SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 2322

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DATE	D-PG	OFFICIAL STATUS
03/10/2025	706	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health occupations; establishing the Minnesota Health Care Workforce Advisory Council; requiring reporting; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **[144.0515] HEALTH CARE WORKFORCE ADVISORY COUNCIL.**

Subdivision 1. **Establishment.** (a) The legislature has recognized the need for a body that has a comprehensive view of the health care workforce needs of the state, can advise the legislature on health care workforce issues, is a neutral convenor of competing perspectives, and is committed to working across all sectors to promote action toward resolving persistent health care workforce challenges. The Minnesota Health Care Workforce Advisory Council is established to:

(1) provide objective health care workforce research and data analysis;

(2) collaborate and coordinate with other entities on health care workforce policies;

(3) review, comment, and advise the legislature and other stakeholders on relevant workforce legislation for education, training, retention, diversity and demographics, changes in health care delivery, practice, and financing; and

(4) recommend appropriate public and private sector policies, programs, and other efforts to address identified health care workforce needs.

(b) The council shall consult and collaborate with other health care workforce planning entities, including but not limited to the governor's Workforce Development Board, area councils on graduate medical education, advisory committees that support health care

workforce education and clinical training, health professional associations, licensing bodies, and certification and educational institutions in developing their program or legislative recommendations.

(c) The council shall focus on health care workforce supply, demand, and distribution; health equity; efforts to increase participation by those underrepresented in health professions education; education, training, and practice across oral health, behavioral health, pharmacy, nursing, primary and specialty care training and practice, allied health care, and direct care; and health care workforce data, evaluation, and analysis.

(d) The council shall establish discipline-, profession-, or issue-specific standing or ad hoc committees with subject matter experts to advise and support the work of the council. The council shall intentionally include perspectives that represent rural needs and workforce diversity in all committees.

Subd. 2. **Membership.** The Minnesota Health Care Workforce Advisory Council shall consist of 16 members appointed as follows:

(1) two members of the senate, one appointed by the majority leader and one appointed by the minority leader;

(2) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader;

(3) the commissioner of employment and economic development or a designee;

(4) one member of the Office of Higher Education or a designee; and

(5) ten members appointed by the governor who have expertise regarding the council's priorities.

Subd. 3. **Appointments.** In making appointments to the council, the governor shall ensure geographic and demographic representation. Appointees shall demonstrate a commitment to the council's broader charge, proven experience in addressing health care workforce needs, and subject matter expertise that benefit the council's priorities.

Subd. 4. **Terms of public members.** (a) The terms of the members appointed under subdivision 2 shall be four years, except for the initial appointment where the appointing authority shall appoint as nearly as possible one-half of the members to a two-year term. Members may serve until their successors are appointed.

(b) Initial appointments must be made by October 30, 2025. The commissioner of health shall convene the first meeting no later than January 5, 2026. Appointees to the council shall elect a chair and advise on hiring an executive director.

(c) Except for section 15.059, subdivisions 2 and 3, section 15.059 shall apply to the council and to all council member appointments, except those members who are commissioners or their designees. The members of the council shall receive no compensation other than reimbursement for expenses. Notwithstanding section 15.059, subdivision 6, the council shall not expire.

Subd. 5. **Staffing.** (a) An executive director of the council shall be hired by the commissioner of health with advice from the council. The executive director of the council may offer advice to the governor on applicants seeking appointments to the council.

(b) The commissioner of health shall provide adequate staffing to the council and the committees to carry out the council's responsibilities, including administrative, research, planning, and strategy facilitation services. The commissioner shall provide comprehensive, nonpartisan, and methodologically rigorous data, research, and recommendations on health care workforce issues as requested by the council.

Subd. 6. **Duties.** The council, with staffing support from the commissioner of health, shall:

(1) regularly convene stakeholders from various groups across the state to identify and prioritize the pressing needs related to the health care workforce. The council may seek public input via town halls, listening sessions, or surveys. Issues may include but are not limited to health care workforce shortages, training and workforce supply needs, demographic and geographic distribution, retention, models of care that relate to health care access and equity, emerging health care professions and roles, and emerging health professional education programs and institutions;

(2) advise the legislature, educational institutions, the Office of Higher Education, relevant state agencies, and other stakeholders on current and proposed health care workforce initiatives, including training and pipeline development, workforce shortages and maldistribution, retention and burnout, evolving roles of health care providers, health equity, and geographic and demographic diversity in the workforce;

(3) consider objective, nonpartisan research and develop actionable recommendations regarding the following:

(i) health care workforce supply and demand, including:

(A) employment trends and demand across all professions, including but not limited to primary care, behavioral health, and oral health;

(B) strategies that entities in Minnesota or other states are using or may use to address health care workforce shortages, recruitment, and retention; and

(C) future investments to increase the supply of health care professionals, with particular focus on critical areas of need within Minnesota;

(ii) options for training and educating the health care workforce, including:

(A) increasing the diversity of health care workers to reflect Minnesota's communities;

(B) addressing the maldistribution of primary care, behavioral health, nursing, oral, and other providers in greater Minnesota and in underserved communities;

(C) increasing interprofessional training and clinical practice;

(D) addressing the need for sufficient quality faculty, preceptors, and supervisors to train a growing workforce; and

(E) developing advancement paths or career ladders for health care workers;

(iii) funding for strategies to diversify and address gaps in the health care workforce, including but not limited to:

(A) increasing access to financing for graduate medical education that is responsive to state workforce needs;

(B) changes in practice scopes to address gaps in care;

(C) identifying future models of care delivery and future roles within the care delivery team that impact the workforce;

(D) expanding pathway programs and engaging the current health care workforce to increase awareness of health care professions among middle and high school, undergraduate, and community college students, particularly from communities that are underrepresented in the health care workforce;

(E) reducing or eliminating tuition for entry-level health care positions in high-demand settings; expanding other existing financial support programs such as loan forgiveness and scholarship programs, especially for underrepresented communities; and consider awarding credit for prior and noncredit learning;

(F) incentivizing recruitment into the health care field from greater Minnesota and underrepresented communities;

(G) incentivizing recruitment and retention for providers practicing in greater Minnesota and in underserved communities; and

(H) expanding existing programs, or investing in new programs, that provide wraparound support services to the existing health care workforce, especially People of Color and professionals from other underrepresented identities, to acquire training and advance within the health care workforce; and

(iv) other Minnesota health care workforce priorities as determined by the council; and

(4) submit a comprehensive five-year workforce plan to the legislature as defined in subdivision 7 and, as feasible, provide information and analysis on health care workforce needs and trends to the legislature, any state department, or any other workforce planning entity.

Subd. 7. **Workforce plan and reporting.** (a) Every five years the Minnesota Health Care Workforce Advisory Council shall develop health care workforce priorities to meet the workforce needs of the state and prepare a comprehensive health care workforce plan along with performance and progress metrics. The first plan must be submitted to the legislature by January 15, 2027, and an updated plan must be submitted every five years thereafter. The comprehensive health care workforce plan must include but is not limited to the following:

(1) an assessment of the current supply and distribution of health care providers in the state, trends in health care delivery and reform, and the effects of such trends on workforce needs;

(2) five-year projections of the demand and supply of health care workers to meet the needs of health care within the state;

(3) identification of all funding sources for which the state has administrative control that are available for health professions training and education, and how the funds are spent; and

(4) recommendations and action plans to meet the projected demand for health care workers over the five years of the plan.

(b) In the interim between the publication of comprehensive health care workforce plans, the commissioner of health, on behalf of the Minnesota Health Care Workforce Advisory Council, shall provide periodic updates to the governor on the performance metrics and the progress made toward achieving the goals as noted in the work plan and identify emerging needs.

Subd. 8. **Data and access to information.** (a) The commissioner may request that a state agency provide data in a usable format as requested by the commissioner at no cost to the commissioner.

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

(c) Notwithstanding any provisions to the contrary, the commissioner may use data collected and maintained under section 62U.04 to carry out the duties required under this section.