONS)** provides notice and disclosure requirements for health care entities engaging in a transfer of control transaction. Authorizes the commissioner of health and attorney general to review and enjoin such transactions in certain circumstances adverse to the public

interest. Provides for substantial limitations on nonprofit corporations formed under chapter 317A, including review and enforcement of transactions including such organizations. Authorizes the attorney general or commissioner to bring an action in district court to compel compliance.

Section 38 **(144.587 – REQUIREMENTS FOR SCREENING FOR ELIGIBILTY FOR HEALTH COVERAGE OR ASSISTANCE)** requires hospitals to determine for every patient who is uninsured or whose insured status is unknown if the patient is eligible for a public health insurance program or the hospitals charity care program, and if they are to assist the patient in applying for coverage or charity care. Hospitals must do so prior to taking certain actions to collect on medical debt.

Section 39 **(144.588 – CERTIFICATION OF EXPERT REVIEW)** requires hospitals to take certain steps prior to taking legal action to collect, garnishing wages, or referring medical debt to a collection agency.

Section 40 **(144.589 – BILLING OF UNINSURED PATIENTS)** limits the total amount of medical debt a hospital may seek to recover to the amount the hospital would receive from the lowest paying nongovernmental third-party payor for the services received by the patient.

Section 41 **(144.645 – SUPPORTING HEALTHY DEVELOPMENT OF BABIES GRANT PROGRAM)** requires the commissioner of health to establish a grant program to support healthy development of babies, including development of babies during pregnancy and postpartum. Nonprofit organizations are eligible recipients of this grant.

Section 42 **(144.6504 – ALZHEIMER'S DISEASE AND DEMENTIA TRAINING PROGRAM)** requires the commissioner of health to develop and provide training for community health workers on recognizing and understanding Alzheimer's disease and dementia.

Section 43 **(144.651, subdivision 10a – Designated support person for pregnant patient)** requires a health care provider or health care facility to allow a designated support person to be physically present while a pregnant patient is receiving care. Restrictions are allowed when necessary to meet the appropriate standard of care.

Section 44 **(144.9501, subdivision 9 – Elevated blood lead level)** lowers the threshold of micrograms of lead per deciliter of whole blood in the definition of "elevated blood lead level."

Section 45 **(144.9821 – ADVANCING HEALTH EQUITY THROUGH CAPACITY BUILDING AND RESOURCE ALLOCATION)** requires the commissioner of health to establish a grant program to award infrastructure capacity building grants to assist organizations serving populations of people who have been disproportionately impacted by health and other inequities to be better equipped for successfully procuring grants and contracts with the department. The commissioner must create a framework to maintain equitable practices in grantmaking. The commissioner must consult with various stakeholders and groups and provide outreach, technical assistance to organizations and service providers. The commissioner must ensure that grant funds are prioritized and awarded to organizations within communities that have a higher proportion of identified communities.

Section 46 **(144.9981 – Climate resiliency)** requires the commissioner of health to implement a climate resilience program. The commissioner must manage a grant program for climate resiliency planning.

Section 47 **(145.361 – Long COVID)** requires the commissioner of health to establish a program to assess and monitor long COVID and related conditions, share information, and identify priority activities to address the needs to support survivors of long COVID or related conditions. The commissioner must award grants and enter into contracts to implement the identified priority activities.

Section 48 **(145.561 – 988 SUICIDE AND CRISIS LIFELINE)** requires the commissioner of health to oversee a lifeline center or network of lifeline centers to answer 988 contacts from people in Minnesota accessing the Suicide and Crisis Lifeline. Establishes monthly fee on cell phone and landline bills. The fee pays for the lifeline.

Section 49 **(145.87, subdivision 4 - Administration)** allows the commissioner of health to use appropriations for the home visit program to provide training, technical assistance, administration, and evaluation of the program.

Section 50 **(145.9011 – FETAL AND INFANT DEATH STUDIES)** allows the commissioner of health to conduct fetal and infant death studies. The commissioner must be provided with access to data from various sources, including data from medical records, health records, and social support services records. Classifies data and provides for maintaining and destroying data. Allows the commissioner to convene case review committees to conduct death study reviews.

Section 51 **(145.903 – SCHOOL-BASED HEALTH CENTERS)** requires the commissioner of health to provide grants to school districts and school-based health centers to support existing centers and facilitate new centers. School-based health centers may provide a variety of services but must not replace daily student support provided in the school.

Section 52 **(145.924 – HIV Prevention Grants)** allows the commissioner of health to award grants to organizations that provide services to additional populations at risk for acquiring HIV. The commissioner must administer a grant program to assist with HIV outbreaks.

Section 53 **(145.9275 – SKIN-LIGHTENING PRODUCTS PUBLIC AWARENESS AND EDUCATION GRANT PROGRAM)** requires the commissioner of health to award grants to organizations to conduct public awareness and education activities that are culturally specific and community-based and focus on the health dangers associated with using skin-lightening products, developing training curriculum, and combat skin-lightening practices and chemical exposure.

Section 54 **(145.9571 – HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT)** establishes the Healthy Beginnings, Healthy Families Act, which includes sections 54 to 59.

Section 55 **(145.9572 – MINNESOTA PERINATAL QUALITY COLLABORATIVE)** establishes the Minnesota perinatal quality collaborative to improve pregnancy outcomes for pregnant people and newborns. Authorizes grants.

Section 56 **(145.9573 – MINNESOTA PARTNERSHIP TO PREVENT INFANT MORTALITY)** requires the commissioner of health to establish the Minnesota partnership to prevent infant mortality program to improve birth outcomes and eliminate preventable infant mortality.

Section 57 **(145.9574 – GRANTS)** requires the commissioner of health to make grants to improve pregnancy and infant outcomes and improve infant health. Requires the commissioner to provide grant recipients with technical assistance.

Section 58 **(145.9575 – DEVELOPMENTAL AND SOCIAL-EMOTIONAL SCREENING WITH FOLLOW-UP)** establishes goals of developmental and social-emotional screening. Requires the commissioner of health to undertake specified duties related to screenings. Authorizes a grant.

Section 59 **(145.9576 – MODEL JAIL PRACTICES)** allows the commissioner of health to make grants to counties to implement model jail practices and to counties, Tribal governments, or nonprofit organizations to partner with county jails to support children of incarcerated parents and their caregivers. Requires the commissioner to provide technical assistance.

Section 60 **(145.987 – HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL)** requires the commissioner to establish a health equity and leadership (HEAL) council to provide guidance to the commissioner on how to strengthen and improve the health of communities most impacted by health inequities across the state.

Section 61 **(145.988 – COMPREHENSIVE AND COLLABORATIVE RESOURCE AND REFERRAL SYSTEM FOR CHILDREN)** requires the commissioner to establish the comprehensive and collaborative resource and referral system (also called Help Me Connect) to support resources and referral systems for children from prenatal through 8 years-old.

Section 62 to 64 **(145A.131, subdivisions 1, 2, and 5)** requires funding for foundational public health to be distributed based on a formula developed by the commissioner and the State Community Health Services Advisory Committee. Updates a cross-reference. Requires funding for foundational public health responsibilities to be used to fulfil responsibilities defined by the commissioner in consultation with the State Community Health Services Advisory Committee.

Section 65 **(145A.14, subdivision 2b – Grants to Tribes)** requires the commissioner of health to distribute grants to Tribal governments four foundational health responsibilities as defined by each Tribal government.

Section 66 **(256B.0625, subdivision 49 – Community health worker)** requires certain community health workers to complete a training program in Alzheimer's disease and dementia care.

Section 67 **(259.83, subdivision 1 – Services provided)** requires an adoption agency to provide information to adoptive parents, birth parents, and adults who were adopted about the right to obtain birth records.

Section 68 to 69 (**259.83, subdivisions 1a and 1b)** amend terminology to be consistent with other sections relating to adoptions. Refers to a person who is 18 years of age instead of a person who is at least 19 years old.

Section 70 **(259.83, subd. 3a – Birth parent identifying information)** when an adult who was adopted makes a written request, the adoption agency who handled the adoption must provide specified information from the person's original birth record. This applies when the adopted person does not have a record of live birth registered in this state.

Section 71 **(260C.317, subdivision 4 – Rights of terminated parent)** requires a court, at the time parental rights are terminated, to provide written notice that the person may file a contact preference form with the state registrar. Strikes other notification requirements consistent with other changes made in this article.
Section 72 to 79 impose a monthly fee on prepaid wireless services to fund the 988 suicide and crisis lifeline. The fee is imposed and collected in the same manner as the E911 fee.

Section 80 **(MORATORIUM ON CONVERSION TRANSACTIONS)** extends the moratorium on for-profit HMOs to 2026, requiring such entities to maintain non-profit status under chapter 317A.

Section 81 **(Membership terms; palliative care advisory council)** specifies that the term for members of the Palliative Care Advisory Council is three years.

Section 82 **(Study of the development of a statewide registry for provider orders for life-sustaining treatment)** requires the commissioner of health to develop recommendations for a statewide registry of provider order for life-sustaining treatment (POLST) forms. The commissioner must create an advisory committee to advise the commissioner.

Section 83 **(Direction to the commissioner; Alzheimer's public information program)** requires the commissioner of health to make available information on Alzheimer's disease and dementia awareness. To the extent possible, the commissioner must implement a statewide public information campaign using these materials.

Section 84 **(Moratorium on green burials; study)** places a two-year moratorium on green burials. Requires the commissioner of health to study the environmental and health impacts of green burials and develop recommendations for green burials to prevent environmental harm.

Section 85 **(Adoption law changes; public awareness campaign)** requires the commissioner of human services to provide information to adopted persons and birth parents about the adoption law changes in this act. The commissioner must also provide notice of the changes on the department's website.

Section 86 **(Emmett Louis Till victims recovery program)** requires the commissioner of health to establish the Emmett Louis Till Victims Recovery Program to address the health and wellness needs of victims, and their families and heirs, of trauma based on the victim's race, ethnicity, or national origin. The commissioner must award grants to provide services to victims, families, and heirs.

Section 87 **(Employee safety and security grants)** requires the commissioner of health to establish a grant program for grants to health care entities to increase employee safety or security.

Section 88 **(Equitable health care task force)** requires the commissioner of health to establish an equitable health care task force to examine inequities in how people access and receive health care based on specified factors.

Section 89 **(RULEMAKING AUTHORITY)** requires the commissioner of health to adopt rules to implement the requirements on the installation of submerged closed loop heat exchanger systems.

Section 90 **(REPORT; CLOSED LOOP HEAT EXCHANGER SYSTEM)** requires the commissioner of health to submit a report to the legislature by December 31, 2024. The report must include a recommendation on whether additional requirements are needed to ensure the safety of closed loop heat exchanger systems.

Section 91 **(CLOSED LOOP HEAT EXCHANGER SYSTEM MONITORING AND REPORTING)** requires the owner of a closed loop heat exchanger system owner to monitor and report to the commissioner on specified information. The commissioner must evaluate whether additional permit conditions are necessary to ensure the safety of such systems.

Section 92 **(Repealer)**, paragraph (a) repeals the sunset date for the palliative care advisory council. Paragraph (b) repeals provisions relating to adoption and birth records.

ARTICLE 5

MEDICAL EDUCATION AND RESEARCH COSTS

Section 1 **(62J.692, subdivision 1 – Definitions)** amends definition related to medical education. Includes pharmacy and dental students and residents in the definition of "clinical medical education program." Amends definition of "eligible trainee FTE's" to include training that occurs as part of or under the scope of practice in inpatient or ambulatory patient care settings as opposed to happening in those settings.

Section 2 **(62J.692, subdivision 3 – Application process)** requires a clinical medical education program to include training hours in settings outside of a hospital or clinic site in order to be eligible for medical education funding. Strikes specific information required for application for medical education funds and replaces the stricken language with a requirement that the commissioner determine the timeline and the necessary information for an application.

Section 3 **(62J.692, subdivision 4 – Distribution of funds)** modifies the distribution methodology for payments from the medical education and research cost (MERC) account to clinical medical education programs. Requires that payments under this section are for eligible sites that do not receive the MERC rate factor under 256.969, subdivision 2b, paragraph (k)

(long-term hospitals, rehabilitation hospitals, and other acute care hospitals other than critical access hospitals), or 256B.75, paragraph (b) (critical access hospitals). Requires that undistributed funds be returned to the MERC fund and may be used in the subsequent distribution cycle. Requires any money appropriated from any source other than the MERC account in the special revenue fund be distributed to non-hospital training sites.

Section 4 **(62J.692, subdivision 5 – Report)** modifies the requirements for the medical education grant verification reports (GVRs).

Section 5 **(62J.692, subdivision 8 – Federal financial participation)** requires the commissioner of human services to seek federal financial participation (FFP) in the payments from the MERC account funded by the cigarette tax.

Section 6 **(144.1501, subdivision 2 – Creation of account)** amends a provision that establishes a health professional education loan forgiveness program account by striking a cross-reference to a repealed statute and replacing the cross-reference with the current statute on assisted living facilities.

Section 7 **(144.1501, subdivision 3 – Eligibility)** amends eligibility for the health professional education loan forgiveness program by including individuals who are obtaining required supervised hours.

Section 8 **(144.1506, subdivision 4 – Consideration of expansion grant applications**) creates a fifth psychiatry resident position in the state.

Section 9 **(144.1507 – PEDIATRIC PRIMARY CARE MENTAL HEALTH TRAINING GRANT PROGRAM)** establishes the pediatric primary care mental health training grant program. Grants must be awarded for developing child mental health training programs located in outpatient primary care clinics.

Section 10 **(144.1511 – MENTAL HEALTH CULTURAL COMMUNITY CONTINUING EDUCATION GRANT PROGRAM)** establishes the mental health cultural community continuing education grant program. Grants must be awarded for continuing education necessary for specified mental health professionals to become supervisors for others pursuing licensure in a metal health profession.

Section 11 **(144.1913 – CLINICAL DENTAL EDUCATION INNOVATION GRANTS)** requires the commissioner of health to award clinical dental education innovation grants to teaching institutions and clinical training sites for projects that increase dental access to underserved population and promote innovative clinical training.

Section 12 **(144.88 – MENTAL HEALTH AND SUBSTANCE USE DISORDER EDUCATION CENTER)** establishes the Mental Health Substance Use Disorder Education Center in the Department of Health. The Center must work to increase the number of professionals and the diversity of professionals working in mental health and substance use disorder treatment and facilitate a culturally informed and responsive mental health and substance use disorder treatment workforce.

Section 13 **(145.9272 – FEDERALLY QUALIFIED HEALTH CENTERS APPRENTICESHIP PROGRAM)** requires the commissioner of health award a grant to a nonprofit organization of community health centers to establish apprenticeship programs for medical and dental assistants in federally qualified health centers.

Section 14 **(245.4663, subdivision 4 – Allowable uses of grant funds)** allows a mental health provider to use mental health provider supervision grant proceeds to provide a weekend training program for workers to become supervisors.

Section 15 **(245.4664 – MENTAL HEALTH PROFESSIONAL SCHOLARSHIP GRANT PROGRAM)** establishes the mental health professional scholarship program in the Department of Human Services to assist mental health providers in funding employee scholarships for master's degree-level education programs to create a pathway to becoming a mental health professional.

Section 16 **(256.969, subdivision 2b – Hospital payment rates)** requires the commissioner to include MERC distributions from the MERC account in the inpatient rates for long-term care hospitals, rehabilitation hospitals and non-critical access acute care hospitals.

Section 17 **(256B.75 – Hospital outpatient reimbursement)** requires the commissioner to include MERC distributions from the MERC account in the outpatient rates for critical access acute care hospitals.

Section 18 **(297F.10, subdivision 1 – Tax and use tax cigarettes)** reduces the annual statutory appropriation to the MERC account from the cigarette tax by 3.78% from $3,937,000 to $3,788,000.

Section 19 **(Repealer)** repeals an alternative MERC distribution plan, a distribution of medical education funding dependent on a federally prohibited practice of including medical education costs in managed care rates, a dental education grant, and the federally prohibited practice of including medical education costs in managed care rates.

ARTICLE 6

HEALTH LICENSING BOARDS

Section 1 **(144E.001, subdivision 1 – Scope)** makes a technical change.

Section 2 **(144E.001, subdivision 8b – Medical resource communication center)** defines "medical resource communication center."

Section 3 **(144E.35 – Reimbursement to ambulance services for volunteer education costs)** increases the maximum reimbursement amounts for volunteer ambulance attendant education costs.

Section 4 **(144E.53 – MEDICAL RESOURCE COMMUNICATION CENTER GRANTS)** authorized EMSRB to makes grants to medical resource communication centers.

Section 5 **(148.635 – FEE)** establishes a $20 nonrefundable license verification fee for dietitians and nutritionists.

Section 6 **(148B.392, subdivision 2 – Licensure and application fees)** increases license and application fees imposed by the board of marriage and family therapy.

Section 7 to 8 updates the terminology to refer to "dental assistants."

Section 9 **(150A.091, subdivision 23 – Mailing list services)** requires a person licensed by the Board of Dentistry to submit a nonrefundable $5 fee to request a mailing address list.

Section 10 **(150A.13, subdivision 10 – Failure to report)** strikes an obsolete date in a provision that requires reports to the Board of Dentistry.

Section 11 **(151.065, subdivision 1 – Application fee)** increases application fees imposed by the Board of Dentistry.

Section 12 **(151.065, subdivision 2 – Original license fee)** increases the original license fees for pharmacists.

Section 13 **(151.065, subdivision 3 – Annual renewal fees)** increases the annual licensure and registration fees collected by the Board of Pharmacy.

Section 14 **(151.065, subdivision 4 – Miscellaneous fees)** increases fees collected by the Board of Pharmacy for issuing affidavits and duplicate licenses.

Section 15 **(151.065, subdivision 6 – Reinstatement fees)** increases the maximum reinstatement fee for pharmacy technicians.

Section 16 **(151.555 – Medication repository program)** renames the prescription drug repository program as the medication repository program. Provides requirements for the contract between the Board of Pharmacy and a central repository to include: 1) a requirement that the board transfer to the central repository any money appropriated to the board for the purpose of the program; 2) reporting on performance measures; and 3) a requirement to annually audit the central repository's expenditures. Allows a central repository to seek grants and funds from non-state sources.

Section 17 **(151.74, subdivision 3 – Access to urgent-need insulin)** allows an individual who is in urgent need of insulin to provide an individual taxpayer identification number as proof of residency.

Section 18 **(151.74, subdivision 4 – Continuing safety net program; general)** allows an individual seeking to participate in a manufacturer's patient insulin assistance program to provide an individual taxpayer identification number as proof of residency.

Section 19 **(152.126, subdivision 4 – Reporting requirements; notice)** amends the prescription monitoring program. Specifies when a dispenser is not required to submit data. Allows a

dispenser to provide notice of the reporting requirements to a patient's authorized representative. Dispensers must submit accurate information to the database in a timely manner.
Section 20 **(152.126, subdivision 5 – Use of data by board)** makes clarifying changes. Specifies that data reported for prescriptions dispensed on or after January 1, 2020, must be destroyed no later than 12 months from the date the prescription was reported.

Section 21 **(152.126, subdivision 6 – Access to reporting system data)** modifies who may access data in the prescription monitoring system. Allows licensed dispensing practitioners or licensed pharmacists to access the data to determine whether corrections made are accurate. Amends the provision related to authorized personnel of a vendor to refer to authorized personnel under contract with the board or the state who are approved by the board to access the data. Allows Board of Pharmacy personnel to access data to conduct an investigation of a specific licensee or registrant.

Section 22 **(152.126, subdivision 9 – Immunity from liability)** amends the immunity provisions. Strikes the language regarding a pharmacist or prescriber not seeking or obtaining information from the prescription monitoring program. Specifies that the immunity from liability does not extend to the requirements to access the data on patients receiving an opiate.

Section 23 **(Licensed traditional midwives; authority to purchase certain drugs)** requires the Board of Medical Practice to consult with the Advisory Council on Licensed Traditional Midwifery to either issue an administrative order to allow midwives to purchase specified drugs or to make recommendations to the legislature on how to amend statute to allow midwives to purchase specified drugs.

ARTICLE 7

BACKGROUND STUDIES

Section 1 **(13.46, subd. 4 – Licensing data)** removes the reason for a disqualification from being public data and changes, after a disqualification is affirmed, the reason for a disqualification and the reason to not set aside the disqualification to be private data rather than public.

Section 2 **[245C.02, subd. 7a – Conservator]** adds a definition of "conservator" to background studies chapter.

Section 3 **[245C.02, subd. 11f – Guardian]** adds a definition of "guardian" to background studies chapter.

Section 4 **(245C.02, subd. 13e – NETStudy 2.0)** adds that the NETStudy 2.0 system is designed to increase efficiencies and the speed of the hiring process by providing electronic access to certain notices for entities and background study subjects.

Section 5 **(245C.03, subd. 1 – Licensing programs)** clarifies that the commissioner of human services shall conduct background studies for treatment programs for persons with sexual psychopathic personality or sexually dangerous persons.

Section 6 **(245C.03, subd. 1a – Procedure)** states that all data obtained by the commissioner of human services for a background study is classified as private data on individuals.

Section 7 **(245C.031, subd. 1 – Alternative background studies)** states that all data obtained by the commissioner of human services for a background study is classified as private data on individuals.

Section 8 **[245C.033 - GUARDIANS AND CONSERVATORS; MALTREATMENT AND STATE LICENSING AGENCY CHECKS]**

> **Subdivision 1** requires requests for maltreatment data to include information regarding whether the guardian or conservator has been a perpetrator of substantiated maltreatment of a vulnerable adult or minor, and if so, requires the commissioner to include a copy of any available public portion of the investigation memorandum.
>
> **Subdivision 2** requires requests for state licensing agency data to include information from a check of state licensing agency records and that the commissioner must provide the court with licensing agency data related to specific affiliations.
>
> **Subdivision 3** requires maltreatment and licensing agency checks to be submitted by the guardian or conservator to the commissioner of human services.
>
> **Subdivision 4** states that all data obtained by the commissioner of human services for a background study is classified as private data on individuals.

Section 9 **(245C.04, subd. 1 – Licensed programs; other child care programs)** modifies background study requirements for legal nonlicensed child care providers.

> **Paragraph (c)** requires an individual to provide certain information to the commissioner of human services, and be fingerprinted and photographed, at reauthorization or when a new background study is needed for a legal nonlicensed child care provider. Requires the commissioner to verify the information received and submit the request in NETStudy 2.0.
>
> **Paragraph (d)** removes legal nonlicensed child care providers from requirements for family child care license reapplications and requires the commissioner to submit any requests received in NETStudy 2.0.

Section 10 **(245C.05, subd. 1 – Individual studied)** requires a background study subject who has access to the NETStudy 2.0 applicant portal to provide updated contact information any time the subject’s personal information changes. Also requires an entity to update contact information in NETStudy 2.0 for a subject on that entity’s roster any time the entity receives new contact information for that subject.

Section 11 **(245C.05, subd. 2c – Privacy notice to background study subject)** removes from the notice provided to an agency initiating a background study the reason for a background study subject’s disqualification and information on the decision to set-aside the disqualification.

Section 12 **(245C.05, subd. 4 – Electronic transmission)** removes mention of legal nonlicensed child care providers and requires background study subjects to access background study-related documents electronically.

Section 13 **(245C.08, subd. 1 – Background studies conducted by Department of Human Services)** states that a background study required for treatment programs for sexual psychopathic personalities or sexually dangerous persons shall only include a review of certain information, including information already received by the commissioner, information from juvenile courts, and information from the Bureau of Criminal Apprehension.

Section 14 to 32; 45 **(245C.10, subd. 2-6, 8-14, 16-17, 20-22; 245C.32, subd. 2)** increase fees for background studies conducted by the Department of Human Services.

Section 33 **(245C.15, subd. 2 – 15-year disqualification)** adds specific drug sale crimes into offenses that are subject to a 15-year disqualification and removes language that included all felony-level drug crimes under chapter 152 and felony-level convictions involving alcohol or drug use.

Section 34 **[245C.15, subd. 4b – Five-year disqualification]** proposes a new category for five-year disqualifications.

> **Paragraph (a)** lists the following new offenses to be included in the five-year disqualification category:
>
> - 152.021, subd. 2 or 2a (controlled substance possession crime in the first degree; methamphetamine manufacture crime)
> - 152.022, subd. 2 (controlled substance possession crime in the second degree)
> - 152.023, subd. 2 (controlled substance possession crime in the third degree)
> - 152.024, subd. 2 (controlled substance possession crime in the fourth degree)
> - 152.025 (controlled substance crime in the fifth degree)
> - 152.0261 (importing controlled substances across state borders)
> - 152.0262 (possession of substances with intent to manufacture methamphetamine)
> - 152.027, subd. 6, paragraph (c) (sale of synthetic cannabinoids)
> - 152.096 (conspiracy to commit controlled substance crime)
> - 152.097 (simulated controlled substances)
> - 152.137 (methamphetamine-related crimes involving children and vulnerable adults)
>
> **Paragraph (b)** provides that an individual is disqualified is less than five years have passed since the individual aided and abetted, attempted, or conspired to commit any offenses under paragraph (a).
>
> **Paragraph (c)** provides that an individual is disqualified if less than five years have passed since the discharge of a sentence imposed in another state or country for an offense whose elements are substantially similar to the elements of any offenses listed under paragraph (a).

Paragraph (d) provides varying disqualification start dates for a judicial determination other than a conviction, an admission, an Alford Plea, or a preponderance of evidence of a disqualifying act.

States the section is effective date for all background studies requested on or after August 1, 2024.

Section 35 **(245C.17, subd. 2 – Disqualification notice sent to subject)** removes a notice being provided to the entity that initiated a background study on why a disqualified individual's disqualification is set aside and removes requirement that that individual's identity and reason for disqualification become public data.

Section 36 **(245C.17, subd. 3 – Disqualification notification)** removes requirement that a disqualified individual must provide a copy of the individual's notice of disqualification prior to being in a position allowing direct contact with persons receiving services.

Section 37 **(245C.17, subd. 6 – Notice to county agency)** removes legal nonlicensed child care providers from list of entities that also require a county agency to be notified for background studies.

Section 38 **(245C.21, subd. 1a – Submission of reconsideration request)** requires that a reconsideration request be submitted within 30 days of the individual's receipt of the disqualification notice.

Section 39 **(245C.21, subd. 2 – Time frame for requesting reconsideration)** changes the time period for when an individual must submit a request for reconsideration from within 15 days to within 30 days of an individual's receipt of the notice of disqualification.

Section 40 **(245C.22, subd. 7 – Classification of certain data)** makes data relating to the

grant of a set aside and data relating to the grant of a variance private data, rather than public.

Section 41 **(245C.23, subd. 1 – Disqualification that is rescinded or set aside)** modifies certain notice information for when a disqualification is set aside.

Paragraph (c) removes the ability of license holder to be informed of the factors that were the basis of the disqualification being set aside without the consent of the background study subject.

Paragraph (d) removes the requirement that the commissioner inform the applicant, license holder, or other entity that a disqualifying criminal record is sealed under a court order.

Paragraph (e) makes a conforming change by removing language related to paragraph (c).

Section 42 **(245C.23, subd. 2 – Commissioner's notice of disqualification that is not set aside)** removes legal nonlicensed child care providers from list of entities that also require a county to be notified on the results of a reconsideration.

Section 43 **(245C.24, subd. 2 – Permanent bar to set aside a disqualification)** allows the commissioner of human services to set aside or grant a variance for any disqualification that is based on conduct in an individual's juvenile record.

Section 44 **(245C.30, subd. 2 – Disclosure of reason for disqualification)** removes permission for the reason a variance is granted to be disclosed to a license holder without the disqualified individual's consent.

Section 46 **(524.5-118 – MALTREATMENT AND STATE LICENSING AGENCY CHECKS; CRIMINAL HISTORY CHECK)** makes conforming changes to allow maltreatment and state licensing checks to remain at the Department of Human Services, while allowing guardian and conservator checks to move to the Bureau of Criminal Apprehension.

Section 47 **[REPEALER]** repeals statutory provisions related to public law background studies that are no longer needed when the Department of Humans Services obtains fingerprint-based criminal history checks from the Bureau of Criminal Apprehension. Also repeals a statutory provision related to legal nonlicensed child care providers.

ARTICLE 8

LICENSING

Section 1 **(119B.16, subd. 1a – Fair hearing allowed for providers)** allows a provider to request a fair hearing unless the provider is entitled to an administrative review or a contested case hearing.

Section 2 **(245.095 - LIMITS ON RECEIVING PUBLIC FUNDS)**

> **Subdivision 1** expands the commissioner's authority to exclude associated individuals and entities associated with individuals and entities excluded from programs and grants administered by the commissioner.
>
> **Subdivision 2** adds definitions of "associated entity" and "associated individual" and modifies definitions of "excluded" and "provider."
>
> **Subdivision 3** adds a notice requirement prior to excluding someone or an organization from programs administrated by the commissioner.
>
> **Subdivision 4** adds appeal rights for those excluded from programs administered by the commissioner.
>
> **Subdivision 5** expands the commissioner's authority to withhold payments from those excluded from programs administered by the commissioner.

Section 3 **[245.7351 - PURPOSE AND ESTABLISHMENT]** creates a certified community behavioral health clinic (CCBHC) model of integrated payment and mental health service delivery.

Section 4 **[245.7352 - DEFINITIONS]** provides definitions related to the CCBHC model.
Section 5 **[245.7353 - APPLICABILITY]** requires the Department of Human Services to establish a state certification process for certified community behavioral health clinics.

Section 6 **[245.7354 - MINIMUM STAFFING STANDARDS]** establishes minimum staffing standards for CCBHCs.

Section 7 **[245.7355 - REQUIRED SERVICES]** establishes required CCBHC services.
Section 8 **[245.7356 - REQUIRED EVIDENCE-BASED SERVICES]** requires a CCBHC must use evidence-based practices in all services.

Section 9 **[245.7357 - DESIGNATED COLLABORATING ORGANIZATION]** permits a CCBHC to contract with a collaborating organization to provide non-core services.

Section 10 and 20 to 24 implement a continuous license for family child care providers.

Section 11 to 19; 27; 29 to 34; 36 to 41 implement a provider licensing and reporting hub.

Section 26 **(245G.03, subdivision 1 – License requirements)** requires a licensed SUD treatment program that is also a part of a CCBHC to satisfy the assessment and treatment plan for a CCBHC.

Section 35 **(245I.011, subdivision 3 - Certification required)** requires a licensed mental health program that is also a part of a CCBHC to satisfy the assessment and treatment plan for a CCBHC.

Section 42 **[DIRECTION TO COMMISSIONER OF HUMAN SERVICES; TRANSITION TO LICENSURE]** directs the commissioner to transition certain mental health services from certification under Minnesota Statutes, chapters 245 and 256B, to licensure under Minnesota Statutes, chapter 245A, on or before January 1, 2026.

ARTICLE 9

BEHAVIORAL HEALTH

Section 1 **(245.0961 - African American Behavioral Health Grant Program)** establishes an African American Behavioral Health grant program to offer culturally specific, comprehensive, trauma-informed, practice- and evidence-based, person- and family-centered mental health and substance use disorder treatment services.

Section 2 **(245.4889, subd. 1 – Establishment and authority)** allows emerging mood disorder services and a public awareness campaign to be eligible for grant funding under children's mental health grants.

Section 3 **(245.4903 - Cultural and Ethnic Minority Infrastructure Grant Program)** establishes a cultural and ethnic minority grant program to ensure that mental health and

substance use disorder treatment supports and services are culturally specific and culturally responsive.

Section 4 **(245.4904 - Emerging Mood Disorder Grant Program)** establishes an emerging mood disorder grant program to fund interventions for youth and young adults who are at risk of developing a mood disorder or experiencing an emerging mood disorder. Also provides for a public awareness campaign on the signs and symptoms of mood disorders in youth and young adults.

Section 5 **(245.735, subd. 3 – Certified community behavioral health clinics)** requires the commissioner of human services to establish a state recertification process for certified community behavioral health clinics, provides specific criteria the commissioner must follow, and requires the commissioner to allow a transition period.

Section 6 **(245.735, subd. 6 – Section 223 Protecting Access to Medicare Act entities)** requires the commissioner of human services to request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act, and if approved, continue participating in the demonstration for as long as federal funding is available.

Section 7 **[245.735, subd. 7 – Addition of CCHBCs to section 223 state demonstration programs]** requires the commissioner of human services to follow all federal guidance for the addition of CCBHCs to section 223 state demonstration programs and requires clinics to meet certain criteria prior to participating.

Section 8 **(254B.02, subd. 5 – Local agency allocation)** sets an allocation floor for county and Tribal behavioral health fund administrative assessments to be no less than 133 percent of the 2009 funding levels.

Section 9 **[256B.0941, subd. 5 – Start-up and capacity-building grants]** establishes start-up and capacity-building grants for psychiatric residential treatment facility sites.

Section 10 **[DIRECTION TO COMMISSIONER; CHANGES TO RESIDENTIAL ADULT MENTAL HEALTH PROGRAM LICENSING REQUIREMENTS]** directs the commissioner of human services to consult with stakeholders to determine the changes to residential adult mental health program licensing requirements.

Section 11 **[LOCAL AGENCY SUBSTANCE USE DISORDER ALLOCATION]** requires the commissioner of human services to evaluate the ongoing need for local agency substance use disorder allocations and develop recommendations on whether such allocations should continue, and if so, make recommendations for the purpose of the allocations and propose an updated methodology.

Section 12 **[MOBILE CRISIS AND STABILIZATION SERVICES PILOT]** establishes a mobile crisis and stabilization services pilot program to promote access to crisis response services. Requires an immediate, face-to-face response within 60 minutes as well as longer-term supports.

Section 13 **[RATE INCREASE FOR MENTAL HEALTH ADULT DAY TREATMENT]** requires the commissioner of human services to increase the reimbursement rate for adult day treatment services by 50 percent over the reimbursement rate in effect as of June 30, 2023.

ARTICLE 10

ECONOMIC ASSISTANCE

Section 1 and 4; 7; 17 to 22; 24 and 25; 27 and 28; 30 and 31; 39; 41; 45 to 47; 49 to 59; 63 set the budget period for MFIP and certain general assistance cases at six months.

Section 2 **(256D.01, subd. 1a – Standards)** aligns the monthly general assistance community assistance rate with the Minnesota Family Investment Program (MFIP) one-person transitional assistance standard and its annual cost of living adjustment.

Section 3 **(256D.024, subd. 1 – Person convicted of drug offenses)** allows persons convicted of felony-level drug offenses during the previous ten years to remain eligible for economic assistance programs but provides they may be subject to random drug testing. Requires a county to provide information on substance use disorder treatment programs to a person who tests positive for an illegal controlled substance. Modifies the definition of "drug offense" to apply only to convictions during the previous ten years.

Section 5 **(256D.06, subd. 5 – Eligibility; requirements)** increases the time a person receiving general assistance or housing support to apply for supplemental security income from 30 days to 90 days.

Section 6 **(256D.44, subd. 5 – Special needs)** changes the representative payee fee for recipients of Minnesota supplemental aid from ten percent of a recipient's gross income or $25 to the maximum monthly amount allowed by the Social Security Administration.

Section 8 **(256E.34, subd. 4 – Use of money)** allows money distributed to food shelf programs to be used to purchase personal hygiene products.

Section 9 **[256E.342 - AMERICAN INDIAN FOOD SOVEREIGNTY FUNDING PROGRAM]** establishes an American Indian food sovereignty funding program to improve access and equity to food security programs within Tribal and American Indian communities.

Section 10 **(256E.35, subd. 1 – Establishment)** adds emergencies to list of what families can save towards as part of the Minnesota family assets for independence initiative (FAIM).

Section 11 **(256E.35, subd. 2 – Definitions)** removes the seven-county metropolitan area limitation from the definition of fiduciary organization under the family assets for independence statute and adds federally recognized Tribal nations and nonprofits organizations to the definition. Also adds contributions to emergency savings accounts and Minnesota 529 savings plans as permissible uses.

Section 12 **(256E.35, subd. 3 – Grants awarded)** allows the commissioner of human services to expend appropriated funds on an evaluation of FAIM.

Section 13 **(256E.35, subd. 4a – Financial coaching)** adds "credit building" to list of financial education a financial must provide and adds saving for emergencies or a child's education to the training a financial coach is required to provide to FAIM participants.

Section 14 **(256E.35, subd. 6 – Withdrawal; matching; permissible uses)** increases the lifetime matching limit from $6,000 to $12,000 for FAIM participants. Also increases the lifetime limit for matching contributions from state grant and TANF funds and nonstate funds from $3,000 to $6,500.

Section 15 **(256E.35, subd. 7 – Program reporting)** adds the amount of contributions made to Minnesota 529 savings plans and emergency savings accounts to the quarterly report provided by fiscal agents of fiduciary organizations participating in the family assets for independence initiative.

Section 16 **(256I.03, subd. 7 – Countable income)** changes the definition of countable income to 30 percent of a recipient's unearned income, after allowable exclusions and disregards, for recipients who live in a housing support community-based setting.

Section 23 **(256J.11, subd. 1 – General citizenship requirements)** modifies citizenship eligibility for MFIP by allowing a nonimmigrant who are victims of a severe form of trafficking in persons or who suffered substantial physical or mental abuse as a result of having been a victim of certain criminal activities to be eligible.

Section 26 **(256J.26, subd. 1 – Person convicted of drug offense)** states persons who are applicants for MFIP benefits or receiving supplemental nutrition assistance program (SNAP) benefits and who are convicted of felony-level drug offenses during the previous ten years may be subject to random drug testing. Requires a county to provide information on substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

Section 29 **(256J.35 - AMOUNT OF ASSISTANCE PAYMENT)** requires the commissioner of human services to adjust the MFIP housing assistance payment for inflation based on the consumer price index for the prior calendar year.

Section 32 **(256J.425, subd. 1 – Eligibility)** removes the requirement that a participant must be in compliance in the participant's 60th counted month in order to be eligible for a hardship extension.

Section 33 **(256J.425, subd. 4 – Employed participants)** removes the requirement that a participant must be in compliance for at least ten out of the 12 months the participant received MFIP benefits in order to be eligible for a hardship extension. Modifies the sanction for failing to meet the requirements with case closure rather than permanent disqualification.

Section 34 **(256J.425, subd. 5 – Accrual of certain exempt months)** removes the requirement that a participant receiving extended MFIP assistance is subject to the MFIP policies that apply to participants during the first 60 months of receiving MFIP benefits.

Section 35 **(256J.425, subd. 7 – Status of disqualified participants)** updates "disqualification" language to "closed cases" and removes hardship extension language for assistance units.

Section 36 **(256J.46, subd. 1 – Participants not complying with program requirements)**

> **Paragraph (a)** removes reference to "this chapter" for when a participant fails to comply with certain requirements and instead references orientation and employment and training services. States good cause may only be granted for the month for which the good cause reason applies.
>
> **Paragraph (b)** removes requirement that a sanction must not be imposed when a participant comes into compliance with the requirements for employment and training services.
>
> **Paragraph (c)** modifies when sanctions for noncompliance are imposed.
>
> **Paragraph (d)** clarifies that the seventh occurrence of noncompliance must be consecutive.
>
> **Paragraph (e)** provides that after May 1, 2026, only consecutive occurrences of noncompliance shall be considered when counting the number of sanction occurrences. Provides that active cases under sanction on May 1, 2026, are considered to have one sanction occurrence.
>
> **Paragraph (f)** allows an assistance unit whose case is closed to reapply for MFIP on a form prescribed by the commissioner and prohibits a county agency from starting a new certification period for a participant who submitted a reapplication within 30 calendar days from case closure.
>
> **Paragraph (g)** removes references to noncompliance.
>
> **Paragraph (h)** allows an assistance unit who is in compliance by the 15th of the month when a sanction was imposed to have their cash grant reduction restored retroactively.

Section 37 **(256J.46, subd. 2 – Sanctions for refusal to cooperate with support requirements)** removes language relating to occurrences of noncooperation and references subdivision 1.

Section 38 **(256J.46, subd. 2a – Dual sanctions)** removes references for sanctions due to noncompliance and noncooperation. Makes other conforming changes.

Section 40 **[256P.01, subd. 5a – Lived-experience engagement]** adds a definition of "lived-experience engagement" into economic assistance program eligibility and verification.

Section 42 **(256P.02, subd. 2 – Personal property limitations)** excludes income received from lived-experience engagement and family asset bank accounts and individual development accounts under FAIM from determination of the equity value of personal property for economic assistance program eligibility.

Section 43 **[256P.02, subd. 4 – Health and human services recipient engagement income]** excludes income received from lived-experience engagement from being part of the calculation when determining the equity value of personal property.

Section 44 **[256P.02, subd. 5 – Account exception]** requires family asset accounts and individual development accounts to be excluded when determining the equity value of personal property for economic assistance programs.

Section 47 **(256P.06, subd. 3 – Income inclusions)** modifies unearned income included in economic assistance program calculations and eliminates Tribal per capita payments and nonrecurring income from countable income when determining eligibility for economic assistance programs.

Section 48 **[256P.06, subd. 4 – Recipient engagement income]** prohibits income received from lived-experience engagement from being counted as income for the purposes of determining or redetermining eligibility or benefits in economic assistance programs.

Section 60 **(609B.425, subd. 2 – Benefit eligibility)** allows persons convicted of felony-level drug offenses during the previous ten years to remain eligible for general assistance and Minnesota supplemental aid but provides they may be subject to random drug testing. Requires a county to provide information on substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

Section 61 **(609B.435, subd. 2 – Drug offenders; random testing; sanctions)** states persons who are applicants for MFIP benefits and who are convicted of felony-level drug offenses may be subject to random drug testing. Requires a county to provide information on substance use disorder treatment programs to a person who tests positive for an illegal controlled substance.

Section 62 **[COUNTY WORKER TRAINING PROGRAM PILOT]** allows Anoka, Dakota, St. Louis, and Wright Counties to provide in-house training for the MAXIS eligibility system and Supplemental Nutrition Assistance Program.

ARTICLE 11

HOUSING AND HOMELESSNESS

Section 1 **(145.4716, subd. 3 – Youth eligible for services)** adds a citation to the new safe harbor and housing grant program established under section 6 of this article and makes a technical correction.

Section 2 **[245.1963 - CONTINUUM OF CARE GRANT PROGRAM]** establishes a continuum of care grant program to maintain funding for shelters and services provided to individuals experiencing homelessness.

Section 3 **[245.0965 - OLMSTED COUNTY HOMELESSNESS GRANT PROGRAM]** establishes a grant program to fund and support shelters and services for persons experiencing homelessness in Olmsted County.

Section 4 **[245.0966 - HENNEPIN COUNTY HOMELESSNESS GRANT PROGRAM]** establishes a grant program to maintain funding for shelters and services provided to individuals experiencing homelessness in Hennepin County.

Section 5 **(256I.04, subd. 1 – Individual eligibility requirements)** establishes presumptive eligibility for housing support for persons with disabilities leaving Minnesota prisons without stable housing for up to three months.

Section 6 **[256K.47 - SAFE HARBOR SHELTER AND HOUSING]** establishes a safe harbor shelter and housing grant program within the Department of Human Services to providers who are committed to serving sexually exploited youth and youth at risk of exploitation.

Section 7 **[256K.50 - FAMILY SUPPORTIVE HOUSING]** creates a family supportive housing program to offer family permanent supportive housing and to provide specialized family support services.

Section 8 **(Laws 2021, First Special Session chapter 7, article 17, section 5, subdivision 1 – Housing transition cost)** removes expiration date of March 31, 2024, and clarifies that eligible populations are those that are moving to their own homes from an institution or a provider-controlled setting.

Section 9 **[HOMELESS YOUTH CASH STIPEND PILOT PROJECT]** establishes a homeless youth cash stipend pilot project to provide a direct cash stipend to homeless youth in Hennepin and St. Louis Counties.

Section 10 **[HOUSING STABILIZATION SERVICES INFLATIONARY ADJUSTMENT]** requires the commissioner of human services to seek federal approval to apply biennial inflationary updates to housing stabilization services rates based on the consumer price index and also requires the commissioner to update the rates using the most recent data beginning January 1, 2024.

ARTICLE 12

CHILDREN AND FAMILIES

Section 1 to 6; 13 to 17; 19 and 20; 27 to 31 create the Department of Children, Youth, and Families, allows for rulemaking, directs transfers from the Departments of Human Services, Education, and Public Safety, and makes other conforming changes.

Section 7 **(119B.011, subd. 2 – Applicant)** expands the definition of "applicant" to include foster care families, relative custodians, and successor custodians or guardians in order for those persons to be eligible to receive child care assistance.

Section 8 **(119B.011, subd. 5 – Child care)** expands the definition of "child care" to include foster care families, relative custodians, and successor custodians or guardians in order for those persons to be eligible to receive child care assistance.

Section 9 **(119B.011, subd. 13 – Family)** expands the definition of "family" to include foster care families, relative custodians, and successor custodians or guardians, and their spouses, in order for those persons to be eligible to receive child care assistance.

Section 10 **(119B.03, subd. 4a – Temporary reprioritization)** reprioritizes funding priorities for the basic sliding fee program.

Section 11 **(119B.13, subd. 1 – Subsidy restrictions)** increases the maximum rate paid for child care assistance to be the greater of the 75th percentile of the 2021 child care provider rate survey or the rates in effect at the time of the update.

Section 12 **[119B.196 - FAMILY, FRIEND, AND NEIGHBOR GRANT PROGRAM]** establishes the family, friend, and neighbor grant program to promote children's social-emotional learning and health development, early literacy, and other skills.

Section 18 **[145.9285 - COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM]** establishes the community solutions for healthy child development grant program in the Department of Health to improve child development outcomes, reduce racial disparities, and promote racial and geographic equity.

Section 21 **[256E.341 - PREPARED MEALS FOOD RELIEF GRANTS]** establishes the prepared meals grant program to provide hunger relief to Minnesotans experiencing food insecurity and who have difficulty preparing meals due to limited mobility, disability, age, or limited resources to prepare their own meal.

Section 22 **[256E.38 - DIAPER DISTRIBUTION GRANT PROGRAM]** establishes a diaper distribution grant program for eligible applicants to provide diapers to underresourced families statewide.

Section 23 **[DIRECTION TO COMMISSIONER; ALLOCATING BASIC SLIDING FEE MONEY]** directs the commissioner of human services to allocate additional basic sliding fee child care money for 2025 to counties and Tribes to account for the change in the definition of "family."

Section 24 **[DIRECTION TO COMMISSIONER; COST ESTIMATION MODEL FOR EARLY CARE AND LEARNING PROGRAMS]** directs the commissioner of human services to develop a cost estimation model for early care and learning programs and requires the commissioner to consult with relevant stakeholders. Requires the commissioner to contract with an organization that has experience in developing these models and requires that a report be submitted to the legislature by January 30, 2025 on the development of the model.

Section 25 **[DIRECTION TO COMMISSIONER; INCREASE FOR MAXIMUM CHILD CARE ASSISTANCE RATES]** directs the commissioner of human services to allocate additional basic sliding fee child care money for 2024 to counties for the updated maximum rates.

Section 26 **[FIRST APPOINTMENTS AND TERMS FOR THE COMMUNITY SOLUTIONS ADVISORY COUNCIL]** requires the commissioner of health to appoint members to the Community Solutions Advisory Council by July 1, 2023, and must convene the first meeting by September 15, 2023. Provides other requirements for member terms and who may be appointed.

Section 32 **[REPEALER]** repeals the current basic sliding fee prioritization.

ARTICLE 13

CHILD CARE WORKFORCE

Section 1 and 4; 6 to 14; 20 and 21 implement a centralized provider registration for child care assistance program providers.

Section 2 **(119B.125, subd. 1 – Authorization)** removes a county from being able to authorize a provider chosen by an applicant and removes reauthorization language for legal nonlicensed child care providers.

Section 3 **(119B.125, subd. 1a – Background study required)** requires the commissioner to perform a background study rather than the county. Provides requirements for background studies conducted for legal nonlicensed child care providers at authorization and reauthorization.

Section 5 **(119B.125, subd. 2 – Persons who cannot be authorized)** requires providers to send necessary information to the commissioner rather than the county for background studies and modifies when a legal nonlicensed child care provider is not authorized under statute governing provider requirements.

Section 15 **(119B.19, subd. 7 – Child care resource and referral programs)** requires a child care resource and referral program to administer the child care one-stop regional assistance network and provide supports that allow individuals to obtain job skills training, career counseling, and job placement to begin a career path in child care.

Section 16 **[119B.252 - EARLY CHILDHOOD REGISTERED APPRENTICESHIP GRANT PROGRAM]** establishes the early childhood registered apprenticeship grant program to provide employment-based training and mentoring opportunities for early childhood workers.

Section 17 **[119B.27 - CHILD CARE RETENTION PROGRAM]** establishes a child care retention program to provide eligible child care programs with payments to improve access to

child care in Minnesota and to strengthen the ability of programs to recruit and retain qualified early educators.

Section 18 **[119B.28 - SHARED SERVICES GRANTS]** establishes a grant program to distribute money for the planning, establishment, expansion, improvement, or operation of shared services to allow family child care providers to achieve economies of scale.

Section 19 **[119B.29 - CHILD CARE PROVIDER ACCESS TO TECHNOLOGY GRANTS]** establishes a grant program for child care providers to access technology intended to improve the providers' business practices.

Section 22 **[DIRECTION TO COMMISSIONER; CHILD CARE AND EARLY EDUCATION PROFESSIONAL WAGE SCALE]** directs the commissioner of human services to develop a child care and early education professional wage scale.

Section 23 **[DIRECTION TO COMMISSIONER; TRANSITION CHILD CARE STABILIZATION GRANTS]** directs the commissioner of human services to continue providing child care stabilization grants through December 31, 2023.

Section 24 **[RECOGNIZING COMPARABLE COMPETENCIES TO ACHIEVE COMPARABLE COMPENSATION TASK FORCE]** establishes the Recognizing Comparable Competencies to Achieve Comparable Compensation Task Force to develop methods for incorporating competencies, experiences, and educational attainment into a compensation model for the early childhood workforce.

ARTICLE 14

CHILD SUPPORT, SAFETY, and PERMANENCY

Section 1 **[245.0962 - QUALITY PARENTING INITIATIVE GRANT PROGRAM]** establishes a quality parenting initiative grant program to implement quality parenting initiative principles and practices to support children and families experiencing foster care placements.

Section 2 **(256N.26, subd. 12 – Treatment of Supplemental Security Income)** removes the ability for a financially responsible agency to apply to be a payee for a child placed in foster care.

Section 3 **[256N.262 - FOSTER CHILDREN BENEFITS TRUST]** establishes the foster children benefits trust. Requires financially responsible agencies to apply to be the payee for a child for whom the agency is responsible and transfer all cash benefits received on behalf of that child to the Office of the Foster Youth Ombudsperson to be deposited in the trust. Allows for disbursements when a child turns 18 years old. Authorizes rulemaking.

Section 4 **[260.014 - FAMILY FIRST PREVENTION AND EARLY INTERVENTION ALLOCATION PROGRAM]** requires the commissioner of human services to allocate money

to counties and Tribes to provide prevention and early intervention services to help children remain at home.

Section 5 **[260.0141 - FAMILY FIRST PREVENTION SERVICES ACT KINSHIP NAVIGATOR GRANT PROGRAM]** establishes a grant program for kinship navigator services as outlined by the federal Family First Prevention Services Act.

Section 6 and 8; 10 to 23 implement an enhanced child protection response to reports of child sex trafficking by establishing a new non-caregiver sex trafficking assessment track.

Section 7 **(260C.007, subd. 6 – Child in need of protection or services)** modifies the definition of child in need or protection or services to state that parents of children reported to be in an emergency department or hospital setting due to mental health or disability who cannot be safely discharged must not be viewed as unable or unwilling to provide care unless other factors are present.

Section 9 **(260C.80, subd. 1 – Office of the Foster Youth Ombudsperson)** provides that the ombudsperson may be removed from office only for just cause.

Section 24 **(518A.31 - Social Security or Veterans' Benefit Payments Received on Behalf of the Child)** allows any regular or lump sum payment of Social Security or apportioned veterans' benefit received for the benefit of the joint child to be used to satisfy arrears upon a motion to modify child support.

Section 25 **(518A.32, subd. 3 – Parent not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis)** provides that a parent is not considered voluntarily unemployed, underemployed, or employed on a less than full-time basis when a governmental agency determines the individual is eligible to receive general assistance or supplemental Social Security Income. Provides income earned by the parent may be considered for calculating child support.

Section 26 **(518A.32, subd. 4 – TANF recipient)** provides that if a parent is a recipient of MFIP benefits, and not just Temporary Assistance to Needy Families benefits, no potential income is to be imputed to that parent.
Section 27 **(518A.34 - Computation of Child Support Obligations)** prohibits benefits received by an obligee for the benefit of the joint child based on the obligor's disability or past earnings in excess of the child support obligation from being treated as an arrearage payment or future payment.

Section 28 **(518A.41 - Medical Support)** modifies medical support within child support obligations.

> **Subdivision 1** modifies the definition of "health care coverage" to mean private health care coverage or public health care coverage under which medical or dental services could be provided to a dependent child. Removes the definition of "health carrier," "health plan," and "public coverage," and adds a definition of "private health care coverage" and "public health care coverage." Modifies the definition of "medical support." Makes other conforming changes throughout the statute.

Subdivision 2 adds references to private and public health care coverage.

Subdivision 3 states that public health care coverage is presumed appropriate. Provides factors a court must consider when determining whether private health care coverage is appropriate.

Subdivision 4 modifies health care coverage for when a joint child is currently enrolled. Requires the court to order that the parent who currently has the joint child enrolled in health care coverage continue that enrollment if that coverage is appropriate.

Subdivision 5 makes references to private health care coverage and health-related expenses. States that the contribution toward private health care coverage must not be charged in any month in which the party ordered to carry the coverage fails to maintain it. Adds requirements for when a joint child is receiving public health care coverage.

Subdivision 6 makes conforming references to private health care coverage.

Subdivision 7 makes conforming references to private health care coverage.

Subdivision 8 makes conforming references to health care coverage.

Subdivision 9 makes conforming references to health-related expenses.

Subdivision 11 makes conforming references to private health care coverage and health-related expenses.

Subdivision 12 makes conforming references to private health care coverage and health-related expenses.

Subdivision 13 makes conforming references to private health care coverage and health-related expenses.

Subdivision 15 makes conforming references to private health care coverage and health-related expenses.

Subdivision 16 makes conforming references to private health care coverage.

Subdivision 16a adds language for when a suspension or reinstatement of medical support contribution occurs.

Subdivision 17 makes conforming references to health-related expenses.

Subdivision 18 makes conforming references to health-related expenses.

Section 29 **(518A.42, subd. 1 – Ability to pay)** requires a court to subtract any Social Security or Veterans' benefit payments from an obligor's parental income for determining child support before subtracting the self-support reserve.

Section 30 **(518A.42, subd. 3 – Exception)** excludes obligors who are recipients of a general assistance grant, Supplemental Security Income, Temporary Assistance for Needy Families grant, or MFIP benefits from ability to pay.

Section 31 **(518A.65 - Driver's License Suspension)** modifies the suspension of driver's licenses with regards to child support.

Paragraph (a) changes the suspension of a driver's license to be discretionary and provides circumstances for the court to consider when determining whether a suspension is an appropriate remedy. Provides an effective date of July 1, 2023, and an expiration date of December 31, 2025.

Paragraph (b) allows the court to order the commissioner of public safety to suspend an obligor's driver's license under certain circumstances. Allows the court to consider circumstances to determine whether the suspension is an appropriate remedy. Provides an effective date of January 1, 2026.

Paragraph (d) provides that a public authority can exercise administrative discretion when deciding whether to suspend a driver's license. Provides an effective date of July 1, 2023, and an expiration date of December 31, 2025.

Paragraph (e) requires a public authority to suspend a driver's license when specific circumstances are met unless exercising administrative discretion. Provides an effective date of January 1, 2026.

Paragraph (g) allows the court to exercise discretion in determining whether the driver's license suspension is likely to induce payment or if it would have harmful effects.

Paragraph (i) allows a public authority to use administrative authority to end the suspension process for an obligor or inform the commissioner of public safety that an obligor's driving privileges should no longer be suspended under certain circumstances.

Section 32 **(518A.77 - Guidelines Review)** removes expiration date and adds a federal citation to requirement that the Department of Human Services must conduct a review of the child support guidelines every four years.

ARTICLE 15

MISCELLANEOUS

Section 1 **[256.01, subd. 43 – Grant program reporting]** requires the commissioner of human services to submit an annual report to the legislature on the number of grant programs administered by the commissioner that required a full-time equivalent or administrative appropriation, the total amount of funds appropriated for the grant programs, and for each grant program, the amount of funds appropriated, the amount of funds that were spent, and if not all the funds were spent on full-time equivalent staff or administration, what the funds were actually spent on.

Section 2 **[DIRECTION TO COMMISSIONER; CHILD CARE AND DEVELOPMENT BLOCK GRANT ALLOCATIONS)** directs the commissioner of human services to allocate funds from the child care and development block grant for specific purposes.

Section 3 **[INFORMATION TECHNOLOGY PROJECTS FOR SERVICE DELIVERY TRANSFORMATION]** requires the commissioner of human services to expend amounts appropriated on specific information technology outcomes, including transforming service delivery, integrated services for children and families, modernizing the Medicaid Management Information System, provider licensing and reporting hub, and improving the Minnesota Eligibility Technology System.

Section 4 **[OUTCOMES AND EVALUATION CONSULTATION REQUIREMENTS]** directs a commissioner to consult with the commissioner of management and budget for evaluation metrics for any section in this act that includes program outcomes, evaluation metrics or requirements, progress indicators, or other related measurements.

Section 5 **[FINANCIAL REVIEW OF GRANT AND BUSINESS SUBSIDY RECIPIENTS]** requires a granting agency to provide additional oversight for grants and business subsidies awarded from appropriations in this act. This section applies to competitive, sole source, since source, and legislatively named grants.

> **Subd. 1 [Definitions]** defines "grant" to mean a grant or business subsidy funded by an appropriation in this act. Defines "grantee" to mean any business entity organized under state laws; this includes both nonprofit organizations and for-profit business organizations.
>
> **Subd. 2 [Financial information required; determination of ability to perform]** requires the granting agency to assess the risk that a recipient of a grant would not or could not perform duties required of the grantee. Requires the agency to review specified information to make the risk assessment.
>
> **Subd. 3 [Additional measures for some grantees]** authorizes the agency to require additional information and requires the agency to provide enhanced oversight for grants that have not previously received state or federal grants for similar amounts or similar duties.
>
> **Subd. 4 [Assistance from Administration]** authorizes an agency with inadequate resources or experience to assess the risk of a grantee failing to perform under the grant to contract with the department of administration to perform the agency's grant oversight duties under this section.
>
> **Subd. 5 [Agency authority to not award grant]** authorizes an agency to not award a grant, if the agency determines there is an appreciable risk that a grantee could not or would not perform its duties under the grant. Requires the agency to provide the grantee 45 days to address the agency's concern. This subdivision applies to competitive, single source, or sole source grants.
>
> **Subd. 6 [Legislatively named grantees]** requires an agency to delay the awarding of a legislatively named grant when the agency determines there is an appreciable risk a grantee would not or could not perform grant duties. The agency must provide notice to certain legislative members. The award must be delayed until after the adjournment of the next regular or special session of the legislature.

Subd. 7 [Subgrants] requires an agency to be a party to agreements for a recipient of a state grant to grant money to a subgrantee and for the agency to perform the same financial review for subgrantees.

Subd. 8 [Effect] notes that the requirements of this section are in addition to other requirements in law and policy related to state grants.

ARTICLE 16

HEALTH CARE AFFORDABILITY AND DELIVERY

Section 1 **(62J.86 - DEFINITIONS)** Adds a new section of law, Minn. Stat. § 62J.86, which defines key terms for the purposes of new sections 62J.86 to 62J.92, including "Advisory Council," and "Board."

Section 2 **(62J.87 - HEALTH CARE AFFORDABILITY BOARD)** Adds a new section of law, Minn. Stat. § 62J.87, which specifies the 13-person membership of the Health Care Affordability Board, which is intended to protect consumers, state and local governments, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. Prohibits a member from participating in board proceedings if the member has a direct or indirect financial interest. Establishes terms for board members and requires the board to hire a full-time executive director and other staff.

Section 3 **(62J.88 - HEALTH CARE AFFORDABILITY ADVISORY COUNCIL)** Adds a new section of law, Minn. Stat. § 62J.88, which requires the governor to appoint a Health Care Affordability Advisory Council to provide advice to the board on health care costs and access issues and to represent the views of patients and other stakeholders. Clarifies that the council must provide technical recommendations to the board and a summary of its activities to the board at least annually. Specifies terms for council members.

Section 4 **(62J.89 - DUTIES OF THE BOARD)** Adds a new section of law, Minn. Stat. § 62J.89, which requires the board to monitor the administration and reform of the health care delivery and payment systems in the state. Such duties include: (1) setting health care spending growth targets; (2) enhancing the transparency of provider organizations; and (3) monitoring the adoption and effectiveness of alternative payment methodologies, among other duties. This section further requires the board to make recommendations for legislative policy, market, or other reforms.

Section 5 **(62J.90 - HEALTH CARE SPENDING GROWTH TARGETS)** Adds a new section of law, Minn. Stat. § 62J.90, which requires the board to establish and administer the health care spending growth target program to limit health care spending growth in the state, and to report regularly to the legislature and the public on progress towards these targets. Requires the board to develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels. The

section specifies additional parameters that must be used in determining the health care spending growth target. Provides that, the board, by June 15 of each year beginning in 2024 must establish annual health care spending growth targets for the next calendar year, and that the board must annually hold public hearings to present findings from spending growth target monitoring.

Section 6 **(62J.91 - NOTICE TO HEALTH CARE ENTITIES)** Adds a new section of law, Minn. Stat. § 62J.91, which requires the board to provide notice to all health care entities that have been identified by the board as exceeding the spending growth target for any given year. Requires the board to implement procedures for a performance improvement plan for such health care entities. Establishes requirements for such performance improvement plans and specifies conditions which the board must consider in approving or rejecting a performance improvement plan. Establishes a civil penalty, to be imposed under certain circumstances, of not more than $500,000 for noncomplying health care entities.

Section 7 **(62J.92 - REPORTING REQUIREMENTS)** Adds a new section of law, Minn. Stat. § 62J.92, which establishes reporting requirements for the board to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy. Such requirements include mandating the board to submit written progress updates about the development and implementation of the health care spending growth target program and a report on health care spending trends.

Section 8 **(62K.15 - ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS)** Amends Minn. Stat. § 62K.15 to require health carriers offering individual health plans through MNsure to provide a special enrollment period as required under the easy enrollment health insurance outreach program established under the new section of law Minn. Stat. § 62V.13.

Section 9 **(62U.04, subdivision 11 – Restricted uses of the all-payer claims data)** Amends subdivision 11 of Minn. Stat. § 62U.04 to clarify that the commissioner of health may use the data submitted under subdivision 4 and 5 of that statute to provide technical assistance to the Health Care Affordability Board to implement new sections of law 62J.56 to 62J.92.

Section 10 **(62V.12 - STATE-FUNDED COST-SHARING REDUCTIONS)** Requires the board of directors of MNsure to develop a state-funded cost-sharing reduction program for eligible persons who enroll in a silver level qualified health plan through MNsure for plan years beginning on or after January 1, 2024. Provides that the program must use state funds to reduce enrollee cost-sharing by increasing the actuarial value of silver level health plans for eligible persons beyond the 73 percent value established in the Code of Federal Regulations to an actuarial value of 87 percent. This section further provides that, beginning for plan year 2026, the cost-sharing reduction program applies for eligible individuals expected to have a household income above 250 percent of the federal poverty level but that does not exceed 300 percent.

Section 11 **(62V.13 - EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM)** Creates a new section of law, Minn. Stat. § 62V.13, which requires the Board of Directors of MNsure to, in cooperation with the commissioner of revenue, establish the easy enrollment health insurance outreach program. Under the program, MNsure may make a projected assessment on whether the interested taxpayer's household may qualify for a financial

assistance program for health insurance coverage, based on return information received from the commissioner of revenue. Eligible taxpayers may enroll during a special enrollment period required under this section.

Section 12 **(256.962, subdivision 5 – Incentive Program)** Amends Minn. Stat. § 256.962 to increase the bonus paid to the organization or licensed insurance producer for each applicant who is successfully enrolled in MinnesotaCare or medical assistance.

Section 13 **(256B.04, subdivision 26 – Disenrollment under medical assistance and MinnesotaCare)** Amends subdivision 26 of Minn. Stat. § 256B.04 and requires the commissioner of human services to regularly update contact information for medical assistance and MinnesotaCare enrollees in cases of returned mail and nonresponse using information available from other sources. Prohibits the commissioner from disenrolling medical assistance and MinnesotaCare enrollees in cases of returned mail unless the commissioner made two attempts to contact the enrollee and waited at least 30 days for an enrollee to respond.

Section 14 **(256B.056, subdivision 7 – Period of eligibility)** Amends subdivision 7 of Minn. Stat. § 256B.056 and provides for continuous eligibility for children under 21 years of age for certain lengths of time depending on the child's age. Also provides for when this eligibility may be terminated. This section has an effective date of January 1, 2024, or upon any necessary federal approval, whichever is later.

Section 15 **(256B.0631, subdivision 1a – Prohibition on cost-sharing and deductibles)** Amends Minn. Stat. § 256B.0631 to add a new subdivision that prohibits a medical assistance benefit plan from including cost-sharing or deductibles for any medical assistance recipient or benefit, effective July 1, 2025.

Section 16 **(256L.04, subdivision 7a – Ineligibility)** Exempts persons enrolled under the public option from a provision that prohibits adults from being enrolled in MinnesotaCare if their income is greater than the program income limit. Effective January 1, 2026, or upon federal approval, whichever is later.

Section 17 **(256L.04, subdivision 10 – Citizenship requirements)** Amends subdivision 10 of Minn. Stat. § 256L.04 and exempts children under the age of 19 from the prohibition against undocumented noncitizens being eligible for MinnesotaCare.

Section 18 **(256L.04, subdivision 15 – Persons eligible for public option)** Amends existing eligibility requirements to allow families and individuals with income above the MinnesotaCare maximum income eligibility limit. Requires that eligible families and individuals meet all other eligibility requirements for MinnesotaCare. Permits eligible families to only enroll during open enrollment or a special enrollment period.

Section 19 **(256L.07, subdivision 1 – General requirements)** Permits individuals whose income increases above 200 percent of the federal poverty guidelines to remain enrolled in MinnesotaCare if they utilize the public option.

Section 20 **(256L.15, subdivision 2 – Sliding fee scale; monthly individual or family income)** Requires the commissioner to continue to adjust premiums according to federal compliance

required by American Rescue Plan Act of 2021. Deletes premium scale. Requires commissioner to establish a sliding premium scale for individuals eligible for the public option. Exempts individuals younger than 20 years of age, eligible through the public option, from paying premiums.

Section 21 **(270B.14, subdivision 22 – Disclosure to MNsure board)** Adds a new subdivision 22 to Minn. Stat. § 270B.14 that authorizes the commissioner of revenue to disclose a return or return information to the MNsure board if a taxpayer makes an easy enrollment designation.

Section 22 **(290.433 - EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF)** Creates a new section of law, Minn. Stat. § 290.433, which provides that any individual filing an income tax return may designate a request that the commissioner of revenue provide their return information to the MNsure board for purposes of providing the individual about potential eligibility for financial assistance and health insurance enrollment options.

Section 23 **(DIRECTION TO MNSURE BOARD AND COMMISSIONER)** Requires the MNsure board and commissioner of the Department of Revenue to develop systems and procedures that facilitate and streamline data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose of the easy enrollment health insurance outreach program for operation beginning with tax year 2023.

Section 24 **(RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION)** Requires the commissioners of human services, health, and commerce, and the board of directors of MNsure, to submit to the health care affordability board and the chairs and ranking minority members of the legislative committees with primary jurisdiction over health and human services finance and policy and commerce, by January 15, 2024, a report on the organization and duties of the Office of Patient Protection.

Section 25 **(TRANSITION TO MINNESOTACARE PUBLIC OPTION)** Requires the commissioner to present an implementation plan for the MinnesotaCare public option to legislatures in health and finance by December 15, 2024. Requires plan to include recommendations for any changes to public option to continue federal funding. Requires plan to include recommendations for small employers with public option to allow any employee payments toward premiums to be pretax. Recommendations to ensure sufficient provider participation in MinnesotaCare and estimates of state costs relating to MinnesotaCare public option. Requires plan to include description of a premium scale for individuals eligible through the public option. Requires plan to ensure affordable premiums for individuals across income spectrum. Requires plan to avoid premium cliffs for persons moving to and enrolling under the public option. Requires commissioner to draft legislation necessary to implement the MinnesotaCare public option implementation plan recommendations. Requires commissioner to present a report, by January 15, 2025, comparing service delivery and payment system models for MinnesotaCare.

Section 26 **(REQUEST FOR FEDERAL APPROVAL)** Requires commissioner to seek any necessary federal waivers, approvals, and law changes necessary to implement this article. Requires commissioner to seek such changes to: continue receiving federal basic health program

payments for basic health program-eligible MinnesotaCare enrollees; receive federal payment equal to the value of premium tax credits and cost-sharing reductions that certain MinnesotaCare enrollees would have otherwise receive; and receive federal payments equal to the value of emergency medical assistance that would otherwise have been paid to the state for services provided to eligible enrollees. Requires commissioner of human services to consult with commissioner of commerce and board. Permits the commissioner to contract for technical and actuarial assistance.

Section 27 **(ANALYSIS OF BENEFITS AND COSTS OF A UNIVERSAL HEALTH CARE SYSTEM)** Defines key terms including "total public and private health care spending," and "all necessary care." Requires the analysts conducting the study to recognize certain specified assumptions, and prohibits the analysts from making other assumptions, when calculating administrative savings and costs under the universal health proposal.

Section 28 **(BENEFIT AND COST ANALYSIS OF A UNIVERSAL HEALTH REFORM PROPOSAL)** Requires the commissioner of health to contract with an independent entity to conduct an analysis of the benefits and costs of a legislative proposal for a universal health care financing system and a similar analysis of the current health care financing system to assist the state in comparing the proposal to the current system. This section further requires the commissioner of health, with consultation from the commissioners of human services and commerce, to submit to the contractor for analysis the legislative proposal known as the Minnesota Health Plan. Specifies that the analysis must measure the performance of both the proposed Minnesota Health Plan and the current public and private health care financing system over a ten-year period to contrast the impact on: (1) coverage; (2) benefit completeness; (3) underinsurance; (4) system capacity; and (5) health care spending. Requires the commissioner to issue a final report by January 15, 2026.

Section 29 **(APPOINTMENTS AND INITIAL MEETING OF THE HEALTH CARE AFFORDABILITY BOARD)** Requires appointing authorities to make first appointments to the Health Care Affordability Board by October 1, 2023. Requires the governor to designate one member to serve as an acting chair until the council selects a chair at its first meeting.
Section 30 **(TERMS OF INITIAL APPOINTEES OF THE HEALTH CARE AFFORDABILITY ADVISORY COUNCIL)** Provides that the initial appointed members of the Health Care Affordability Advisory Council must serve staggered terms as determined by lot by the secretary of state.

Section 31 **(REPEALER)** Repeals subdivisions 1, 2, and 3 of Minn. Stat. § 256B.0631, effective July 1, 2025, which subdivisions provided for cost-sharing for medical assistance recipients.

Section 32 **(CONTINGENT EFFECTIVE DATE)** Provides that certain sections relating to the public option are effective January 1, 2027, or upon federal approval, whichever is later, but only if the commissioner makes various certifications to the legislature regarding the implementation of the program and impacts on existing programs.