SENATE
STATE OF MINNESOTA
NINETY-THIRD SESSION

S.F. No. 2995

(SENATE AUTHORS: WIKLUND)

DATE	D-PG	OFFICIAL STATUS
03/20/2023		Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health; appropriating money for the Department of Health, health-related boards, Council on Disability, ombudsman for mental health and disabilities, ombudsperson for families, ombudsperson for American Indian families, Office of the Foster Youth Ombudsperson, MNsure, Rare Disease Advisory Council, and the Department of Revenue; establishing the Health Care Spending Growth Target Commission and Health Care Spending Technical Advisory Council; identifying ways to reduce spending by health care organizations and group purchasers and low-value care; assessing alternative payment methods in rural health care; assessing feasibility for a health provider directory; requiring compliance with the No Surprises Act in billing; modifying prescription drug price provisions and continuity of care provisions; compiling health encounter data; establishing certain advisory councils, committees, and grant programs; modifying lead testing in schools and remediation requirements; modifying lead service line requirements; requiring lead testing in drinking water in child care settings; establishing Minnesota One Health Microbial Stewardship Collaborative, a comprehensive drug overdose and morbidity program, a Sentinel Event Review Committee, law enforcement-involved deadly force encounters advisory committee, and cultural communications program; setting certain fees; providing for clinical health care training; establishing a climate resiliency program; changing assisted living provisions; establishing a program to monitor long COVID, a 988 suicide crisis lifeline, school-based health centers, Healthy Beginnings, Healthy Families Act, and Comprehensive and Collaborative Resource and Referral System for Children; funding for community health boards; developing COVID-19 pandemic delayed preventive care; changing certain health board fees; establishing easy enrollment health insurance outreach program; setting certain fees; requiring reports; amending Minnesota Statutes 2022, sections 12A.08, subdivision 3; 62J.84, subdivisions 2, 3, 4, 6, 7, 8, 9, by adding subdivisions; 62K.15; 62Q.01, by adding a subdivision; 62Q.021, by adding a subdivision; 62Q.55, subdivision 5; 62Q.556; 62Q.56, subdivision 2; 62Q.73, subdivisions 1, 7; 62U.04, subdivisions 4, 5, 6; 121A.335, subdivisions 3, 5, by adding a subdivision; 144.122; 144.1505; 144.226, subdivisions 3, 4; 144.383; 144G.16, subdivision 7; 144G.18; 144G.57, subdivision 8; 145.925; 145A.131, subdivisions 1, 5; 145A.14, by adding a subdivision; 148B.392, subdivision 2; 151.065, subdivisions 1, 2, 3, 4, 6; 270B.14, by adding a subdivision; 403.161; 403.162; Laws 2022, chapter 99, article 1, section 46; article 3, section 9; proposing coding for new law in Minnesota Statutes, chapters 62J; 62V; 115; 144; 145; 148; 290; repealing Minnesota Statutes 2022, sections 62J.84, subdivision 5; 62U.10, subdivisions 6, 7, 8; 145.4235; 145.4241; 145.4242;

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

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

ARTICLE 1

APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2024" and "2025" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2024, or June 30, 2025, respectively. "The first year" is fiscal year 2024. "The second year" is fiscal year 2025. "The biennium" is fiscal years 2024 and 2025.

	APPROPRIATIONS Available for the Year Ending June 30	
	2024	**2025**
Sec. 2. **COMMISSIONER OF HEALTH**		
Subdivision 1. **Total Appropriation**	**$ 457,377,000**	**$ 454,644,000**

Appropriations by Fund

	2024	2025
General	310,084,000	300,108,000
State Government Special Revenue	83,373,000	85,902,000
Health Care Access	52,207,000	56,921,000
Federal TANF	11,713,000	11,713,000

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

Subd. 2. **Health Improvement**

Appropriations by Fund

General	240,491,000	230,169,000

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

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

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

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

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

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

144.9821. Of the total appropriation each year, $500,000 is for grants and $1,382,000 is for administration. The base for this appropriation is $1,510,000 in fiscal year 2026 and $1,510,000 in fiscal year 2027. Of the total appropriated in fiscal year 2026 and fiscal year 2027, $500,000 is for grants and $1,010,000 is for administration.

(f) **Advancing Equity through Community Engagement and Systems Transformation.** $1,602,000 in fiscal year 2024 and $1,602,000 in fiscal year 2025 are from the general fund to advance equitable and inclusive community engagement under Minnesota Statutes, section 144.9282. Of the total appropriation each year in fiscal year 2024 and fiscal year 2025, $930,000 is for grants and $672,000 is for administration. The base for this appropriation is $1,930,000 in fiscal year 2026 and $1,930,000 in fiscal year 2027. Of this total appropriation in fiscal year 2026 and fiscal year 2027, $1,000,000 is for grants and $930,000 is for administration.

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

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

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

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

(j) **Comprehensive Overdose and Morbidity Prevention Act.** $11,428,000 in fiscal year 2024 and $10,770,000 in fiscal year 2025 are from the general fund for comprehensive overdose and morbidity prevention strategies under Minnesota Statutes, section 144.0526. Of the total appropriation in fiscal year 2024, $7,580,000 is for grants and $3,848,000 is for administration and in fiscal year 2025, $7,580,000 is for grants and $3,190,000 is for administration. The base for this appropriation is $9,708,000 in fiscal year 2026 and $9,708,000 in fiscal year 2027. Of the total base appropriation in fiscal year 2026 and fiscal year 2027, $7,480,000 is for grants and $2,228,000 is for administration.

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

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

(l) **Emergency Preparedness and Response.** $16,825,000 in fiscal year 2024 and $16,662,000 in fiscal year 2025 are from the general fund for public health emergency preparedness and response, the sustainability of the strategic stockpile, and COVID-19 pandemic response transition. Of this total appropriation in fiscal year 2024, $8,400,000 is for grants and $8,425,000 is for administration and in fiscal year 2025, $8,400,000 is for grants and $8,262,000 is for administration. The general fund base for this appropriation is $15,141,000 in fiscal year 2026 and $15,141,000 in fiscal year 2027. Of the total general fund base appropriated in fiscal year 2026 and fiscal year 2027 under this paragraph, $8,400,000 is for grants and $6,741,000 is for administration.

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

$3,302,000 is for administration and in fiscal year 2025, $8,750,000 is for grants and $3,103,000 is for administration. The general fund base for this appropriation is $11,798,000 in fiscal year 2026 and $11,798,000 in fiscal year 2027. Of the total general fund base appropriation in fiscal year 2024 and in fiscal year 2025, $8,750,000 is for grants and $3,048,000 is for administration.

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

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

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

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

(q) **No Surprises Act Enforcement.** $1,210,000 in fiscal year 2024 and $1,090,000 in fiscal year 2025 are from the general fund for implementation of the federal No Surprises Act portion of the Consolidated Appropriations Act, 2021, under Minnesota Statutes, section 62Q.021, and assessment of feasibility of a statewide provider directory. The general fund base for this appropriation is $855,000 in fiscal year 2026 and $855,000 in fiscal year 2027.

(r) **African American Health.** $2,182,000 in fiscal year 2024 and $2,182,000 in fiscal year 2025 are from the general fund to establish an Office of African American Health at the Minnesota Department of Health under Minnesota Statutes, section 144.0756. Of the total appropriation in fiscal year 2024 and in fiscal year 2025, $1,000,000 each year is for grants and $1,182,000 is for administration. The general fund base for this appropriation is $2,182,00 in fiscal year 2026 and $2,117,000 in fiscal year 2027. Of the total base appropriation in fiscal year 2026, $1,000,000 is for grants and $1,182,000 is for administration and in fiscal year 2027, $1,000,000 is for grants and $1,117,000 is for administration.

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

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

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

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

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

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

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

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

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

grants under Minnesota Statutes, section 144.1508;

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

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

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

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

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

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

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

(v) **School Health.** $1,432,000 in fiscal year 2024 and $1,932,000 in fiscal year 2025 are from the general fund for school-based health centers under Minnesota Statutes, section 145.903. Of the total appropriation in fiscal year 2024 and in fiscal year 2025, $800,000 is for grants and $632,000 is for administration. The general fund base for this appropriation is $2,983,000 in fiscal year 2026 and $2,983,000 in fiscal year 2027. Of the total base appropriation in fiscal year 2026 and in fiscal year 2027, $2,300,000 is for grants and $683,000 is for administration.

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

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

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

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

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

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

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

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

Minnesota Statutes, section 145A.14, subdivision 2a;

(iv) $1,156,000 in fiscal year 2024 and $1,156,000 in fiscal year 2025 are from the TANF fund for family planning grants under Minnesota Statutes, section 145.925; and

(v) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

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

Subd. 3. **Health Protection**

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

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

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

is $2,292,000 in fiscal year 2026 and $2,292,000 in fiscal year 2027, of which $1,292,000 is for administration and $1,000,000 is for grants.

(c) **Homeless Mortality Study.** $134,000 in fiscal year 2024 and $149,000 in fiscal year 2025 are from the general fund for a homeless mortality study. The general fund base for this appropriation is $104,000 in fiscal year 2026 and $0 in fiscal year 2027.

(d) **Lead Remediation in Schools and Child Care Settings.** $500,000 in fiscal year 2024 and $500,000 in fiscal year 2025 are from the general fund to reduce lead in drinking water in schools and child care facilities under Minnesota Statutes, section 145.9272. Of the total appropriation in fiscal year 2024, $146,000 is for grants and $354,000 is for administration and in fiscal year 2025, $239,000 is for grants and $261,000 is for administration.

(e) **Lead Service Line Inventory.** $3,000,000 in fiscal year 2024 and $3,000,000 in fiscal year 2025 are from the general fund for lead service line inventories under Minnesota Statutes, section 144.383. Of the total appropriation in fiscal year 2024 and in fiscal year 2025, $2,678,000 is for grants and $322,000 is for administration. This is a onetime appropriation.

(f) **Antimicrobial Stewardship.** $312,000 in fiscal year 2024 and $312,000 in fiscal year 2025 are from the general fund for the Minnesota One Health Antibiotic Stewardship

Collaborative under Minnesota Statutes, section 144.0526.

(g) **Strengthening Public Drinking Water Systems Infrastructure.** $8,155,000 in fiscal year 2024 and $8,155,000 in fiscal year 2025 are from the general fund to strengthen the infrastructure and security of public water systems and their source water protection areas under Minnesota Statutes, section 144.3832. Of the total appropriation in fiscal year 2024 and in fiscal year 2025, $2,630,000 is for administration and $5,525,000 is for grants. The general fund base for this appropriation is $3,323,000 in fiscal year 2026 and $3,323,000 in fiscal year 2027. Of the total base appropriation in fiscal year 2026 and in fiscal year 2027, $1,348,000 is for administration and $1,975,000 is for grants.

Subd. 4. **Health Operations**

	Appropriations by Fund	
General	18,492,000	18,405,000

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

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

	Appropriations by Fund	
State Government Special Revenue	30,748,000	31,534,000
Health Care Access	76,000	38,000

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

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

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

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

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

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

appropriation, $200,000 in fiscal year 2024 and $200,000 in fiscal year 2025 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification by a health-related board to the administrative services unit that costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance for an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

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

	Appropriations by Fund		
State Government			
Special Revenue	5,266,000	5,206,000	
Health Care Access	76,000	38,000	

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 3,441,000 $ 3,644,000**

Department of Psychiatry Monitoring. $100,000 in fiscal year 2024 and $100,000 in fiscal year 2025 are for monitoring the Department of Psychiatry at the University of Minnesota.

Sec. 7. **OMBUDSPERSON FOR FAMILIES** **$ 759,000 $ 776,000**

Sec. 8. **OMBUDSPERSON FOR AMERICAN INDIAN FAMILIES** **$ 336,000 $ 340,000**

Sec. 9. **OFFICE OF THE FOSTER YOUTH OMBUDSPERSON** **$ 742,000 $ 759,000**

Sec. 10. **MNSURE.**

	Appropriations by Fund	
General	11,095,000	14,296,000
Health Care Access	800,000	0

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

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

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

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

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

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

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

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

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

Sec. 15. **EXPIRATION OF UNCODIFIED LANGUAGE.**

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

ARTICLE 2
HEALTH DEPARTMENT POLICY

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

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

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

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

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

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

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

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

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

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

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

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

(1) two members who are persons with expertise and experience in advocating on behalf of patients;

(2) two Minnesota residents who are health care consumers;

(3) two members of the business community who purchase health insurance for their employees;

(4) two members representing public purchasers of health insurance for their employees;

(5) one licensed and certified health care provider employed at a federally qualified health center;

(6) one member representing a health care system or urban hospitals;

(7) one member representing rural hospitals;

(8) one member representing health plans;

(9) one member who is an expert in health care financing and administration; and

(10) one member who is an expert in health economics.

(b) All members appointed must have the knowledge and demonstrated expertise in:

(1) health care finance, health economics, and health care management or administration at a senior level;

(2) health care consumer advocacy;

(3) representing the health care workforce as a leader in a labor organization;

(4) purchasing health insurance representing business management or health benefits administration;

(5) delivering primary care, health plan administration, or public or population health; or

(6) addressing health disparities and structural inequities.

(c) No member may participate in commission proceedings involving an individual provider, purchaser, or patient, or specific activity or transaction, if the member has direct financial interest in the outcome of the commissions' proceedings other than as an individual consumer of health care services.

Subd. 3. **Terms.** (a) The commissioner shall make recommendations for commission membership. Commission members shall be appointed by the governor. The initial appointments to the commission shall be made by September 1, 2023. The initial appointed

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

(b) The commission is governed by section 15.059.

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

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

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

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

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

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

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

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

(1) establishing a statement of purpose;

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

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

(ii) promote a predictable and sustainable rate of growth for total health care spending as measured by an established economic indicator, such as the rate of increase of the state's economy or of the personal income of residents of the state, or a combination;

(iii) apply to all health care providers and health plan companies in the health care system in the state; and

(iv) be measurable on a per capita basis, statewide basis, health plan basis, and health care provider basis;

(3) establishing a methodology for calculating health care cost growth:

(i) statewide;

(ii) for each health care provider and health plan company, which, at the discretion of the commission, may account for variability by age and sex; and

(iii) taking into consideration the need for variability in targets across public and private payers;

(iv) incorporating health equity considerations; and

(v) considering the impact of targets on health care access and disparities;

(4) identifying data to be used for tracking performance under the targets and methods of data collection necessary for efficient implementation by the commissioner as specified in subdivision 9. In identifying data and methods, the commission shall:

(i) consider the availability, timeliness, quality, and usefulness of existing data;

(ii) assess the need for additional investments in data collection, data validation, or analysis capacity to support efficient collection and aggregation of data to support the commission's activities;

(iii) limit the reporting burden as much as possible; and

(iv) identify and define the entities which are required to report;

(5) establishing requirements for health care providers and health plan companies to report data and other information necessary to calculate health care cost growth, after accounting for analysis under clause (3). Health care providers and health plans must report data in the form and manner established by the commissioner;

(6) by June 15, 2024, establishing target levels consistent with the methodology in clause (2) for a five-year period with the goal of limiting health care spending growth;

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

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

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

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

(11) completing the reports in subdivision 10.

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

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

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

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

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

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

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

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

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

(4) synthesizing and reporting to the commission;

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

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

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

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

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

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

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

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

(ii) findings from the analyses of cost drivers of health care spending growth;

(iii) estimates of the impact of health care spending growth on Minnesota residents, including for those communities most impacted by health disparities, related to Minnesota residents' access to insurance and care, value of health care, and ability to pursue other spending priorities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) health care spending trends and drivers;

(2) equitable access to health care services;

(3) health insurance operation and finance;

(4) actuarial science;

(5) the practice of medicine;

(6) patient perspectives;

(7) clinical and health services research; and

(8) the health care marketplace.

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

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

(2) the commissioner of health or a designee;

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

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

(5) two members who represent nonprofit group purchasers;

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

(7) two members who represent medical care systems;

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

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

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

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

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

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

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

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

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

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

(3) advise how to measure the impact on:

(i) communities most impacted by health disparities;

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

(iii) individuals with disabilities;

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

(v) individuals who reside in rural areas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

(2) the factors that contributed to the price increase;

(3) the name of any generic version of the prescription drug available on the market;

(4) the introductory price of the prescription drug when it was ~~approved for marketing by the Food and Drug Administration and the net yearly increase, by calendar year, in the price of the prescription drug during the previous five years~~ introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the price increase;

(5) the direct costs incurred during the previous 12-month period by the manufacturer that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(6) the total sales revenue for the prescription drug during the previous 12-month period;

(7) the manufacturer's net profit attributable to the prescription drug during the previous 12-month period;

(8) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the previous 12-month period, if applicable;

(9) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(10) the patent expiration date of the prescription drug if it is under patent;

(11) the name and location of the company that manufactured the drug; ~~and~~

(12) if a brand name prescription drug, the ~~ten~~ highest ~~prices~~ price paid for the prescription drug during the previous calendar year in ~~any country other than~~ the ten countries, excluding the United States~~.~~, that charged the highest single price for the prescription drug; and

(13) if the prescription drug was acquired by the manufacturer during the previous 12-month period, all of the following information:

(i) price at acquisition;

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

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

(iv) date of acquisition; and

(v) acquisition price.

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength;

(v) the package size;

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

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

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

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) failing to register under subdivision 15;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) which the manufacturer manufactures or repackages;

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

(i) the day one year prior to the date of the notification to report;

(ii) the introduced to market date; or

(iii) the acquisition date;

(3) the price of the drug product on the date of the notification to report;

(4) the introductory price of the prescription drug when it was introduced for sale in the United States and the price of the drug on the last day of each of the five calendar years preceding the date of the notification to report;

(5) the direct costs incurred during the 12-month period prior to the date of the notification to report by the manufacturers that are associated with the prescription drug, listed separately:

(i) to manufacture the prescription drug;

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

(iii) to distribute the prescription drug;

(6) the number of units of the prescription drug sold during the 12-month period prior to the date of the notification to report;

(7) the total sales revenue for the prescription drug during the 12-month period prior to the date of the notification to report;

(8) the total rebate payable amount accrued for the prescription drug during the 12-month period prior to the date of the notification to report;

(9) the manufacturer's net profit attributable to the prescription drug during the 12-month period prior to the date of the notification to report;

(10) the total amount of financial assistance the manufacturer has provided through patient prescription assistance programs during the 12-month period prior to the date of the notification to report, if applicable;

(11) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the prescription drug;

(12) the patent expiration date of the prescription drug if the prescription drug is under patent;

(13) the name and location of the company that manufactured the drug;

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

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

(i) the price at acquisition;

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

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

(iv) the date of acquisition; and

(v) the acquisition price.

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

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

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

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

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

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

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

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

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

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

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

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

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

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

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

(i) the national drug code;

(ii) the product name;

(iii) the dosage form;

(iv) the strength; and

(v) the package size;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62Q.556 ~~UNAUTHORIZED PROVIDER SERVICES~~ CONSUMER PROTECTIONS AGAINST BALANCE BILLING.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) an acute condition;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) the enrollee has met the requirements of subdivision 6, paragraph (e)~~.~~<u>; or</u>

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

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

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

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

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

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

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

(1) medical records;

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

(3) consulting reports from health care professionals;

(4) the terms of coverage;

(5) federal Food and Drug Administration approval; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) promote medication-assisted treatment options;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Bureau of Criminal Apprehension;

(2) Board of Peace Officer Standards and Training;

(3) Department of Health;

(4) Department of Human Rights;

(5) Department Of Corrections;

(6) Department of Human Services;

(7) A Minnesota medical examiner or coroner; and

(8) two appointed members at large.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) African American secondary or college students;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) maintain open communication channels with respective constituencies;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.122 LICENSE, PERMIT, AND SURVEY FEES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) promote racial and geographic equity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

144.1505 HEALTH PROFESSIONALS CLINICAL TRAINING EXPANSION AND RURAL AND UNDERSERVED CLINICAL ROTATIONS GRANT ~~PROGRAM~~ PROGRAMS.

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

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

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

(i) approved by the Board of Dentistry; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) travel and lodging for students;

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

(6) development and implementation of cultural competency training;

(7) evaluations;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand ~~a physician assistant, advanced practice registered nurse, pharmacy, dental therapy, or mental health professional~~ training program; and

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

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs and physician and dental programs seeking a grant shall apply to the commissioner. Applications must include a description of the number of additional students who will be trained using grant funds; attestation that funding will be used to support an increase in the number of clinical training slots; a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected; and a plan to maintain or operate any component included in the project after the grant period. The applicant must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization. Applicants applying under subdivision 2, paragraph (b), must include information about length of training and training site settings, geographic location of rural sites, and rural populations expected to be served.

Subd. 4. **Consideration of applications.** The commissioner shall review each application to determine whether or not the application is complete and whether the program and the project are eligible for a grant. In evaluating applications, the commissioner shall score each application based on factors including, but not limited to, the applicant's clarity and thoroughness in describing the project and the problems to be addressed, the extent to which the applicant has demonstrated that the applicant has made adequate provisions to ensure proper and efficient operation of the training program once the grant project is completed, the extent to which the proposed project is consistent with the goal of increasing access to primary care and mental health services for rural and underserved urban communities, the extent to which the proposed project incorporates team-based primary care, and project costs and use of funds.

Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant to be given to an eligible program based on the relative score of each eligible program's application, including rural locations as applicable under subdivision 2, paragraph (b), other

relevant factors discussed during the review, and the funds available to the commissioner. Appropriations made to the program do not cancel and are available until expended. During the grant period, the commissioner may require and collect from programs receiving grants any information necessary to evaluate the program.

Sec. 54. **[144.1507] PRIMARY CARE RESIDENCY TRAINING GRANT PROGRAM.**

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

(b) "Eligible program" means a program that meets the following criteria:

(1) is located in Minnesota;

(2) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency training programs or in community-based ambulatory care centers that primarily serve the underserved; and

(3) is accredited by the Accreditation Council for Graduate Medical Education or presents a credible plan to obtain accreditation.

(c) "Rural residency training program" means a residency program that provides an initial year of training in an accredited residency program in Minnesota. The subsequent years of the residency program are based in rural communities, utilizing local clinics and community hospitals, with specialty rotations in nearby regional medical centers.

(d) "Community-based ambulatory care centers" means federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian Tribe or Tribal organization, or an urban American Indian organization or an entity receiving funds under Title X of the Public Health Service Act.

(e) "Eligible project" means a project to establish and maintain a rural residency training program.

Subd. 2. **Rural residency training program.** (a) The commissioner of health shall award rural residency training program grants to eligible programs to plan, implement, and sustain rural residency training programs. A rural residency training program grant shall not exceed $250,000 per year for up to three years for planning and development, and $225,000 per resident per year for each year thereafter to sustain the program.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing accredited rural residency training programs;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education or another national body that accredits rural residency training programs;

(3) establishing new rural residency training programs;

(4) recruitment, training, and retention of new residents and faculty related to the new rural residency training program;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new rural residency training programs;

(7) training site improvements, fees, equipment, and supplies required for new rural residency training programs; and

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

Subd. 3. **Applications for rural residency training program grants.** Eligible programs seeking a grant shall apply to the commissioner. Applications must include the number of new primary care rural residency training program slots planned, under development or under contract; a description of the training program, including location of the established residency program and rural training sites; a description of the project, including all costs associated with the project; all sources of funds for the project; detailed uses of all funds for the project; the results expected; proof of eligibility for federal graduate medical education funding, if applicable; and a plan to seek the funding. The applicant must describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals in the organization.

Subd. 4. **Consideration of grant applications.** The commissioner shall review each application to determine if the residency program application is complete, if the proposed rural residency program and residency slots are eligible for a grant, and if the program is eligible for federal graduate medical education funding, and when the funding is available. If eligible programs are not eligible for federal graduate medical education funding, the commissioner may award continuation funding to the eligible program beyond the initial grant period. The commissioner shall award grants to support training programs in family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general surgery, and other primary care focus areas.

Subd. 5. **Program oversight.** During the grant period, the commissioner may require and collect from grantees any information necessary to evaluate the program. Notwithstanding

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

Sec. 55. **[144.1508] CLINICAL HEALTH CARE TRAINING.**

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

(b) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body that reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health.

(c) "Clinical medical education program" means the accredited clinical training of physicians, medical students, residents, doctors of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses, clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, certified nurse midwives, physician assistants, dental therapists and advanced dental therapists, psychologists, clinical social workers, community paramedics, community health workers, and other medical professions as determined by the commissioner.

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

(e) "Eligible entity" means an organization that is located in Minnesota, provides a clinical medical education experience, and hosts students, residents or other trainee types as determined by the commissioner and are from an accredited Minnesota teaching program and institution.

(f) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are training in Minnesota at an entity with either currently active medical assistance enrollment status and a National Provider Identification (NPI) number or documentation that they provide sliding fee services. Training may occur in an inpatient or ambulatory patient care setting or alternative setting as determined by the commissioner. Training that occurs in nursing facility settings is not eligible for funding under this section.

(g) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota that is accountable to the accrediting body.

(h) "Trainee" means a student, resident, fellow, or other postgraduate involved in a clinical medical education program from an accredited Minnesota teaching program and institution.

Subd. 2. **Application process.** (a) An eligible entity hosting clinical trainees from a clinical medical education program and teaching institution is eligible for funds under subdivision 3, if the entity:

(1) is funded in part by sliding fee scale services or enrolled in the Minnesota health care program;

(2) faces increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in rural or underserved areas of Minnesota.

(b) An entity hosting a clinical medical education program for advanced practice nursing is eligible for funds under subdivision 3, if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or an institution that is part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) An application must be submitted to the commissioner by an eligible entity through the teaching institution and contain the following information:

(1) the official name and address and the site addresses of the clinical medical education programs where eligible trainees are hosted;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each applicant, the type and specialty orientation of trainees in the program; the name, entity address, medical assistance provider number, and national provider identification number of each training site used in the program, as appropriate; the federal tax identification number of each training site, where available; the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary.

(d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 3. **Distribution of funds.** (a) The commissioner may distribute funds for clinical training in areas of Minnesota and for the professions listed in subdivision 1, paragraph (d), determined by the commissioner as a high need area and profession shortage area. The commissioner shall annually distribute medical education funds to qualifying applicants under this section based on the costs to train, service level needs, and profession or training site shortages. Use of funds is limited to related clinical training costs for eligible programs.

(b) To ensure the quality of clinical training, eligible entities must demonstrate that they hold contracts in good standing with eligible educational institutions that specify the terms, expectations, and outcomes of the clinical training conducted at sites. Funds shall be distributed in an administrative process determined by the commissioner to be efficient.

Subd. 4. **Report.** (a) Teaching institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify funding was distributed as specified in the GVR. If the teaching institution fails to submit the GVR by the stated deadline, the teaching institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) Teaching institutions receiving funds under this section must provide any other information the commissioner deems appropriate to evaluate the effectiveness of the use of funds for medical education.

Sec. 56. Minnesota Statutes 2022, section 144.226, subdivision 3, is amended to read:

Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. The state registrar or local issuance office shall forward this amount to the commissioner of management and budget each month following the collection of the surcharge for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (b). Upon certification by the commissioner of management and budget that the assets in that fund exceed $20,000,000, this surcharge shall be discontinued.

(b) In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of $10 for each certified birth record. The state registrar or local issuance office

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

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

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

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

144.383 AUTHORITY OF COMMISSIONER.

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

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

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

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

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

~~(e) To~~ (5) promulgate rules, pursuant to chapter 14 but no less stringent than federal regulation, which may include the granting of variances and exemptions~~.~~; and

(6) maintain a database of lead service lines, provide technical assistance to community systems, and ensure the lead service line inventory data is accessible to the public with relevant educational materials about health risks related to lead and ways to reduce exposure.

Sec. 59. **[144.3832] PUBLIC WATER SYSTEM INFRASTRUCTURE STRENGTHENING GRANTS.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall establish a grant program to ensure the uninterrupted delivery of safe water through emergency power supplies and back-up wells, backflow prevention, water reuse, increased cybersecurity, floodplain mapping, support for very small water system infrastructure, and piloting solar farms in source water protection areas.

Subd. 2. **Grants authorized.** (a) The commissioner shall award grants for emergency power supplies, back-up wells, and cross connection prevention programs through a request for proposals process to public water systems. Priority shall be given to small and very small public water systems that serve populations of less than 3,300 and 500 respectively. The commissioner shall award matching grants to public water systems that serve populations of less than 500 for infrastructure improvements supporting system operations and resiliency.

(b) Grantees must address one or more areas of infrastructure strengthening with the goals of:

(1) ensuring the uninterrupted delivery of safe and affordable water to their customers;

(2) anticipating and mitigating potential threats arising from climate change such as flooding and drought;

(3) providing resiliency to maintain drinking water supply capacity in case of a loss of power;

(4) providing redundancy by having more than one source of water in case the main source of water fails; or

(5) preventing contamination by cross connections through a self-sustaining cross connection control program.

Sec. 60. **[144.9282] ADVANCING EQUITY THROUGH COMMUNITY ENGAGEMENT AND SYSTEMS TRANSFORMATION GRANTS.**

Subdivision 1. **Grant establishment.** The commissioner of health shall establish a grant program to advance equitable and inclusive community engagement by cultivating a

community of practice and building community engagement capacity within the department's system and local public health organizations to:

(1) ensure that capacity building efforts are translated into practice and that community relationships and partnerships are strengthened, and avenues for meaningful participation of Minnesota's diverse communities such as populations of color, American Indians, LGBTQIA+, and those with disabilities in metro and rural communities in public health programs are created;

(2) ensure that current and future policies, procedures, and strategies facilitate meaningful engagement of communities and focus to create their own healthy futures;

(3) identify new strategies and actions to support efforts to listen authentically to, and partner with, Minnesotans most impacted by inequities;

(4) reduce health inequities; and

(5) promote racial and geographic equity.

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

(1) develop a request for proposals for the community engagement capacity building grant program in consultation with community stakeholders, and local public health organizations;

(2) provide outreach, technical assistance, and program development support to increase capacity for staff, local public health organizations, and communities of practice;

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

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

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

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

(8) establish a process or mechanism to evaluate the success of the grant program and to build the evidence base for effective community engagement in reducing health disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such as

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

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

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

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

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

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

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

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

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

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

(2) create a framework at the department to maintain equitable practices in grantmaking to ensure that internal grantmaking and procurement policies and practices prioritize equity, transparency, and accessibility to include:

(i) a tracking system for the department to better monitor and evaluate equitable procurement and grantmaking processes and their impacts; and

(ii) technical assistance and coaching to department leadership in grantmaking and procurement processes and programs and providing tools and guidance to ensure equitable and transparent competitive grantmaking processes and award distribution across communities most impacted by inequities and develop measures to track progress over time.

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

(1) in consultation with community stakeholders, community health boards and Tribal nations, develop a request for proposals for infrastructure capacity building grant program to help community-based organizations, including faith-based organizations, to be better equipped and prepared for success in procuring grants and contracts at the department and beyond;

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

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

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

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

(6) maintain data on outcomes reported by grantees; and

(7) establish a process or mechanism to evaluate the success of the capacity building grant program and to build the evidence base for effective community-based organizational capacity building in reducing disparities.

Subd. 3. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: organizations or entities that work with diverse communities such populations

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

Subd. 4. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with community stakeholders, shall develop a request for proposals for equity in procurement and grantmaking capacity building grant program to help community-based organizations, including faith-based organizations to be better equipped and prepared for success in procuring grants and contracts at the department and addressing inequities.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from organizations or entities led by populations of color, American Indians and those serving communities of color, American Indians; LGBTQIA+, and disability communities.

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

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

Sec. 62. **[144.9981] CLIMATE RESILIENCY.**

Subdivision 1. **Climate resiliency program.** The commissioner of health shall implement a climate resiliency program to:

(1) increase awareness of climate change;

(2) track the public health impacts of climate change and extreme weather events;

(3) provide technical assistance and tools that support climate resiliency to local public health, Tribal health, soil and water conservation districts, and other local governmental and nongovernmental organizations; and

(4) coordinate with the commissioners of the pollution control agency, natural resources, and agriculture and other state agencies in climate resiliency related planning and implementation.

Subd. 2. **Grants authorized; allocation.** (a) The commissioner of health shall manage a grant program for the purpose of climate resiliency planning. The commissioner shall award grants through a request for proposals process to local public health, Tribal health,

soil and water conservation districts, or other local organizations for planning for the health impacts of extreme weather events and developing adaptation actions. Priority shall be given to organizations that serve communities that are disproportionately impacted by climate change.

(b) Grantees must use the funds to develop a plan or implement strategies that will reduce the risk of health impacts from extreme weather events. The grant application must include:

(1) a description of the plan or project for which the grant funds will be used;

(2) a description of the pathway between the plan or project and its impacts on health;

(3) a description of the objectives, a work plan, and a timeline for implementation; and

(4) the community or group the grant proposes to focus on.

Sec. 63. Minnesota Statutes 2022, section 144G.16, subdivision 7, is amended to read:

Subd. 7. **Fines and penalties.** (a) The ~~fee~~ fine for failure to comply with the notification requirements in section 144G.52, subdivision 7, is $1,000.

(b) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 64. Minnesota Statutes 2022, section 144G.18, is amended to read:

144G.18 NOTIFICATION OF CHANGES IN INFORMATION.

Subdivision 1. **Notification.** A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, clause (1), (3), (4), (17), or (18).

Subd. 2. **Fines and penalties.** (a) The fine for failure to comply with the notification requirements of this section is $1,000.

(b) Fines and penalties collected under this subdivision shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 65. Minnesota Statutes 2022, section 144G.57, subdivision 8, is amended to read:

Subd. 8. ~~**Fine**~~ **Fines and penalties.** (a) The commissioner may impose a fine for failure to follow the requirements of this section.

(b) The fine for failure to comply with this section is $1,000.

(c) Fines and penalties collected under this section shall be deposited in a dedicated special revenue account. On an annual basis, the balance in the special revenue account shall be appropriated to the commissioner to implement the recommendations of the advisory council established in section 144A.4799.

Sec. 66. **[145.361] LONG COVID.**

Subdivision 1. **Definition.** For the purpose of this section, "long COVID" means health problems that people experience four or more weeks after being infected with SARS-CoV-2, the virus that causes COVID-19. Long COVID is also called post COVID conditions, long-haul COVID, chronic COVID, post-acute COVID, or post-acute sequelae of COVID-19 (PASC).

Subd. 2. **Establishment.** The commissioner of health shall establish a program to conduct community assessments and epidemiologic investigations to monitor and address impacts of long COVID. The purposes of these activities are to:

(1) monitor trends in: incidence, prevalence, mortality, and health outcomes; care management and costs; changes in disability status, employment, and quality of life; and service needs of individuals with long COVID and to detect potential public health problems, predict risks, and assist in investigating long COVID health inequities;

(2) more accurately target information and resources for communities and patients and their families;

(3) inform health professionals and citizens about risks, early detection, and treatment of long COVID known to be elevated in their communities; and

(4) promote evidence-based practices around long COVID prevention and management and to address public concerns and questions about long COVID.

Subd. 3. **Partnerships.** The commissioner of health shall, in consultation with health care professionals, the Department of Human Services, local public health, health insurers, employers, schools, long COVID survivors, and community organizations serving people at high risk of long COVID, identify priority actions and activities to address the needs for

communication, services, resources, tools, strategies, and policies to support long COVID survivors and their families.

Subd. 4. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement evidence-informed priority actions through community-based grants and contracts. The commissioner of health shall award contracts and grants to organizations that serve communities disproportionately impacted by COVID-19 and long COVID, including but not limited to rural and low-income areas, Black and African Americans, African immigrants, American Indians, Asian American-Pacific Islanders, Latino(a), LGBTQ+, and persons with disabilities. Organizations may also address intersectionality within the groups. The commissioner shall award grants and contracts to eligible organizations to plan, construct, and disseminate resources and information to support survivors of long COVID, including caregivers, health care providers, ancillary health care workers, workplaces, schools, communities, and local and Tribal public health.

Sec. 67. **[145.561] 988 SUICIDE AND CRISIS LIFELINE.**

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

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

(c) "Department" means the Department of Health.

(d) "988" means the universal telephone number designated as the universal telephone number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline, or its successor, maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(e) "988 administrator" means the administrator of the national 988 Suicide and Crisis Lifeline maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act.

(f) "988 contact" means a communication with the 988 Suicide and Crisis Lifeline system within the United States via modalities offered including call, chat, or text.

(g) "988 Lifeline Center" means a state identified center that is a member of the Suicide and Crisis Lifeline network that responds to statewide or regional 988 contacts.

(h) "988 Suicide and Crisis Lifeline (988 Lifeline)" means the national suicide prevention and mental health crisis hotline system maintained by the Assistant Secretary for Mental Health and Substance Use under section 520E-3 of the Public Health Service Act (United States Code, title 42, sections 290bb-36c).

(i) "Veterans Crisis Line" means the Veterans Crisis Line maintained by the Secretary of Veterans Affairs under United States Code, title 38, section 170F(h).

Subd. 2. **988 Lifeline.** (a) The commissioner shall administer the designation of and oversight for a 988 Lifeline center or a network of 988 Lifeline centers to answer contacts from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24 hours per day, seven days per week.

(b) The designated 988 Lifeline Center must:

(1) have an active agreement with the 988 Suicide and Crisis Lifeline program for participation in the network and the department;

(2) meet the 988 Lifeline program requirements and best practice guidelines for operational and clinical standards;

(3) provide data and reports, and participate in evaluations and related quality improvement activities as required by the 988 Lifeline program and the department;

(4) identify or adapt technology that is demonstrated to be interoperable across Mobile Crisis and Public Safety Answering Points used in the state for the purpose of crisis care coordination;

(5) facilitate crisis and outgoing services, including mobile crisis teams in accordance with guidelines established by the 988 Lifeline program and the department;

(6) actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers including certified community behavioral health clinics and community behavioral health centers, mobile crisis teams, and community based and hospital emergency departments;

(7) offer follow-up services to individuals accessing the Lifeline Center that are consistent with guidance established by the 988 Lifeline program and the department; and

(8) meet the requirements set by the 988 Lifeline program and the department for serving at-risk and specialized populations.

(c) The department shall adopt rules and regulations to allow appropriate information sharing and communication between and across crisis and emergency response systems.

(d) The department, having primary oversight of suicide prevention, shall work with the 988 Lifeline program, veterans crisis line, and other SAMHSA-approved networks for the purpose of ensuring consistency of public messaging about 988 services. The department may use funds under this section or provide grants to organizations in order to publicize and raise awareness about 988 services.

(e) The department shall work with representatives from 988 Lifeline Centers and public safety answering points, other public safety agencies and the commissioner of public safety to facilitate the development of protocols and procedures for interactions between 988 and 911 services across Minnesota. Protocols and procedures shall be developed following available national standards and guidelines.

(f) The department shall provide an annual report of the 988 Lifeline usage including answer rates, abandoned calls, and referrals to 911 emergency response.

Subd. 3. **988 special revenue account established.** (a) There is established a dedicated account in the special revenue fund to create and maintain a statewide 988 suicide and crisis lifeline system pursuant to the National Suicide Hotline Designation Act of 2020, the Federal Communications Commission's rules adopted July 16, 2020, and national guidelines for crisis care.

(b) The account shall consist of:

(1) a 988 telecommunications fee imposed;

(2) a prepaid wireless 988 fee imposed under section 403.161;

(3) appropriations made by the state legislature;

(4) grants and gifts intended for deposit;

(5) interest, premiums, gains, or other earnings on the account; and

(6) money from any other source that is deposited in or transferred to the account.

(c) The fund shall be administered by the department and money in the account shall be expended to offset costs that are or can be reasonably attributed to:

(1) implementing, maintaining, and improving the 988 suicide and crisis lifeline including staffing and technological infrastructure enhancements necessary to achieve operational standards and best practices set by the 988 lifeline and the department;

(2) personnel for 988 lifeline centers;

(3) data collection, reporting, participation in evaluations, public promotion, and related quality improvement activities as required by the 988 administrator and the department; and

(4) administration, oversight, and evaluation of the fund.

(d) Money in the fund:

(1) does not revert at the end of any state fiscal year but remains available for the purposes of the fund in subsequent state fiscal years;

(2) is not subject to transfer to any other fund or to transfer, assignment, or reassignment for any other use or purpose; and

(3) is continuously appropriated to the commissioner for the purposes of the account.

(e) An annual report of funds, deposits, and expenditures shall be made to the Federal Communications Commission.

Subd. 4. **988 telecommunications fee.** (a) In compliance with the National Suicide Hotline Designation Act of 2020, the department shall impose a monthly statewide fee on each subscriber of a wireline, wireless, and IP-enabled voice service at a rate that provides for the robust creation, operation, and maintenance of a statewide 988 suicide prevention and crisis system.

(b) The commissioner shall annually recommend to the Public Utilities Commission an adequate and appropriate fee to implement sections of 145.561. The commissioner shall provide telecommunication service providers and carriers a minimum of 30 days' notice of each fee change.

(c) The amount of the 988 telecommunication fee must not be less than 12 cents and no more than 25 cents a month on or after January 1, 2024, for each consumer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1. The 988 telecommunication fee must be the same for all subscribers.

(d) Each wireline, wireless, and IP-enabled voice telecommunications service provider shall collect the 988 telecommunication fee and transfer the amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d).

(e) The commissioner of public safety shall deposit the money collected from the 988 telecommunication fee to the 988 account to be expended only in support of 988 services, or enhancements of such services.

(f) Consistent with United States Code, title 47, section 251(a), the revenue generated by a 988 telecommunication fee must only be used to offset costs that are or will be reasonably attributed to:

(1) ensuring the efficient and effective routing and handling of calls, chats, and texts made to the 988 Suicide and Crisis Lifeline centers including staffing and technological infrastructure enhancements necessary to achieve operational, performance, and clinical standards and best practices set by the 988 Lifeline program and the department; and

(2) personnel and providing acute mental health and crisis outreach services by directly responding to the 988 Suicide and Crisis Lifeline.

(g) All 988 telecommunications fee revenue must be used to supplement, not supplant, any federal, state, or local funding for suicide prevention.

(h) The 988 telecommunications fee amount shall be adjusted as needed to provide for continuous operation, volume increases, and maintenance of the 988 service.

(i) The commissioner shall report on revenue generated by the 988 telecommunications fee to the Federal Communications Commission.

Subd. 5. **988 fee for prepaid wireless telecommunications services.** (a) The 988 telecommunications fee established in subdivision 4 does not apply to prepaid wireless telecommunications services. Prepaid wireless telecommunications services are subject to the prepaid wireless 988 fee established in section 403.161, subdivision 1, paragraph (c).

(b) Collection, remittance, and deposit of prepaid wireless 988 fees are governed by sections 403.161 and 403.162.

Sec. 68. **[145.57] ADOLESCENT MENTAL HEALTH PROMOTION; GRANTS AUTHORIZED.**

Subdivision 1. **Goal and establishment.** (a) It is the goal of the state to increase protective factors for mental well-being and decrease disparities in rates of mental health issues among adolescent populations. The commissioner of health shall administer grants to community-based organizations to facilitate mental health promotion programs for adolescents, particularly those from populations that report higher rates of specific mental health needs.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in mental health promotion among adolescents.

Subd. 2. **Grants authorized.** (a) The commissioner of health shall award grants to eligible community organizations, including nonprofit organizations, community health boards, and Tribal public health entities, to implement community-based mental health promotion programs for adolescents in community settings to improve adolescent mental health and reduce disparities between adolescent populations in reported rates of mental health needs.

(b) The commissioner of health, in collaboration with community and professional stakeholders, shall establish criteria for review of applications received under this subdivision to ensure funded programs operate using best practices such as trauma-informed care and positive youth development principles.

(c) Grant funds distributed under this subdivision shall be used to support new or existing community-based mental health promotion programs that include but are not limited to:

(1) training community-based members to facilitate discussions or courses on adolescent mental health promotion skills;

(2) training trusted community members to model positive mental health skills and practices in their existing roles;

(3) training and supporting adolescents to provide peer support; and

(4) supporting community dialogue on mental health promotion and collective stress or trauma.

Subd. 3. **Evaluation.** The commissioner shall conduct an evaluation of the community-based grant programs funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation, and at the direction of the commissioner, shall provide the commissioner with the information needed to conduct the evaluation.

Sec. 69. **[145.903] SCHOOL-BASED HEALTH CENTERS.**

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

(b) "School-based health center" or "comprehensive school-based health center" means a safety net health care delivery model that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, provided by licensed and qualified health professionals in accordance with federal, state, and local law. When not located on school property, the school-based health center must

have an established relationship with one or more schools in the community and operate to primarily serve those student groups.

(c) "Sponsoring organization" means any of the following that operate a school-based health center:

(1) health care providers;

(2) community clinics;

(3) hospitals;

(4) federally qualified health centers and look-alikes as defined in section 145.9269;

(5) health care foundations or nonprofit organizations;

(6) higher education institutions; or

(7) local health departments.

Subd. 2. **Expansion of Minnesota school-based health centers.** (a) The commissioner of health shall administer a program to provide grants to school districts and school-based health centers to support existing centers and facilitate the growth of school-based health centers in Minnesota.

(b) Grant funds distributed under this subdivision shall be used to support new or existing school-based health centers that:

(1) operate in partnership with a school or school district and with the permission of the school or school district board;

(2) provide health services through a sponsoring organization that meets the requirements in subdivision 1, paragraph (c); and

(3) provide health services to all students and youth within a school or school district, regardless of ability to pay, insurance coverage, or immigration status, and in accordance with federal, state, and local law.

(c) The commissioner of health shall administer a grant to a nonprofit organization to facilitate a community of practice among school-based health centers to improve quality, equity, and sustainability of care delivered through school-based health centers; encourage cross-sharing among school-based health centers; support existing clinics; and expand school-based health centers in new communities in Minnesota.

(d) Grant recipients shall report their activities and annual performance measures as defined by the commissioner in a format and time specified by the commissioner.

(e) The commissioners of health and of education shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote coordinated efforts.

Subd. 3. **School-based health center services.** Services provided by a school-based health center may include but are not limited to:

(1) preventive health care;

(2) chronic medical condition management, including diabetes and asthma care;

(3) mental health care and crisis management;

(4) acute care for illness and injury;

(5) oral health care;

(6) vision care;

(7) nutritional counseling;

(8) substance abuse counseling;

(9) referral to a specialist, medical home, or hospital for care;

(10) additional services that address social determinants of health; and

(11) emerging services such as mobile health and telehealth.

Subd. 4. **Sponsoring organizations.** A sponsoring organization that agrees to operate a school-based health center must enter into a memorandum of agreement with the school or school district. The memorandum of agreement must require the sponsoring organization to be financially responsible for the operation of school-based health centers in the school or school district and must identify the costs that are the responsibility of the school or school district, such as Internet access, custodial services, utilities, and facility maintenance. To the greatest extent possible, a sponsoring organization must bill private insurers, medical assistance, and other public programs for services provided in the school-based health centers in order to maintain the financial sustainability of school-based health centers.

Sec. 70. Minnesota Statutes 2022, section 145.925, is amended to read:

145.925 FAMILY PLANNING GRANTS.

Subdivision 1. ~~**Eligible organizations; purpose**~~ **Goal and establishment.** ~~The commissioner of health may make special grants to cities, counties, groups of cities or counties, or nonprofit corporations to provide prepregnancy family planning services.~~ (a)

It is the goal of the state to increase access to sexual and reproductive health services for people who experience barriers, whether geographic, cultural, financial, or other, in access to such services. The commissioner of health shall administer grants to facilitate access to sexual and reproductive health services for people of reproductive age, particularly those from populations that experience barriers to these services.

(b) The commissioner of health shall coordinate with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts in reproductive and sexual health service promotion among people of reproductive age.

~~Subd. 1a. **Family planning services; defined.** "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.~~

~~Subd. 2. **Prohibition.** The commissioner shall not make special grants pursuant to this section to any nonprofit corporation which performs abortions. No state funds shall be used under contract from a grantee to any nonprofit corporation which performs abortions. This provision shall not apply to hospitals licensed pursuant to sections 144.50 to 144.56, or health maintenance organizations certified pursuant to chapter 62D.~~

Subd. 2a. **Sexual and reproductive health services defined.** For purposes of this section, "sexual and reproductive health services" means services that promote a state of complete physical, mental, and social well-being in relation to sexuality and reproduction, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes, and to sexuality. These services must be provided in accord with nationally recognized standards and include but are not limited to sexual and reproductive health counseling, voluntary and informed decision-making on sexual and reproductive health, information on and provision of contraceptive methods, sexual and reproductive health screenings and treatment, pregnancy testing and counseling, and other preconception services.

Subd. 3. ~~**Minors**~~ **Grants authorized.** ~~No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(2) A description of any attendant discomforts or risks which might reasonably be expected;~~

~~(3) A fair explanation of the likely results, should a method fail;~~

~~(4) A description of any benefits which might reasonably be expected of any method;~~

~~(5) A disclosure of appropriate alternative methods or procedures;~~

~~(6) An offer to answer any inquiries concerning methods of procedures; and~~

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

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

Subd. 9. **Amount of grant; rules.** Notwithstanding any rules to the contrary, including rules proposed in the State Register on April 1, 1991, the commissioner, in allocating grant funds for family planning special projects, shall not limit the total amount of funds that can be allocated to an organization. The commissioner shall allocate to an organization receiving grant funds on July 1, 1997, at least the same amount of grant funds for the 1998 to 1999 grant cycle as the organization received for the 1996 to 1997 grant cycle, provided the organization submits an application that meets grant funding criteria. This subdivision does not affect any procedure established in rule for allocating special project money to the different regions. The commissioner shall revise the rules for family planning special project grants so that they conform to the requirements of this subdivision. In adopting these revisions, the commissioner is not subject to the rulemaking provisions of chapter 14, but is bound by section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.

Sec. 71. **[145.9257] COMMUNITY SOLUTIONS FOR HEALTHY CHILD DEVELOPMENT GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of health shall establish a grant program to improve child development outcomes and the well-being of children of color and American Indian children from prenatal to grade 3 and their families. The purposes of the program are to:

(1) improve child development outcomes related to the well-being of children of color and American Indian children from prenatal to grade 3 and their families, including but not limited to the goals outlined by the Department of Human Services' early childhood systems reform effort: early learning; health and well-being; economic security; and safe, stable, nurturing relationships and environments by funding community-based solutions for challenges that are identified by the affected community;

(2) reduce racial disparities in children's health and development from prenatal to grade 3; and

(3) promote racial and geographic equity.

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

(1) develop a request for proposals for the community solutions healthy child development grant program in consultation with the community solutions advisory council;

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

(3) review responses to requests for proposals, in consultation with the community solutions advisory council, and award grants under this section;

(4) ensure communication with the ethnic councils, Minnesota Indian Affairs Council, and the governor's early learning council on the request for proposal process;

(5) establish a transparent and objective accountability process, in consultation with the community solutions advisory council, focused on outcomes that grantees agree to achieve;

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

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

(8) contract with an independent third-party entity to evaluate the success of the grant program and to build the evidence base for effective community solutions in reducing health disparities of children of color and American Indian children from prenatal to grade 3.

Subd. 3. **Community solutions advisory council; establishment; duties; compensation.** (a) No later than October 1, 2023, the commissioner shall have convened a 12-member community solutions advisory council as follows:

(1) two members representing the African Heritage community;

(2) two members representing the Latino community;

(3) two members representing the Asian-Pacific Islander community;

(4) two members representing the American Indian community;

(5) two parents of children of Black, nonwhite people of color, or that are American Indian with children under nine years of age;

(6) one member with research or academic expertise in racial equity and healthy child development; and

(7) one member representing an organization that advocates on behalf of communities of color or American Indians.

(b) At least three of the 12 members of the advisory council must come from outside the seven-county metropolitan area.

(c) The community solutions advisory council shall:

(1) advise the commissioner on the development of the request for proposals for community solutions healthy child development grants. In advising the commissioner, the council must consider how to build on the capacity of communities to promote child and family well-being and address social determinants of healthy child development;

(2) review responses to requests for proposals and advise the commissioner on the selection of grantees and grant awards;

(3) advise the commissioner on the establishment of a transparent and objective accountability process focused on outcomes the grantees agree to achieve;

(4) advise the commissioner on ongoing oversight and necessary support in the implementation of the program; and

(5) support the commissioner on other racial equity and early childhood grant efforts.

(d) Each advisory council member shall be compensated in accordance with section 15.059, subdivision 3.

Subd. 4. **Eligible grantees.** Organizations eligible to receive grant funding under this section include: (1) organizations or entities that work with Black, non-white communities of color, and American Indian communities;

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

(3) organizations or entities focused on supporting healthy child development.

Subd. 5. **Strategic consideration and priority of proposals; eligible populations; grant awards.** (a) The commissioner, in consultation with the community solutions advisory council, shall develop a request for proposals for healthy child development grants. In developing the proposals and awarding the grants, the commissioner shall consider building on the capacity of communities to promote child and family well-being and address social determinants of healthy child development. Proposals must focus on increasing racial equity and healthy child development and reducing health disparities experienced by children of Black, nonwhite people of color, and American Indian children from prenatal to grade 3 and their families.

(b) In awarding the grants, the commissioner shall provide strategic consideration and give priority to proposals from:

(1) organizations or entities led by Black and other nonwhite people of color and serving Black and nonwhite communities of color;

(2) organizations or entities led by American Indians and serving American Indians, including Tribal nations and Tribal organizations;

(3) organizations or entities with proposals focused on healthy development from prenatal to age three;

(4) organizations or entities with proposals focusing on multigenerational solutions;

(5) organizations or entities located in or with proposals to serve communities located in counties that are moderate to high risk according to the Wilder Research Risk and Reach Report; and

(6) community-based organizations that have historically served communities of color and American Indians and have not traditionally had access to state grant funding.

The advisory council may recommend additional strategic considerations and priorities to the commissioner.

Subd. 6. **Geographic distribution of grants.** The commissioner and the advisory council shall ensure that grant funds are prioritized and awarded to organizations and entities that are within counties that have a higher proportion of Black, nonwhite communities of color, and American Indians than the state average, to the extent possible.

Subd. 7. **Report.** Grantees must report grant program outcomes to the commissioner on the forms and according to the timelines established by the commissioner.

Sec. 72. **[145.9272] LEAD REMEDIATION IN SCHOOL AND CHILD CARE SETTINGS GRANT PROGRAM.**

Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a grant program for the purpose of remediating identified sources of lead in drinking water in schools and licensed child care settings.

Subd. 2. **Grants authorized.** The commissioner shall award grants through a request for proposals process to schools and licensed child care settings. Priority shall be given to schools and licensed child care settings with higher levels of lead detected in water samples, evidence of lead service lines, or lead plumbing materials and school districts that serve disadvantaged communities.

Subd. 3. **Grant allocation.** Grantees must use the funds to address sources of lead contamination in their facilities including but not limited to service connections, premise plumbing, and implementing best practices for water management within the building.

Sec. 73. **[145.9273] TESTING FOR LEAD IN DRINKING WATER IN CHILD CARE SETTINGS.**

Subdivision 1. **Requirement to test.** By July 1, 2024, licensed child care providers must develop a plan to accurately and efficiently test for the presence of lead in drinking water in child care facilities following either the Department of Health's document "Reducing Lead in Drinking Water: A Technical Guidance for Minnesota's School and Child Care Facilities" or the Environmental Protection Agency's "3Ts: Training, Testing, Taking Action" guidance materials.

Subd. 2. **Scope and frequency of testing.** The plan under subdivision 1 must include testing every building serving children and all water fixtures used for consumption of water, including water used in food preparation. All taps must be tested at least once every five years. A licensed child care provider must begin testing in buildings by July 1, 2024, and complete testing in all buildings that serve students within five years.

Subd. 3. **Remediation of lead in drinking water.** The plan under subdivision 1 must include steps to remediate if lead is present in drinking water. A licensed child care provider that finds lead at concentrations at or exceeding five parts per billion at a specific location providing water to children within its facilities must take action to reduce lead exposure following guidance and verify the success of remediation by retesting the location for lead. Remediation actions are actions that reduce lead levels from the drinking water fixture as demonstrated by testing. This includes using certified filters, implementing, and documenting

a building-wide flushing program, and replacing or removing fixtures with elevated lead levels.

Subd. 4. **Reporting results.** (a) A licensed child care provider that tested its buildings for the presence of lead shall make the results of the testing and any remediation steps taken available to parents and staff and notify them of the availability of results. Reporting shall occur no later than 30 days from receipt of results and annually thereafter.

(b) Beginning July 1, 2024, a licensed child care provider must report the provider's test results and remediation activities to the commissioner of health annually on or before July 1 of each year.

Sec. 74. **[145.9571] HEALTHY BEGINNINGS, HEALTHY FAMILIES ACT.**

Subdivision 1. **Purpose.** The purpose of the Healthy Beginnings, Healthy Families Act is to build equitable, inclusive, and culturally and linguistically responsive systems that ensure the health and well-being of young children and their families by supporting the Minnesota perinatal quality collaborative, establishing the Minnesota partnership to prevent infant mortality, increasing access to culturally relevant developmental and social-emotional screening with follow-up, and sustaining and expanding the model jail practices for children of incarcerated parents in Minnesota jails.

Subd. 2. **Minnesota perinatal quality collaborative.** The Minnesota perinatal quality collaborative is established to improve pregnancy outcomes for pregnant people and newborns through efforts to:

(1) advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives that enable equitable outcomes;

(2) review current data, trends, and research on best practices to inform and prioritize quality improvement initiatives;

(3) identify methods that incorporate antiracism into individual practice and organizational guidelines in the delivery of perinatal health services;

(4) support quality improvement initiatives to address substance use disorders in pregnant people and infants with neonatal abstinence syndrome or other effects of substance use;

(5) provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes;

(6) reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

(7) support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Subd. 3. **Eligible organizations.** The commissioner of health shall make a grant to a nonprofit organization to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives.

Subd. 4. **Grants authorized.** The commissioner shall award one grant to a nonprofit organization to support efforts that improve maternal and infant health outcomes aligned with the purpose outlined in subdivision 2. The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state. The commissioner shall provide content expertise to the grant recipient to further the accomplishment of the purpose.

Subd. 5. **Minnesota partnership to prevent infant mortality program.** (a) The commissioner of health shall establish the Minnesota partnership to prevent infant mortality program that is a statewide partnership program to engage communities, exchange best practices, share summary data on infant health, and promote policies to improve birth outcomes and eliminate preventable infant mortality.

(b) The goal of the Minnesota partnership to prevent infant mortality program is to:

(1) build a statewide multisectoral partnership including the state government, local public health agencies, Tribes, private sector, and community nonprofit organizations with the shared goal of decreasing infant mortality rates among populations with significant disparities, including among Black, American Indian, other nonwhite communities, and rural populations;

(2) address the leading causes of poor infant health outcomes such as premature birth, infant sleep-related deaths, and congenital anomalies through strategies to change social and environmental determinants of health; and

(3) promote the development, availability, and use of data-informed, community-driven strategies to improve infant health outcomes.

Subd. 5a. **Grants authorized.** (a) The commissioner of health shall award grants to eligible applicants to convene, coordinate, and implement data-driven strategies and culturally

relevant activities to improve infant health by reducing preterm birth, sleep-related infant deaths, and congenital malformations and address social and environmental determinants of health. Grants shall be awarded to support community nonprofit organizations, Tribal governments, and community health boards. In accordance with available funding, grants shall be noncompetitively awarded to the eleven sovereign Tribal governments if their respective proposals demonstrate the ability to implement programs designed to achieve the purposes in subdivision 2 and meet other requirements of this section. An eligible applicant must submit a complete application to the commissioner of health by the deadline established by the commissioner. The commissioner shall award all other grants competitively to eligible applicants in metropolitan and rural areas of the state and may consider geographic representation in grant awards.

(b) Grantee activities shall:

(1) address the leading cause or causes of infant mortality;

(2) be based on community input;

(3) focus on policy, systems, and environmental changes that support infant health; and

(4) address the health disparities and inequities that are experienced in the grantee's community.

(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to subdivision 2, the commissioner shall establish criteria including but not limited to: the eligibility of the applicant's project under this section; the applicant's thoroughness and clarity in describing the infant health issues grant funds are intended to address; a description of the applicant's proposed project; the project's likelihood to achieve the grant's purposes as described in this section; a description of the population demographics and service area of the proposed project; and evidence of efficiencies and effectiveness gained through collaborative efforts.

(d) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 5b. **Technical assistance.** (a) The commissioner shall provide content expertise, technical expertise, training to grant recipients, and advice on data-driven strategies.

(b) For the purposes of carrying out the grant program under subdivision 5, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) partnership development and capacity building;

(2) Tribal support;

(3) implementation support for specific infant health strategies;

(4) communications by convening and sharing lessons learned; and

(5) health equity.

Subd. 6. **Developmental and social-emotional screening with follow-up.** The goal of the developmental and social-emotional screening is to identify young children at risk for developmental and behavioral concerns and provide follow-up services to connect families and young children to appropriate community-based resources and programs. The commissioner of health shall work with the commissioners of human services and education to implement this section and promote interagency coordination with other early childhood programs including those that provide screening and assessment.

Subd. 6a. **Duties.** The commissioner shall:

(1) increase the awareness of developmental and social-emotional screening with follow-up in coordination with community and state partners;

(2) expand existing electronic screening systems to administer developmental and social-emotional screening to children birth to kindergarten entrance;

(3) provide screening for developmental and social-emotional delays based on current recommended best practices;

(4) review and share the results of the screening with the parent or guardian. Support families in their role as caregivers by providing anticipatory guidance around typical growth and development;

(5) ensure children and families are referred to and linked with appropriate community-based services and resources when any developmental or social-emotional concerns are identified through screening; and

(6) establish performance measures and collect, analyze, and share program data regarding population-level outcomes of developmental and social-emotional screening, referrals to community-based services, and follow-up services.

Subd. 6b. **Grants authorized.** The commissioner shall award grants to community-based organizations, community health boards, and Tribal nations to support follow-up services for children with developmental or social-emotional concerns identified through screening in order to link children and their families to appropriate community-based services and resources. Grants shall also be awarded to community-based organizations to train and utilize cultural liaisons to help families navigate the screening and follow-up process in a culturally and linguistically responsive manner. The commissioner shall provide technical assistance, content expertise, and training to grant recipients to ensure that follow-up services are effectively provided.

Subd. 7. **Model jail practices for incarcerated parents.** (a) The commissioner of health may make special grants to counties and groups of counties to implement model jail practices and to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) "Model jail practices" means a set of practices that correctional administrators can implement to remove barriers that may prevent children from cultivating or maintaining relationships with their incarcerated parents during and immediately after incarceration without compromising safety or security of the correctional facility.

Subd. 7a. **Grants authorized; model jail practices.** (a) The commissioner of health shall award grants to eligible county jails to implement model jail practices and separate grants to county governments, Tribal governments, or nonprofit organizations in corresponding geographic areas to build partnerships with county jails to support children of incarcerated parents and their caregivers.

(b) Grantee activities include but are not limited to:

(1) parenting classes or groups;

(2) family-centered intake and assessment of inmate programs;

(3) family notification, information, and communication strategies;

(4) correctional staff training;

(5) policies and practices for family visits; and

(6) family-focused reentry planning.

(c) Grant recipients shall report their activities to the commissioner in a format and at a time specified by the commissioner.

Subd. 7b. **Technical assistance and oversight; model jail practices.** (a) The commissioner shall provide content expertise, training to grant recipients, and advice on evidence-based strategies, including evidence-based training to support incarcerated parents.

(b) For the purposes of carrying out the grant program under subdivision 7a, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) evidence-based training for incarcerated parents;

(2) partnership building and community engagement;

(3) evaluation of process and outcomes of model jail practices; and

(4) expert guidance on reducing the harm caused to children of incarcerated parents and application of model jail practices.

Sec. 75. **[145.987] HEALTH EQUITY ADVISORY AND LEADERSHIP (HEAL) COUNCIL.**

Subdivision 1. **Establishment; composition of advisory council.** The commissioner shall establish and appoint a health equity advisory and leadership (HEAL) council to provide guidance to the commissioner of health regarding strengthening and improving the health of communities most impacted by health inequities across the state. The council shall consist of 18 members who will provide representation from the following groups:

(1) African American and African heritage communities;

(2) Asian American and Pacific Islander communities;

(3) Latina/o/x communities;

(4) American Indian communities and Tribal governments and nations;

(5) disability communities;

(6) lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities; and

(7) representatives who reside outside the seven-county metropolitan area.

Subd. 2. **Organization and meetings.** The advisory council shall be organized and administered under section 15.059. Meetings shall be held at least quarterly and hosted by

the department. Subcommittees may be convened as necessary. Advisory council meetings are subject to the open meeting law under chapter 13D.

Subd. 3. **Duties.** The advisory council shall:

(1) advise the commissioner on health equity issues and the health equity priorities and concerns of the populations specified in subdivision 1;

(2) assist the agency in efforts to advance health equity, including consulting in specific agency policies and programs, providing ideas and input about potential budget and policy proposals, and recommending review of agency policies, standards, or procedures that may create or perpetuate health inequities; and

(3) assist the agency in developing and monitoring meaningful performance measures related to advancing health equity.

Subd. 4. **Expiration.** The advisory council shall remain in existence until health inequities in the state are eliminated. Health inequities will be considered eliminated when race, ethnicity, income, gender, gender identity, geographic location, or other identity or social marker will no longer be predictors of health outcomes in the state. Section 145.928 describes nine health disparities that must be considered when determining whether health inequities have been eliminated in the state.

Sec. 76. **[145.988] COMPREHENSIVE AND COLLABORATIVE RESOURCE AND REFERRAL SYSTEM FOR CHILDREN.**

Subdivision 1. **Establishment; purpose.** The commissioner shall establish the Comprehensive and Collaborative Resource and Referral System for Children to support a comprehensive, collaborative resource and referral system for children from prenatal through age eight, and their families. The commissioner of health shall work collaboratively with the commissioners of human services and education to implement this section.

Subd. 2. **Duties.** (a) The Help Me Connect system shall facilitate collaboration across sectors, including child health, early learning and education, child welfare, and family supports by:

(1) providing early childhood provider outreach to support knowledge of and access to local resources that provide early detection and intervention services;

(2) identifying and providing access to early childhood and family support navigation specialists that can support families and their children's needs; and

(3) linking children and families to appropriate community-based services.

(b) The Help Me Connect system shall provide community outreach that includes support for, and participation in, the Help Me Connect system, including disseminating information on the system and compiling and maintaining a current resource directory that includes but is not limited to primary and specialty medical care providers; early childhood education and child care programs; developmental disabilities assessment and intervention programs; mental health services; family and social support programs; child advocacy and legal services; public health services and resources; and other appropriate early childhood information.

(c) The Help Me Connect system shall maintain a centralized access point for parents and professionals to obtain information, resources, and other support services.

(d) The Help Me Connect system shall collect data to increase understanding of the current and ongoing system of support and resources for expectant families and children through age eight and their families, including identification of gaps in service, barriers to finding and receiving appropriate services, and lack of resources.

Sec. 77. Minnesota Statutes 2022, section 145A.131, subdivision 1, is amended to read:

Subdivision 1. **Funding formula for community health boards.** (a) Base funding for each community health board eligible for a local public health grant under section 145A.03, subdivision 7, shall be determined by each community health board's fiscal year 2003 allocations, prior to unallotment, for the following grant programs: community health services subsidy; state and federal maternal and child health special projects grants; family home visiting grants; TANF MN ENABL grants; TANF youth risk behavior grants; and available women, infants, and children grant funds in fiscal year 2003, prior to unallotment, distributed based on the proportion of WIC participants served in fiscal year 2003 within the CHS service area.

(b) Base funding for a community health board eligible for a local public health grant under section 145A.03, subdivision 7, as determined in paragraph (a), shall be adjusted by the percentage difference between the base, as calculated in paragraph (a), and the funding available for the local public health grant.

(c) Multicounty or multicity community health boards shall receive a local partnership base of up to $5,000 per year for each county or city in the case of a multicity community health board included in the community health board.

(d) The State Community Health Advisory Committee may recommend a formula to the commissioner to use in distributing funds to community health boards.

(e) Notwithstanding any adjustment in paragraph (b), community health boards, all or a portion of which are located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright, are eligible to receive an increase equal to ten percent of the grant award to the community health board under paragraph (a) starting July 1, 2015. The increase in calendar year 2015 shall be prorated for the last six months of the year. For calendar years beginning on or after January 1, 2016, the amount distributed under this paragraph shall be adjusted each year based on available funding and the number of eligible community health boards.

(f) Funding for foundational public health responsibilities must be distributed based on a formula determined by the commissioner in consultation with the State Community Health Services Advisory Committee. A portion of these funds may be used to fund new organizational models, including multijurisdictional and regional partnerships. These funds shall be used in accordance with subdivision 5.

Sec. 78. Minnesota Statutes 2022, section 145A.131, subdivision 5, is amended to read:

Subd. 5. **Use of funds.** (a) Community health boards may use the base funding of their local public health grant funds as outlined in subdivision 1, paragraphs (a) to (e), to address the areas of public health responsibility and local priorities developed through the community health assessment and community health improvement planning process.

(b) Funding for foundational public health responsibilities as outlined in subdivision 1, paragraph (f), must be used to fulfill foundational public health responsibilities as defined by the commissioner in consultation with the State Community Health Service Advisory Committee unless a community health board can demonstrate fulfillment of foundational public health responsibilities. If a community health board can demonstrate foundational public health responsibilities are fulfilled, funds may be used for local priorities developed through the community health assessment and community health improvement planning process.

(c) By July 1, 2028, all local public health grant funds must be used first to fulfill foundational public health responsibilities. Once a community health board can demonstrate foundational public health responsibilities are fulfilled, funds can be used for local priorities developed through the community health assessment and community health improvement planning process.

Sec. 79. Minnesota Statutes 2022, section 145A.14, is amended by adding a subdivision to read:

Subd. 2b. **Grants to Tribes.** The commissioner shall distribute grants to Tribal governments for foundational public health responsibilities as defined by each Tribal government.

Sec. 80. Minnesota Statutes 2022, section 403.161, is amended to read:

403.161 PREPAID WIRELESS FEES IMPOSED; COLLECTION; REMITTANCE.

Subdivision 1. **Fees imposed.** (a) A prepaid wireless E911 fee of 80 cents per retail transaction is imposed on prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(b) A prepaid wireless telecommunications access Minnesota fee, in the amount of the monthly charge provided for in section 237.52, subdivision 2, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

(c) A prepaid wireless 988 fee, in the amount of the monthly charge, is imposed on each retail transaction for prepaid wireless telecommunications service until the fee is adjusted as an amount per retail transaction under subdivision 7.

Subd. 2. **Exemption.** The fees established under subdivision 1 are not imposed on a minimal amount of prepaid wireless telecommunications service that is sold with a prepaid wireless device and is charged a single nonitemized price, and a seller may not apply the fees to such a transaction. For purposes of this subdivision, a minimal amount of service means an amount of service denominated as either ten minutes or less or $5 or less.

Subd. 3. **Fee collected.** The prepaid wireless E911 ~~and~~, telecommunications access Minnesota, and 988 fees must be collected by the seller from the consumer for each retail transaction occurring in this state. The amount of each fee must be combined into one amount, which must be separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller.

Subd. 4. **Sales and use tax treatment.** For purposes of this section, a retail transaction conducted in person by a consumer at a business location of the seller must be treated as occurring in this state if that business location is in this state, and any other retail transaction must be treated as occurring in this state if the retail transaction is treated as occurring in this state for purposes of the sales and use tax as specified in section 297A.669, subdivision 3, paragraph (c).

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

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

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

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

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

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

403.162 ADMINISTRATION OF PREPAID WIRELESS E911 FEES.

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

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

Subd. 3. **Department of Revenue provisions.** The audit, assessment, appeal, collection, refund, penalty, interest, enforcement, and administrative provisions of chapters 270C and 289A that are applicable to the taxes imposed by chapter 297A apply to any fee imposed under section 403.161.

Subd. 4. **Procedures for resale transactions.** The commissioner of revenue shall establish procedures by which a seller of prepaid wireless telecommunications service may document that a sale is not a retail transaction. These procedures must substantially coincide with the procedures for documenting sale for resale transactions as provided in chapter 297A.

Subd. 5. **Fees deposited.** (a) The commissioner of revenue shall, based on the relative proportion of the prepaid wireless E911 fee ~~and~~, the prepaid wireless telecommunications access Minnesota fee, and the prepaid wireless 988 fee, imposed per retail transaction, divide the fees collected in corresponding proportions. Within 30 days of receipt of the collected fees, the commissioner shall:

(1) deposit the proportion of the collected fees attributable to the prepaid wireless E911 fee in the 911 emergency telecommunications service account in the special revenue fund; ~~and~~

(2) deposit the proportion of collected fees attributable to the prepaid wireless telecommunications access Minnesota fee in the telecommunications access fund established in section 237.52, subdivision 1~~.~~; and

(3) deposit the proportion of the collected fees attributable to the prepaid wireless 988 fee in the 988 special revenue fund established.

(b) The commissioner of revenue may deduct and deposit in a special revenue account an amount not to exceed two percent of collected fees. Money in the account is annually appropriated to the commissioner of revenue to reimburse its direct costs of administering the collection and remittance of prepaid wireless E911 fees, ~~and~~ prepaid wireless telecommunications access Minnesota fees~~.~~, and prepaid wireless 988 fees.

Sec. 82. Laws 2022, chapter 99, article 1, section 46, is amended to read:

Sec. 46. **MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

Subdivision 1. **Grants authorized.** (a) The commissioner of health shall develop a grant program to award grants to health care entities, including but not limited to health care systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of health care professionals.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 83. Laws 2022, chapter 99, article 3, section 9, is amended to read:

Sec. 9. **APPROPRIATION; MENTAL HEALTH GRANTS FOR HEALTH CARE PROFESSIONALS.**

$1,000,000 in fiscal year 2023 is appropriated from the general fund to the commissioner of health for the health care professionals mental health grant program. This is a onetime appropriation and is available until June 30, 2027.

Sec. 84. **COVID-19 PANDEMIC DELAYED PREVENTIVE CARE.**

Subdivision 1. **Establishment.** The commissioner of health shall develop a comprehensive program to increase access and utilization of preventive care and ongoing disease management to improve the health and well-being of all Minnesotans and contribute to reducing health care costs. The purpose is to:

(1) address disparities in health outcomes focused on the leading causes of morbidity and mortality, including but not limited to cardiovascular disease, stroke, diabetes, cancer, asthma, mental health, and oral health for residents statewide;

(2) promote use of community-led programs to meet local needs;

(3) promote partnerships between local communities, Tribal and local public health agencies and health care providers;

(4) address how underlying determinants of health including food, housing, and economic insecurity impact health outcomes;

(5) ensure programs use innovative and evidence-based and practice informed strategies including but not limited to telehealth and use of paraprofessionals such as community health workers and use of community locations outside of medical settings including but not limited to libraries and mobile sites; and

(6) support implementation of state plans to improve health outcomes for Minnesotans.

Subd. 2. **Partnerships.** The commissioner of health shall consult and collaborate with organizations and agencies including but not limited to health care, local public health, and community organizations that serve people who are disproportionately experiencing health inequities, to assess, prioritize and implement strategies and policies that will improve health.

Subd. 3. **Grants and contracts.** The commissioner of health shall coordinate and collaborate with community and organizational partners to implement health improvement

strategies. The commissioner of health shall award contracts and grants to organizations including but not limited to community-led organizations, Tribal and local public health agencies, and health care organizations that serve communities disproportionately impacted by health inequities. The commissioner of health shall award grants and contracts to eligible organizations to assess or implement steps to reduce barriers to implementation of chronic disease prevention and management programs.

Subd. 4. **Evaluation.** The commissioner of health shall assess and evaluate grants awarded to assess changes in access and utilization of screening and disease management services from statewide data sources.

Sec. 85. **REPEALER.**

(a) Minnesota Statutes 2022, sections 62J.84, subdivision 5; and 62U.10, subdivisions 6, 7, and 8, are repealed.

(b) Minnesota Statutes 2022, sections 145.4235; 145.4241; 145.4242; 145.4243; 145.4244; 145.4245; 145.4246; 145.4247; 145.4248; 145.4249; and 145.925, subdivisions 1a, 3, 4, 7, and 8, are repealed.

ARTICLE 3
HEALTH BOARDS POLICY

Section 1. **[148.635] FEE.**

Subdivision 1. **Nonrefundable fee.** The fee in this section is nonrefundable.

Subd. 2. **Licensure verification fee.** The fee for verification of licensure is $20.

Sec. 2. Minnesota Statutes 2022, section 148B.392, subdivision 2, is amended to read:

Subd. 2. **Licensure and application fees.** Licensure and application fees established by the board shall not exceed the following amounts:

(1) application fee for national examination is ~~$110~~ $150;

(2) application fee for Licensed Marriage and Family Therapist (LMFT) state examination is ~~$110~~ $150;

(3) initial LMFT license fee is prorated, but cannot exceed $125;

(4) annual renewal fee for LMFT license is ~~$125~~ $225;

(5) late fee for LMFT license renewal is ~~$50~~ $100;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(9) drug wholesaler, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(10) third-party logistics provider, ~~$260~~ $300;

(11) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,300;

(12) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,300;

(13) drug manufacturer, nonlegend or veterinary legend drugs, ~~$5,260~~ $5,300;

(14) drug manufacturer, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(15) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,300;

(16) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,300;

(17) medical gas dispenser, $260;

(18) controlled substance researcher, ~~$75~~ $150; and

(19) pharmacy professional corporation, $150.

Sec. 4. Minnesota Statutes 2022, section 151.065, subdivision 2, is amended to read:

Subd. 2. **Original license fee.** The pharmacist original licensure fee, ~~$175~~ $210.

Sec. 5. Minnesota Statutes 2022, section 151.065, subdivision 3, is amended to read:

Subd. 3. **Annual renewal fees.** Annual licensure and registration renewal fees are as follows:

(1) pharmacist, ~~$175~~ $210;

(2) pharmacy technician, ~~$50~~ $60;

(3) pharmacy, ~~$260~~ $300;

(4) drug wholesaler, legend drugs only, ~~$5,260~~ $5,300;

(5) drug wholesaler, legend and nonlegend drugs, ~~$5,260~~ $5,300;

(6) drug wholesaler, nonlegend drugs, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(7) drug wholesaler, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(8) third-party logistics provider, ~~$260~~ $300;

(9) drug manufacturer, nonopiate legend drugs only, ~~$5,260~~ $5,300;

(10) drug manufacturer, nonopiate legend and nonlegend drugs, ~~$5,260~~ $5,300;

(11) drug manufacturer, nonlegend, veterinary legend drugs, or both, ~~$5,260~~ $5,300;

(12) drug manufacturer, medical gases, ~~$5,260~~ $5,300 for the first facility and ~~$260~~ $300 for each additional facility;

(13) drug manufacturer, also licensed as a pharmacy in Minnesota, ~~$5,260~~ $5,300;

(14) drug manufacturer of opiate-containing controlled substances listed in section 152.02, subdivisions 3 to 5, ~~$55,260~~ $55,300;

(15) medical gas dispenser, $260;

(16) controlled substance researcher, ~~$75~~ $150; and

(17) pharmacy professional corporation, ~~$100~~ $150.

Sec. 6. Minnesota Statutes 2022, section 151.065, subdivision 4, is amended to read:

Subd. 4. **Miscellaneous fees.** Fees for issuance of affidavits and duplicate licenses and certificates are as follows:

(1) intern affidavit, ~~$20~~ $30;

(2) duplicate small license, ~~$20~~ $30; and

(3) duplicate large certificate, $30.

Sec. 7. Minnesota Statutes 2022, section 151.065, subdivision 6, is amended to read:

Subd. 6. **Reinstatement fees.** (a) A pharmacist who has allowed the pharmacist's license to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears, up to a maximum of $1,000.

(b) A pharmacy technician who has allowed the technician's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears, up to a maximum of ~~$90~~ $250.

(c) An owner of a pharmacy, a drug wholesaler, a drug manufacturer, third-party logistics provider, or a medical gas dispenser who has allowed the license of the establishment to lapse may reinstate the license with board approval and upon payment of any fees and late fees in arrears.

(d) A controlled substance researcher who has allowed the researcher's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

(e) A pharmacist owner of a professional corporation who has allowed the corporation's registration to lapse may reinstate the registration with board approval and upon payment of any fees and late fees in arrears.

ARTICLE 4
MNSURE POLICY

Section 1. Minnesota Statutes 2022, section 62K.15, is amended to read:

62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT PERIODS.

(a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNsure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.

(b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.

(c) Health carriers offering individual health plans must provide a special enrollment period for enrollment in the individual market by employees of a small employer that offers a qualified small employer health reimbursement arrangement in accordance with United States Code, title 26, section 9831(d). The special enrollment period shall be available only to employees newly hired by a small employer offering a qualified small employer health reimbursement arrangement, and to employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement. For employees newly hired by the small employer, the special enrollment period shall last for 30 days after the employee's first day of employment. For employees employed by the small employer at the time the small employer initially offers a qualified small employer health reimbursement arrangement, the special enrollment period shall last for 30 days after the date the arrangement is initially offered to employees.

(d) The commissioner of commerce shall enforce this section.

(e) Health carriers offering individual health plans through MNsure must provide a special enrollment period as required under the easy enrollment health insurance outreach program under section 62V.12.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 2. **[62V.12] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM.**

Subdivision 1. **Establishment.** The board, in cooperation with the commissioner of revenue, must establish the easy enrollment health insurance outreach program to:

(1) reduce the number of uninsured Minnesotans and increase access to affordable health insurance coverage;

(2) allow the commissioner of revenue to provide return information, at the request of the taxpayer, to MNsure to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options through MNsure;

(3) allow MNsure to estimate taxpayer potential eligibility for financial assistance for health insurance coverage; and

(4) allow MNsure to conduct targeted outreach to assist interested taxpayer households in applying for and enrolling in affordable health insurance options through MNsure, including connecting interested taxpayer households with a navigator or broker for free enrollment assistance.

Subd. 2. **Screening for eligibility for insurance assistance.** Upon receipt of and based on return information received from the commissioner of revenue under section 270B.14, subdivision 22, MNsure may make a projected assessment on whether the interested taxpayer's household may qualify for a financial assistance program for health insurance coverage.

Subd. 3. **Outreach letter and special enrollment period.** (a) MNsure must provide a written letter of the projected assessment under subdivision 2 to a taxpayer who indicates to the commissioner of revenue that the taxpayer is interested in obtaining information on access to health insurance.

(b) MNsure must allow a special enrollment period for taxpayers who receive the outreach letter in paragraph (a) and are determined eligible to enroll in a qualified health plan through MNsure. The triggering event for the special enrollment period is the day the outreach letter under this subdivision is mailed to the taxpayer. An eligible individual, and their dependents, have 65 days from the triggering event to select a qualifying health plan and coverage for the qualifying health plan is effective the first day of the month after plan selection.

(c) Taxpayers who have a member of the taxpayer's household currently enrolled in a qualified health plan through MNsure are not eligible for the special enrollment under paragraph (b).

(d) MNsure must provide information about the easy enrollment health insurance outreach program and the special enrollment period described in this subdivision to the general public.

Subd. 4. **Appeals.** (a) Projected eligibility assessments for financial assistance under this section are not appealable.

(b) Qualification for the special enrollment period under this section is appealable to MNsure under this chapter and Minnesota Rules, chapter 7700.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023, and applies to health plans offered, issued, or sold on or after January 1, 2024.

Sec. 3. Minnesota Statutes 2022, section 270B.14, is amended by adding a subdivision to read:

Subd. 22. **Disclosure to MNsure board.** The commissioner may disclose a return or return information to the MNsure board if a taxpayer makes the designation under section 290.433 on an income tax return filed with the commissioner. The commissioner must only disclose data necessary to provide the taxpayer with information about the potential eligibility for financial assistance and health insurance enrollment options under section 62V.12.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. **[290.433] EASY ENROLLMENT HEALTH INSURANCE OUTREACH PROGRAM CHECKOFF.**

Subdivision 1. **Taxpayer designation.** Any individual who files an income tax return may designate on their original return a request that the commissioner provide their return information to the MNsure board for purposes of providing the individual with information about potential eligibility for financial assistance and health insurance enrollment options under section 62V.12, to the extent necessary to administer the easy enrollment health insurance outreach program.

Subd. 2. **Form.** The commissioner shall notify filers of their ability to make the designation in subdivision 1 on their income tax return.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2023.

Sec. 5. **DIRECTION TO MNSURE BOARD AND COMMISSIONER.**

The MNsure board and the commissioner of the Department of Revenue must develop and implement systems, policies, and procedures that encourage, facilitate, and streamline

data sharing, projected eligibility assessments, and notice to taxpayers to achieve the purpose of the easy enrollment health insurance outreach program under Minnesota Statutes, section 62V.12, for operation beginning with tax year 2023.

62J.84 PRESCRIPTION DRUG PRICE TRANSPARENCY.

Subd. 5. **Newly acquired prescription drug price reporting.** (a) Beginning January 1, 2022, the acquiring drug manufacturer must submit to the commissioner the information described in paragraph (b) for each newly acquired prescription drug for which the price was $100 or greater for a 30-day supply or for a course of treatment lasting less than 30 days and:

(1) for a newly acquired brand name drug where there is an increase of ten percent or greater in the price over the previous 12-month period or an increase of 16 percent or greater in price over the previous 24-month period; and

(2) for a newly acquired generic drug where there is an increase of 50 percent or greater in the price over the previous 12-month period.

(b) For each of the drugs described in paragraph (a), the acquiring manufacturer shall submit to the commissioner no later than 60 days after the acquiring manufacturer begins to sell the newly acquired drug, in the form and manner prescribed by the commissioner, the following information, if applicable:

(1) the price of the prescription drug at the time of acquisition and in the calendar year prior to acquisition;

(2) the name of the company from which the prescription drug was acquired, the date acquired, and the purchase price;

(3) the year the prescription drug was introduced to market and the price of the prescription drug at the time of introduction;

(4) the price of the prescription drug for the previous five years;

(5) any agreement between a manufacturer and another entity contingent upon any delay in offering to market a generic version of the manufacturer's drug; and

(6) the patent expiration date of the drug if it is under patent.

(c) The manufacturer may submit any documentation necessary to support the information reported under this subdivision.

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

Subd. 6. **Projected spending baseline.** Beginning February 15, 2016, and each February 15 thereafter, the commissioner of health shall report the projected impact on spending from specified health indicators related to various preventable illnesses and death. The impacts shall be reported over a ten-year time frame using a baseline forecast of private and public health care and long-term care spending for residents of this state, beginning with calendar year 2009 projected estimates of costs, and updated annually for each of the following health indicators:

(1) costs related to rates of obesity, including obesity-related cancers, coronary heart disease, stroke, and arthritis;

(2) costs related to the utilization of tobacco products;

(3) costs related to hypertension;

(4) costs related to diabetes or prediabetes; and

(5) costs related to dementia and chronic disease among an elderly population over 60, including additional long-term care costs.

Subd. 7. **Outcomes reporting; savings determination.** (a) Beginning November 1, 2016, and each November 1 thereafter, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar

year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 and 5, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Subd. 8. **Transfers.** When accumulated annual savings accruing to state-administered health care programs, as calculated under subdivision 7, meet or exceed $50,000,000 for all health indicators in aggregate statewide, the commissioner of health shall certify that event to the commissioner of management and budget, no later than December 15 of each year. In the next fiscal year following the certification, the commissioner of management and budget shall transfer $50,000,000 from the general fund to the health care access fund. This transfer shall repeat in each fiscal year following subsequent certifications of additional cumulative savings, up to $50,000,000 per year. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

145.4235 POSITIVE ABORTION ALTERNATIVES.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given:

(1) "abortion" means the use of any means to terminate the pregnancy of a woman known to be pregnant with knowledge that the termination with those means will, with reasonable likelihood, cause the death of the unborn child. For purposes of this section, abortion does not include an abortion necessary to prevent the death of the mother;

(2) "nondirective counseling" means providing clients with:

(i) a list of health care providers and social service providers that provide prenatal care, childbirth care, infant care, foster care, adoption services, alternatives to abortion, or abortion services; and

(ii) nondirective, nonmarketing information regarding such providers; and

(3) "unborn child" means a member of the species Homo sapiens from fertilization until birth.

Subd. 2. **Eligibility for grants.** (a) The commissioner shall award grants to eligible applicants under paragraph (c) for the reasonable expenses of alternatives to abortion programs to support, encourage, and assist women in carrying their pregnancies to term and caring for their babies after birth by providing information on, referral to, and assistance with securing necessary services that enable women to carry their pregnancies to term and care for their babies after birth. Necessary services must include, but are not limited to:

(1) medical care;

(2) nutritional services;

(3) housing assistance;

(4) adoption services;

(5) education and employment assistance, including services that support the continuation and completion of high school;

(6) child care assistance; and

(7) parenting education and support services.

An applicant may not provide or assist a woman to obtain adoption services from a provider of adoption services that is not licensed.

(b) In addition to providing information and referral under paragraph (a), an eligible program may provide one or more of the necessary services under paragraph (a) that assists women in carrying their pregnancies to term. To avoid duplication of efforts, grantees may refer to other public or private programs, rather than provide the care directly, if a woman meets eligibility criteria for the other programs.

(c) To be eligible for a grant, an agency or organization must:

(1) be a private, nonprofit organization;

(2) demonstrate that the program is conducted under appropriate supervision;

(3) not charge women for services provided under the program;

(4) provide each pregnant woman counseled with accurate information on the developmental characteristics of babies and of unborn children, including offering the printed information described in section 145.4243;

(5) ensure that its alternatives-to-abortion program's purpose is to assist and encourage women in carrying their pregnancies to term and to maximize their potentials thereafter;

(6) ensure that none of the money provided is used to encourage or affirmatively counsel a woman to have an abortion not necessary to prevent her death, to provide her an abortion, or to directly refer her to an abortion provider for an abortion. The agency or organization may provide nondirective counseling; and

(7) have had the alternatives to abortion program in existence for at least one year as of July 1, 2011; or incorporated an alternative to abortion program that has been in existence for at least one year as of July 1, 2011.

(d) The provisions, words, phrases, and clauses of paragraph (c) are inseverable from this subdivision, and if any provision, word, phrase, or clause of paragraph (c) or its application to any person or circumstance is held invalid, the invalidity applies to all of this subdivision.

(e) An organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this program. An affiliate of an organization that provides abortions, promotes abortions, or directly refers to an abortion provider for an abortion is ineligible to receive a grant under this section unless the organizations are separately incorporated and independent from each other. To be independent, the organizations may not share any of the following:

(1) the same or a similar name;

(2) medical facilities or nonmedical facilities, including but not limited to, business offices, treatment rooms, consultation rooms, examination rooms, and waiting rooms;

(3) expenses;

(4) employee wages or salaries; or

(5) equipment or supplies, including but not limited to, computers, telephone systems, telecommunications equipment, and office supplies.

(f) An organization that receives a grant under this section and that is affiliated with an organization that provides abortion services must maintain financial records that demonstrate strict compliance with this subdivision and that demonstrate that its independent affiliate that provides abortion services receives no direct or indirect economic or marketing benefit from the grant under this section.

(g) The commissioner shall approve any information provided by a grantee on the health risks associated with abortions to ensure that the information is medically accurate.

Subd. 3. **Privacy protection.** (a) Any program receiving a grant under this section must have a privacy policy and procedures in place to ensure that the name, address, telephone number, or any other information that might identify any woman seeking the services of the program is not made public or shared with any other agency or organization without the written consent of the woman. All communications between the program and the woman must remain confidential. For purposes of any medical care provided by the program, including, but not limited to, pregnancy tests or ultrasonic scanning, the program must adhere to the requirements in sections 144.291 to 144.298 that apply to providers before releasing any information relating to the medical care provided.

(b) Notwithstanding paragraph (a), the commissioner has access to any information necessary to monitor and review a grantee's program as required under subdivision 4.

Subd. 4. **Duties of commissioner.** The commissioner shall make grants under subdivision 2 beginning no later than July 1, 2006. In awarding grants, the commissioner shall consider the program's demonstrated capacity in providing services to assist a pregnant woman in carrying her pregnancy to term. The commissioner shall monitor and review the programs of each grantee to ensure that the grantee carefully adheres to the purposes and requirements of subdivision 2 and shall cease funding a grantee that fails to do so.

Subd. 5. **Severability.** Except as provided in subdivision 2, paragraph (d), if any provision, word, phrase, or clause of this section or its application to any person or circumstance is held invalid, such invalidity shall not affect the provisions, words, phrases, clauses, or applications of this section that can be given effect without the invalid provision, word, phrase, clause, or application and to this end, the provisions, words, phrases, and clauses of this section are severable.

Subd. 6. **Minnesota Supreme Court jurisdiction.** The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of this section and shall expedite the resolution of the action.

145.4241 DEFINITIONS.

Subdivision 1. **Applicability.** As used in sections 145.4241 to 145.4249, the following terms have the meanings given them.

Subd. 2. **Abortion.** "Abortion" means the use or prescription of any instrument, medicine, drug, or any other substance or device to intentionally terminate the pregnancy of a female known to be pregnant, with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead fetus.

Subd. 3. **Attempt to perform an abortion.** "Attempt to perform an abortion" means an act, or an omission of a statutorily required act, that, under the circumstances as the actor believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance of an abortion in Minnesota in violation of sections 145.4241 to 145.4249.

Subd. 3a. **Fetal anomaly incompatible with life.** "Fetal anomaly incompatible with life" means a fetal anomaly diagnosed before birth that will with reasonable certainty result in death of the unborn child within three months. Fetal anomaly incompatible with life does not include conditions which can be treated.

Subd. 4. **Medical emergency.** "Medical emergency" means any condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 4a. **Perinatal hospice.** (a) "Perinatal hospice" means comprehensive support to the female and her family that includes support from the time of diagnosis through the time of birth and death of the infant and through the postpartum period. Supportive care may include maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses.

(b) The availability of perinatal hospice provides an alternative to families for whom elective pregnancy termination is not chosen.

Subd. 5. **Physician.** "Physician" means a person licensed as a physician or osteopathic physician under chapter 147.

Subd. 6. **Probable gestational age of the unborn child.** "Probable gestational age of the unborn child" means what will, in the judgment of the physician, with reasonable probability, be the gestational age of the unborn child at the time the abortion is planned to be performed.

Subd. 7. **Stable Internet website.** "Stable Internet website" means a website that, to the extent reasonably practicable, is safeguarded from having its content altered other than by the commissioner of health.

Subd. 8. **Unborn child.** "Unborn child" means a member of the species Homo sapiens from fertilization until birth.

145.4242 INFORMED CONSENT.

(a) No abortion shall be performed in this state except with the voluntary and informed consent of the female upon whom the abortion is to be performed. Except in the case of a medical emergency or if the fetus has an anomaly incompatible with life, and the female has declined perinatal hospice care, consent to an abortion is voluntary and informed only if:

(1) the female is told the following, by telephone or in person, by the physician who is to perform the abortion or by a referring physician, at least 24 hours before the abortion:

(i) the particular medical risks associated with the particular abortion procedure to be employed including, when medically accurate, the risks of infection, hemorrhage, breast cancer, danger to subsequent pregnancies, and infertility;

(ii) the probable gestational age of the unborn child at the time the abortion is to be performed;

(iii) the medical risks associated with carrying her child to term; and

(iv) for abortions after 20 weeks gestational, whether or not an anesthetic or analgesic would eliminate or alleviate organic pain to the unborn child caused by the particular method of abortion to be employed and the particular medical benefits and risks associated with the particular anesthetic or analgesic.

The information required by this clause may be provided by telephone without conducting a physical examination or tests of the patient, in which case the information required to be provided may be based on facts supplied to the physician by the female and whatever other relevant information is reasonably available to the physician. It may not be provided by a tape recording, but must be provided during a consultation in which the physician is able to ask questions of the female and the female is able to ask questions of the physician. If a physical examination, tests, or the availability of other information to the physician subsequently indicate, in the medical judgment of the physician, a revision of the information previously supplied to the patient, that revised information may be communicated to the patient at any time prior to the performance of the abortion. Nothing in this section may be construed to preclude provision of required information in a language understood by the patient through a translator;

(2) the female is informed, by telephone or in person, by the physician who is to perform the abortion, by a referring physician, or by an agent of either physician at least 24 hours before the abortion:

(i) that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;

(ii) that the father is liable to assist in the support of her child, even in instances when the father has offered to pay for the abortion; and

(iii) that she has the right to review the printed materials described in section 145.4243, that these materials are available on a state-sponsored website, and what the website address is. The physician or the physician's agent shall orally inform the female that the materials have been provided by the state of Minnesota and that they describe the unborn child, list agencies that offer alternatives to abortion, and contain information on fetal pain. If the female chooses to view the materials other than on the website, they shall either be given to her at least 24 hours before the abortion or mailed to her at least 72 hours before the abortion by certified mail, restricted delivery to addressee, which means the postal employee can only deliver the mail to the addressee.

The information required by this clause may be provided by a tape recording if provision is made to record or otherwise register specifically whether the female does or does not choose to have the printed materials given or mailed to her;

(3) the female certifies in writing, prior to the abortion, that the information described in clauses (1) and (2) has been furnished to her and that she has been informed of her opportunity to review the information referred to in clause (2), item (iii); and

(4) prior to the performance of the abortion, the physician who is to perform the abortion or the physician's agent obtains a copy of the written certification prescribed by clause (3) and retains it on file with the female's medical record for at least three years following the date of receipt.

(b) Prior to administering the anesthetic or analgesic as described in paragraph (a), clause (1), item (iv), the physician must disclose to the woman any additional cost of the procedure for the administration of the anesthetic or analgesic. If the woman consents to the administration of the anesthetic or analgesic, the physician shall administer the anesthetic or analgesic or arrange to have the anesthetic or analgesic administered.

(c) A female seeking an abortion of her unborn child diagnosed with fetal anomaly incompatible with life must be informed of available perinatal hospice services and offered this care as an alternative to abortion. If perinatal hospice services are declined, voluntary and informed consent by the female seeking an abortion is given if the female receives the information required in paragraphs (a), clause (1), and (b). The female must comply with the requirements in paragraph (a), clauses (3) and (4).

145.4243 PRINTED INFORMATION.

(a) Within 90 days after July 1, 2003, the commissioner of health shall cause to be published, in English and in each language that is the primary language of two percent or more of the state's population, and shall cause to be available on the state website provided for under section 145.4244 the following printed materials in such a way as to ensure that the information is easily comprehensible:

(1) geographically indexed materials designed to inform the female of public and private agencies and services available to assist a female through pregnancy, upon childbirth, and while the child is dependent, including adoption agencies, which shall include a comprehensive list of the agencies available, a description of the services they offer, and a description of the manner, including telephone numbers, in which they might be contacted or, at the option of the commissioner of health, printed materials including a toll-free, 24-hours-a-day telephone number that may be called to obtain, orally or by a tape recorded message tailored to a zip code entered by the caller, such a list and description of agencies in the locality of the caller and of the services they offer;

(2) materials designed to inform the female of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from the time when a female can be known to be pregnant to full term, including any relevant information on the possibility of the unborn child's survival and pictures or drawings representing the development of unborn children at two-week gestational increments, provided that any such pictures or drawings must contain the dimensions of the fetus and must be realistic and appropriate for the stage of pregnancy depicted. The materials shall be objective, nonjudgmental, and designed to convey only accurate scientific information about the unborn child at the various gestational ages. The material shall also contain objective information describing the methods of abortion procedures commonly employed, the medical risks commonly associated with each procedure, the possible detrimental psychological effects of abortion, and the medical risks commonly associated with carrying a child to term; and

(3) materials with the following information concerning an unborn child of 20 weeks gestational age and at two weeks gestational increments thereafter in such a way as to ensure that the information is easily comprehensible:

(i) the development of the nervous system of the unborn child;

(ii) fetal responsiveness to adverse stimuli and other indications of capacity to experience organic pain; and

(iii) the impact on fetal organic pain of each of the methods of abortion procedures commonly employed at this stage of pregnancy.

The material under this clause shall be objective, nonjudgmental, and designed to convey only accurate scientific information.

(b) The materials referred to in this section must be printed in a typeface large enough to be clearly legible. The website provided for under section 145.4244 shall be maintained at a minimum resolution of 70 DPI (dots per inch). All pictures appearing on the website shall be a minimum of 200x300 pixels. All letters on the website shall be a minimum of 11-point font. All information and pictures shall be accessible with an industry standard browser, requiring no additional plug-ins. The materials required under this section must be available at no cost from the commissioner of health upon request and in appropriate number to any person, facility, or hospital.

145.4244 INTERNET WEBSITE.

The commissioner of health shall develop and maintain a stable Internet website to provide the information described under section 145.4243. No information regarding who uses the website shall be collected or maintained. The commissioner of health shall monitor the website on a weekly basis to prevent and correct tampering.

145.4245 PROCEDURE IN CASE OF MEDICAL EMERGENCY.

When a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting the physician's judgment that an abortion is necessary to avert her death or that a 24-hour delay will create serious risk of substantial and irreversible impairment of a major bodily function.

145.4246 REPORTING REQUIREMENTS.

Subdivision 1. **Reporting form.** Within 90 days after July 1, 2003, the commissioner of health shall prepare a reporting form for physicians containing a reprint of sections 145.4241 to 145.4249 and listing:

(1) the number of females to whom the physician provided the information described in section 145.4242, clause (1); of that number, the number provided by telephone and the number provided in person; and of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion;

(2) the number of females to whom the physician or an agent of the physician provided the information described in section 145.4242, clause (2); of that number, the number provided by telephone and the number provided in person; of each of those numbers, the number provided in the capacity of a referring physician and the number provided in the capacity of a physician who is to perform the abortion; and of each of those numbers, the number provided by the physician and the number provided by an agent of the physician;

(3) the number of females who availed themselves of the opportunity to obtain a copy of the printed information described in section 145.4243 other than on the website and the number who did not; and of each of those numbers, the number who, to the best of the reporting physician's information and belief, went on to obtain the abortion; and

(4) the number of abortions performed by the physician in which information otherwise required to be provided at least 24 hours before the abortion was not so provided because an immediate abortion was necessary to avert the female's death and the number of abortions in which such information was not so provided because a delay would create serious risk of substantial and irreversible impairment of a major bodily function.

Subd. 2. **Distribution of forms.** The commissioner of health shall ensure that copies of the reporting forms described in subdivision 1 are provided:

(1) by December 1, 2003, and by December 1 of each subsequent year thereafter to all physicians licensed to practice in this state; and

(2) to each physician who subsequently becomes newly licensed to practice in this state, at the same time as official notification to that physician that the physician is so licensed.

Subd. 3. **Reporting requirement.** By April 1, 2005, and by April 1 of each subsequent year thereafter, each physician who provided, or whose agent provided, information to one or more females in accordance with section 145.4242 during the previous calendar year shall submit to the commissioner of health a copy of the form described in subdivision 1 with the requested data entered accurately and completely.

Subd. 4. **Additional reporting.** Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

Subd. 5. **Failure to report as required.** Reports that are not submitted by the end of a grace period of 30 days following the due date shall be subject to a late fee of $500 for each additional 30-day period or portion of a 30-day period they are overdue. Any physician required to report according to this section who has not submitted a report, or has submitted only an incomplete report, more than one year following the due date, may, in an action brought by the commissioner of health, be directed by a court of competent jurisdiction to submit a complete report within a period stated by court order or be subject to sanctions for civil contempt.

Subd. 6. **Public statistics.** By July 1, 2005, and by July 1 of each subsequent year thereafter, the commissioner of health shall issue a public report providing statistics for the previous calendar year compiled from all of the reports covering that year submitted according to this section for each of the items listed in subdivision 1. Each report shall also provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner of health shall take care to ensure that none of the information included in the public reports could reasonably lead to the identification of any individual providing or provided information according to section 145.4242.

Subd. 7. **Consolidation.** The commissioner of health may consolidate the forms or reports described in this section with other forms or reports to achieve administrative convenience or fiscal savings or to reduce the burden of reporting requirements.

145.4247 REMEDIES.

Subdivision 1. **Civil remedies.** Any person upon whom an abortion has been performed without complying with sections 145.4241 to 145.4249 may maintain an action against the person who performed the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. Any person upon whom an abortion has been attempted without complying with sections 145.4241 to 145.4249 may maintain an action against the person who attempted to perform the abortion in knowing or reckless violation of sections 145.4241 to 145.4249 for actual and punitive damages. No civil liability may be assessed for failure to comply with section 145.4242, clause (2), item (iii), or that portion of section 145.4242, clause (2), requiring written certification that the female has been informed of her opportunity to review the information referred to in section 145.4242, clause (2), item (iii), unless the commissioner of health has made the printed materials or website address available at the time the physician or the physician's agent is required to inform the female of her right to review them.

Subd. 2. **Suit to compel statistical report.** If the commissioner of health fails to issue the public report required under section 145.4246, subdivision 6, or fails in any way to enforce Laws 2003, chapter 14, any group of ten or more citizens of this state may seek an injunction in a court of competent jurisdiction against the commissioner of health requiring that a complete report be issued within a period stated by court order. Failure to abide by such an injunction shall subject the commissioner to sanctions for civil contempt.

Subd. 3. **Attorney fees.** If judgment is rendered in favor of the plaintiff in any action described in this section, the court shall also render judgment for reasonable attorney fees in favor of the plaintiff against the defendant. If judgment is rendered in favor of the defendant and the court finds that the plaintiff's suit was frivolous and brought in bad faith, the court shall also render judgment for reasonable attorney fees in favor of the defendant against the plaintiff.

Subd. 4. **Protection of privacy in court proceedings.** In every civil action brought under sections 145.4241 to 145.4249, the court shall rule whether the anonymity of any female upon whom an abortion has been performed or attempted shall be preserved from public disclosure if she does not give her consent to such disclosure. The court, upon motion or sua sponte, shall make such a ruling and, upon determining that her anonymity should be preserved, shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard her identity from public disclosure. Each order must be accompanied by specific written findings explaining why the anonymity of the female should be preserved from public disclosure, why the order is essential to that end, how the order is narrowly tailored to serve that interest, and why no reasonable, less restrictive alternative exists. In the absence of written consent of the female upon whom an abortion has been performed or attempted, anyone, other than a public official, who brings an action under subdivision 1, shall do so under a pseudonym. This section may not be construed to conceal the identity of the plaintiff or of witnesses from the defendant.

145.4248 SEVERABILITY.

If any one or more provision, section, subsection, sentence, clause, phrase, or word of sections 145.4241 to 145.4249 or the application thereof to any person or circumstance is found to be unconstitutional, the same is hereby declared to be severable and the balance of sections 145.4241 to 145.4249 shall remain effective notwithstanding such unconstitutionality. The legislature hereby declares that it would have passed sections 145.4241 to 145.4249, and each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provision, section, subsection, sentence, clause, phrase, or word be declared unconstitutional.

145.4249 SUPREME COURT JURISDICTION.

The Minnesota Supreme Court has original jurisdiction over an action challenging the constitutionality of sections 145.4241 to 145.4249 and shall expedite the resolution of the action.

145.925 FAMILY PLANNING GRANTS.

Subd. 1a. **Family planning services; defined.** "Family planning services" means counseling by trained personnel regarding family planning; distribution of information relating to family planning, referral to licensed physicians or local health agencies for consultation, examination, medical treatment, genetic counseling, and prescriptions for the purpose of family planning; and the distribution of family planning products, such as charts, thermometers, drugs, medical preparations, and contraceptive devices. For purposes of sections 145A.01 to 145A.14, family

planning shall mean voluntary action by individuals to prevent or aid conception but does not include the performance, or make referrals for encouragement of voluntary termination of pregnancy.

Subd. 3. **Minors.** No funds provided by grants made pursuant to this section shall be used to support any family planning services for any unemancipated minor in any elementary or secondary school building.

Subd. 4. **Parental notification.** Except as provided in sections 144.341 and 144.342, any person employed to provide family planning services who is paid in whole or in part from funds provided under this section who advises an abortion or sterilization to any unemancipated minor shall, following such a recommendation, so notify the parent or guardian of the reasons for such an action.

Subd. 7. **Family planning services; information required.** A grant recipient shall inform any person requesting counseling on family planning methods or procedures of:

(1) Any methods or procedures which may be followed, including identification of any which are experimental or any which may pose a health hazard to the person;

(2) A description of any attendant discomforts or risks which might reasonably be expected;

(3) A fair explanation of the likely results, should a method fail;

(4) A description of any benefits which might reasonably be expected of any method;

(5) A disclosure of appropriate alternative methods or procedures;

(6) An offer to answer any inquiries concerning methods of procedures; and

(7) An instruction that the person is free either to decline commencement of any method or procedure or to withdraw consent to a method or procedure at any reasonable time.

Subd. 8. **Coercion; penalty.** Any person who receives compensation for services under any program receiving financial assistance under this section, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening the person with the loss of or disqualification for the receipt of any benefit or service under a program receiving state or federal financial assistance shall be guilty of a misdemeanor.