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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. **2128**

03/11/2021 Authored by Liebling and Schultz
The bill was read for the first time and referred to the Committee on Health Finance and Policy
04/12/2021 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

1.1 A bill for an act

1.2 relating to health; modifying provisions governing health care, human services,

1.3 licensing and background studies, the Department of Health, health-related licensing

1.4 boards, prescription drugs, health insurance, and telehealth; establishing a budget

1.5 for health and human services; making technical and conforming changes; requiring

1.6 reports; transferring money; appropriating money; amending Minnesota Statutes

1.7 2020, sections 62A.04, subdivision 2; 62A.10, by adding a subdivision; 62A.65,

1.8 subdivision 1, by adding a subdivision; 62C.01, by adding a subdivision; 62D.01,

1.9 by adding a subdivision; 62D.095, subdivisions 2, 3, 4, 5; 62J.495, subdivisions

1.10 1, 2, 3, 4; 62J.497, subdivisions 1, 3; 62J.498; 62J.4981; 62J.4982; 62J.63,

1.11 subdivisions 1, 2; 62Q.01, subdivision 2a; 62Q.02; 62Q.46; 62Q.677, by adding

1.12 a subdivision; 62Q.81; 62U.04, subdivisions 4, 5, 11; 62V.05, by adding a

1.13 subdivision; 62W.11; 62W.12; 103H.201, subdivision 1; 122A.18, subdivision 8;

1.14 144.0724, subdivisions 1, 2, 3a, 5, 7, 8, 9, 12; 144.1205, subdivisions 2, 4, 8, 9,

1.15 by adding a subdivision; 144.125, subdivision 1; 144.1481, subdivision 1; 144.1911,

1.16 subdivision 6; 144.212, by adding a subdivision; 144.225, subdivisions 2, 7;

1.17 144.226, by adding subdivisions; 144.55, subdivisions 4, 6; 144.551, subdivision

1.18 1, by adding a subdivision; 144.555; 144.9501, subdivision 17; 144.9502,

1.19 subdivision 3; 144.9504, subdivisions 2, 5; 144G.08, subdivision 7, as amended;

1.20 144G.84; 145.893, subdivision 1; 145.894; 145.897; 145.899; 145.901, subdivisions

1.21 2, 4; 147.033; 151.01, by adding subdivisions; 151.071, subdivisions 1, 2; 151.37,

1.22 subdivision 2; 151.555, subdivisions 1, 7, 11, by adding a subdivision; 152.01,

1.23 subdivision 23; 152.02, subdivisions 2, 3; 152.11, subdivision 1a, by adding a

1.24 subdivision; 152.12, by adding a subdivision; 152.125, subdivision 3; 152.22,

1.25 subdivisions 6, 11, by adding subdivisions; 152.23; 152.25, by adding a subdivision;

1.26 152.26; 152.27, subdivisions 3, 4, 6; 152.28, subdivision 1; 152.29, subdivisions

1.27 1, 3, by adding subdivisions; 152.31; 152.32, subdivision 3; 156.12, subdivision

1.28 2; 171.07, by adding a subdivision; 174.30, subdivision 3; 245A.05; 245A.07,

1.29 subdivision 1; 245A.10, subdivision 4; 245A.16, by adding a subdivision; 245C.02,

1.30 subdivisions 4a, 5, by adding subdivisions; 245C.03; 245C.05, subdivisions 1, 2,

1.31 2a, 2b, 2c, 2d, 4; 245C.08, subdivision 3, by adding a subdivision; 245C.10,

1.32 subdivision 15, by adding subdivisions; 245C.13, subdivision 2; 245C.14,

1.33 subdivision 1, by adding a subdivision; 245C.15, by adding a subdivision; 245C.16,

1.34 subdivisions 1, 2; 245C.17, subdivision 1, by adding a subdivision; 245C.18;

1.35 245C.24, subdivisions 2, 3, 4, by adding a subdivision; 245C.32, subdivision 1a;

1.36 245G.01, subdivisions 13, 26; 245G.06, subdivision 1; 254A.19, subdivision 5;

1.37 254B.05, subdivision 5; 256.01, subdivision 28; 256.969, subdivisions 2b, 9, by

1.38 adding a subdivision; 256.9695, subdivision 1; 256.98, subdivision 1; 256.983;

2.1 256B.04, subdivisions 12, 14; 256B.055, subdivision 6; 256B.056, subdivision
 2.2 10; 256B.057, subdivision 3; 256B.06, subdivision 4; 256B.0621, subdivision 10;
 2.3 256B.0625, subdivisions 3b, 3c, 3d, 3e, 9, 10, 13, 13c, 13d, 13h, 17, 17b, 18, 18b,
 2.4 20, 20b, 30, 31, 46, 52, 58, by adding subdivisions; 256B.0631, subdivision 1;
 2.5 256B.0638, subdivisions 3, 5, 6; 256B.0659, subdivision 13; 256B.0911,
 2.6 subdivisions 1a, 3a, 3f, 4d; 256B.0924, subdivision 6; 256B.094, subdivision 6;
 2.7 256B.0949, by adding a subdivision; 256B.196, subdivision 2; 256B.49, subdivision
 2.8 14; 256B.69, subdivisions 6, 6d, by adding subdivisions; 256B.6928, subdivision
 2.9 5; 256B.75; 256B.76, subdivisions 2, 4; 256B.766; 256B.767; 256B.79,
 2.10 subdivisions 1, 3; 256J.09, subdivision 3; 256J.45, subdivision 1; 256L.01,
 2.11 subdivision 5; 256L.03, subdivision 5; 256L.04, subdivision 7b; 256L.05,
 2.12 subdivision 3a; 256L.11, subdivisions 6a, 7; 256S.05, subdivision 2; 260C.215,
 2.13 subdivision 4; 295.53, subdivision 1; 326.71, subdivision 4; 326.75, subdivisions
 2.14 1, 2, 3; Laws 2019, First Special Session chapter 9, article 14, section 3, as
 2.15 amended; Laws 2020, First Special Session chapter 7, section 1, subdivision 2, as
 2.16 amended; Laws 2020, Seventh Special Session chapter 1, article 6, section 12,
 2.17 subdivision 4; proposing coding for new law in Minnesota Statutes, chapters 62A;
 2.18 62J; 62Q; 62W; 144; 145; 151; 245C; 256B; repealing Minnesota Statutes 2020,
 2.19 sections 16A.724, subdivision 2; 62A.67; 62A.671; 62A.672; 62J.63, subdivision
 2.20 3; 144.0721, subdivision 1; 144.0722; 144.0724, subdivision 10; 144.693; 245C.10,
 2.21 subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10, 11, 12, 13, 14, 16; 256B.0596;
 2.22 256B.0625, subdivisions 18c, 18d, 18e, 18h; 256B.0924, subdivision 4a; Minnesota
 2.23 Rules, parts 9505.0275; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9,
 2.24 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22; 9505.1699; 9505.1701; 9505.1703;
 2.25 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730;
 2.26 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; 9505.1748.

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

2.28 **ARTICLE 1**

2.29 **DHS HEALTH CARE PROGRAMS**

2.30 Section 1. **[62A.002] APPLICABILITY OF CHAPTER.**

2.31 Any benefit or coverage mandate included in this chapter does not apply to managed
 2.32 care plans or county-based purchasing plans when the plan is providing coverage to state
 2.33 public health care program enrollees under chapter 256B or 256L.

2.34 Sec. 2. Minnesota Statutes 2020, section 62C.01, is amended by adding a subdivision to
 2.35 read:

2.36 Subd. 4. **Applicability.** Any benefit or coverage mandate included in this chapter does
 2.37 not apply to managed care plans or county-based purchasing plans when the plan is providing
 2.38 coverage to state public health care program enrollees under chapter 256B or 256L.

3.1 Sec. 3. Minnesota Statutes 2020, section 62D.01, is amended by adding a subdivision to
3.2 read:

3.3 Subd. 3. **Applicability.** Any benefit or coverage mandate included in this chapter does
3.4 not apply to managed care plans or county-based purchasing plans when the plan is providing
3.5 coverage to state public health care program enrollees under chapter 256B or 256L.

3.6 Sec. 4. **[62J.011] APPLICABILITY OF CHAPTER.**

3.7 Any benefit or coverage mandate included in this chapter does not apply to managed
3.8 care plans or county-based purchasing plans when the plan is providing coverage to state
3.9 public health care program enrollees under chapter 256B or 256L.

3.10 Sec. 5. Minnesota Statutes 2020, section 62Q.02, is amended to read:

3.11 **62Q.02 APPLICABILITY OF CHAPTER.**

3.12 (a) This chapter applies only to health plans, as defined in section 62Q.01, and not to
3.13 other types of insurance issued or renewed by health plan companies, unless otherwise
3.14 specified.

3.15 (b) This chapter applies to a health plan company only with respect to health plans, as
3.16 defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise
3.17 specified.

3.18 (c) If a health plan company issues or renews health plans in other states, this chapter
3.19 applies only to health plans issued or renewed in this state for Minnesota residents, or to
3.20 cover a resident of the state, unless otherwise specified.

3.21 (d) Any benefit or coverage mandate included in this chapter does not apply to managed
3.22 care plans or county-based purchasing plans when the plan is providing coverage to state
3.23 public health care program enrollees under chapter 256B or 256L.

3.24 Sec. 6. Minnesota Statutes 2020, section 174.30, subdivision 3, is amended to read:

3.25 Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special
3.26 transportation service that transports individuals occupying wheelchairs is subject to the
3.27 provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The
3.28 commissioners of transportation and public safety shall cooperate in the enforcement of
3.29 this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to
3.30 ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted
3.31 under this section. Representatives of the Department of Transportation may inspect

4.1 wheelchair securement devices in vehicles operated by special transportation service
4.2 providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates
4.3 under section 299A.14, subdivision 4.

4.4 (b) In place of a certificate issued under section 299A.14, the commissioner may issue
4.5 a decal under subdivision 4 for a vehicle equipped with a wheelchair securement device if
4.6 the device complies with sections 299A.11 to 299A.17 and the decal displays the information
4.7 in section 299A.14, subdivision 4.

4.8 (c) For vehicles designated as protected transport under section 256B.0625, subdivision
4.9 17, paragraph ~~(h)~~ (g), the commissioner of transportation, during the commissioner's
4.10 inspection, shall check to ensure the safety provisions contained in that paragraph are in
4.11 working order.

4.12 Sec. 7. Minnesota Statutes 2020, section 256.01, subdivision 28, is amended to read:

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

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

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

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

4.26 Sec. 8. Minnesota Statutes 2020, section 256.969, subdivision 2b, is amended to read:

4.27 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
4.28 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
4.29 to the following:

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

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

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

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

5.7 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
5.8 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
5.9 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
5.10 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
5.11 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
5.12 years are updated, a Minnesota long-term hospital's base year shall remain within the same
5.13 period as other hospitals.

5.14 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
5.15 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
5.16 area, except for the hospitals paid under the methodologies described in paragraph (a),
5.17 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
5.18 manner similar to Medicare. The base year or years for the rates effective November 1,
5.19 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral,
5.20 ensuring that the total aggregate payments under the rebased system are equal to the total
5.21 aggregate payments that were made for the same number and types of services in the base
5.22 year. Separate budget neutrality calculations shall be determined for payments made to
5.23 critical access hospitals and payments made to hospitals paid under the DRG system. Only
5.24 the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being
5.25 rebased during the entire base period shall be incorporated into the budget neutrality
5.26 calculation.

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

5.33 (e) For discharges occurring on or after November 1, 2014, the commissioner may make
5.34 additional adjustments to the rebased rates, and when evaluating whether additional

6.1 adjustments should be made, the commissioner shall consider the impact of the rates on the
6.2 following:

6.3 (1) pediatric services;

6.4 (2) behavioral health services;

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

6.6 (4) transplant services;

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

6.9 (6) outlier admissions;

6.10 (7) low-volume providers; and

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

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

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

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

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

6.21 (4) in determining hospital payment rates for discharges occurring on or after the rate
6.22 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
6.23 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
6.24 program in effect during the base year or years. In determining hospital payment rates for
6.25 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
6.26 methods and allowable costs of the Medicare program in effect during the base year or
6.27 years.

6.28 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
6.29 the rates established under paragraph (c), and any adjustments made to the rates under
6.30 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the

7.1 total aggregate payments for the same number and types of services under the rebased rates
7.2 are equal to the total aggregate payments made during calendar year 2013.

7.3 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
7.4 thereafter, payment rates under this section shall be rebased to reflect only those changes
7.5 in hospital costs between the existing base year or years and the next base year or years. In
7.6 any year that inpatient claims volume falls below the threshold required to ensure a statically
7.7 valid sample of claims, the commissioner may combine claims data from two consecutive
7.8 years to serve as the base year. Years in which inpatient claims volume is reduced or altered
7.9 due to a pandemic or other public health emergency shall not be used as a base year or part
7.10 of a base year if the base year includes more than one year. Changes in costs between base
7.11 years shall be measured using the lower of the hospital cost index defined in subdivision 1,
7.12 paragraph (a), or the percentage change in the case mix adjusted cost per claim. The
7.13 commissioner shall establish the base year for each rebasing period considering the most
7.14 recent year or years for which filed Medicare cost reports are available. The estimated
7.15 change in the average payment per hospital discharge resulting from a scheduled rebasing
7.16 must be calculated and made available to the legislature by January 15 of each year in which
7.17 rebasing is scheduled to occur, and must include by hospital the differential in payment
7.18 rates compared to the individual hospital's costs.

7.19 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
7.20 for critical access hospitals located in Minnesota or the local trade area shall be determined
7.21 using a new cost-based methodology. The commissioner shall establish within the
7.22 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
7.23 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
7.24 the total cost for critical access hospitals as reflected in base year cost reports. Until the
7.25 next rebasing that occurs, the new methodology shall result in no greater than a five percent
7.26 decrease from the base year payments for any hospital, except a hospital that had payments
7.27 that were greater than 100 percent of the hospital's costs in the base year shall have their
7.28 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
7.29 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
7.30 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
7.31 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
7.32 following criteria:

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

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

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

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

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

8.11 (2) the ratio between the hospital's costs for treating medical assistance patients and the
8.12 hospital's payments received from the medical assistance program for the care of medical
8.13 assistance patients;

8.14 (3) the ratio between the hospital's charges to the medical assistance program and the
8.15 hospital's payments received from the medical assistance program for the care of medical
8.16 assistance patients;

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

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

8.20 (6) geographic location.

8.21 Sec. 9. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to
8.22 read:

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

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

9.1 Sec. 10. Minnesota Statutes 2020, section 256.969, subdivision 9, is amended to read:

9.2 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
9.3 occurring on or after July 1, 1993, the medical assistance disproportionate population
9.4 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
9.5 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
9.6 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
9.7 as follows:

9.8 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic
9.9 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian
9.10 Health Service but less than or equal to one standard deviation above the mean, the
9.11 adjustment must be determined by multiplying the total of the operating and property
9.12 payment rates by the difference between the hospital's actual medical assistance inpatient
9.13 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers
9.14 and facilities of the federal Indian Health Service; and

9.15 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
9.16 deviation above the mean, the adjustment must be determined by multiplying the adjustment
9.17 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
9.18 report annually on the number of hospitals likely to receive the adjustment authorized by
9.19 this paragraph. The commissioner shall specifically report on the adjustments received by
9.20 public hospitals and public hospital corporations located in cities of the first class.

9.21 (b) Certified public expenditures made by Hennepin County Medical Center shall be
9.22 considered Medicaid disproportionate share hospital payments. Hennepin County and
9.23 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning
9.24 July 1, 2005, or another date specified by the commissioner, that may qualify for
9.25 reimbursement under federal law. Based on these reports, the commissioner shall apply for
9.26 federal matching funds.

9.27 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective
9.28 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for
9.29 Medicare and Medicaid Services.

9.30 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
9.31 in accordance with a new methodology using 2012 as the base year. Annual payments made
9.32 under this paragraph shall equal the total amount of payments made for 2012. A licensed
9.33 children's hospital shall receive only a single DSH factor for children's hospitals. Other
9.34 DSH factors may be combined to arrive at a single factor for each hospital that is eligible

10.1 for DSH payments. The new methodology shall make payments only to hospitals located
10.2 in Minnesota and include the following factors:

10.3 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
10.4 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
10.5 fee-for-service discharges in the base year shall receive a factor of 0.7880;

10.6 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
10.7 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
10.8 factor of 0.0160;

10.9 (3) a hospital that has received medical assistance payment ~~from the fee-for-service~~
10.10 ~~program~~ for at least 20 transplant services in the base year shall receive a factor of 0.0435;

10.11 (4) a hospital that has a medical assistance utilization rate in the base year between 20
10.12 percent up to one standard deviation above the statewide mean utilization rate shall receive
10.13 a factor of 0.0468;

10.14 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
10.15 one standard deviation above the statewide mean utilization rate but is less than two and
10.16 one-half standard deviations above the mean shall receive a factor of 0.2300; and

10.17 (6) a hospital that is a level one trauma center and that has a medical assistance utilization
10.18 rate in the base year that is at least two and one-half standard deviations above the statewide
10.19 mean utilization rate shall receive a factor of 0.3711.

10.20 (e) For the purposes of determining eligibility for the disproportionate share hospital
10.21 factors in paragraph (d), clauses (1) to (6), the medical assistance utilization rate and
10.22 discharge thresholds shall be measured using only one year when a two-year base period
10.23 is used.

10.24 ~~(e)~~ (f) Any payments or portion of payments made to a hospital under this subdivision
10.25 that are subsequently returned to the commissioner because the payments are found to
10.26 exceed the hospital-specific DSH limit for that hospital shall be redistributed, proportionate
10.27 to the number of fee-for-service discharges, to other DSH-eligible non-children's hospitals
10.28 that have a medical assistance utilization rate that is at least one standard deviation above
10.29 the mean.

10.30 ~~(f)~~ (g) An additional payment adjustment shall be established by the commissioner under
10.31 this subdivision for a hospital that provides high levels of administering high-cost drugs to
10.32 enrollees in fee-for-service medical assistance. The commissioner shall consider factors
10.33 including fee-for-service medical assistance utilization rates and payments made for drugs

11.1 purchased through the 340B drug purchasing program and administered to fee-for-service
11.2 enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate
11.3 share hospital limit, or if the hospital qualifies for the alternative payment rate described in
11.4 subdivision 2e, the commissioner shall make a payment to the hospital that equals the
11.5 nonfederal share of the amount that exceeds the limit. The total nonfederal share of the
11.6 amount of the payment adjustment under this paragraph shall not exceed \$1,500,000
11.7 \$9,000,000.

11.8 **EFFECTIVE DATE.** This section is effective July 1, 2021, except that the amendment
11.9 to paragraph (g) is effective January 1, 2023.

11.10 Sec. 11. Minnesota Statutes 2020, section 256.9695, subdivision 1, is amended to read:

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

11.22 To appeal a payment rate or payment determination or a determination made from base
11.23 year information, the hospital shall file a written appeal request to the commissioner within
11.24 60 days of the date the preliminary payment rate determination was mailed. The appeal
11.25 request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or
11.26 rule upon which the hospital relies for each disputed item; and (iii) the name and address
11.27 of the person to contact regarding the appeal. Facts to be considered in any appeal of base
11.28 year information are limited to those in existence ~~12~~ 18 months after the last day of the
11.29 calendar year that is the base year for the payment rates in dispute.

11.30 Sec. 12. Minnesota Statutes 2020, section 256.983, is amended to read:

11.31 **256.983 FRAUD PREVENTION INVESTIGATIONS.**

11.32 Subdivision 1. **Programs established.** Within the limits of available appropriations, the
11.33 commissioner of human services shall require the maintenance of budget neutral fraud

12.1 prevention investigation programs in the counties or tribal agencies participating in the
12.2 fraud prevention investigation project established under this section. If funds are sufficient,
12.3 the commissioner may also extend fraud prevention investigation programs to other counties
12.4 or tribal agencies provided the expansion is budget neutral to the state. Under any expansion,
12.5 the commissioner has the final authority in decisions regarding the creation and realignment
12.6 of individual county, tribal agency, or regional operations.

12.7 Subd. 2. **County and tribal agency proposals.** Each participating county and tribal
12.8 agency shall develop and submit an annual staffing and funding proposal to the commissioner
12.9 no later than April 30 of each year. Each proposal shall include, but not be limited to, the
12.10 staffing and funding of the fraud prevention investigation program, a job description for
12.11 investigators involved in the fraud prevention investigation program, and the organizational
12.12 structure of the county or tribal agency unit, training programs for case workers, and the
12.13 operational requirements which may be directed by the commissioner. The proposal shall
12.14 be approved, to include any changes directed or negotiated by the commissioner, no later
12.15 than June 30 of each year.

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

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

12.29 (b) The commissioner will maintain program compliance if for any three consecutive
12.30 month period, a county or tribal agency fails to comply with fraud prevention investigation
12.31 program guidelines, or fails to meet the cost-effectiveness standards developed by the
12.32 commissioner. This result is contingent on the commissioner providing written notice,
12.33 including an offer of technical assistance, within 30 days of the end of the third or subsequent
12.34 month of noncompliance. The county or tribal agency shall be required to submit a corrective
12.35 action plan to the commissioner within 30 days of receipt of a notice of noncompliance.

13.1 Failure to submit a corrective action plan or, continued deviation from standards of more
13.2 than ten percent after submission of a corrective action plan, will result in denial of funding
13.3 for each subsequent month, or billing the county or tribal agency for fraud prevention
13.4 investigation (FPI) service provided by the commissioner, or reallocation of program grant
13.5 funds, or investigative resources, or both, to other counties or tribal agencies. The denial of
13.6 funding shall apply to the general settlement received by the county or tribal agency on a
13.7 quarterly basis and shall not reduce the grant amount applicable to the FPI project.

13.8 Subd. 5. **Child care providers; financial misconduct.** (a) A county or tribal agency
13.9 may conduct investigations of financial misconduct by child care providers as described in
13.10 chapter 245E. Prior to opening an investigation, a county or tribal agency must contact the
13.11 commissioner to determine whether an investigation under this chapter may compromise
13.12 an ongoing investigation.

13.13 (b) If, upon investigation, a preponderance of evidence shows a provider committed an
13.14 intentional program violation, intentionally gave the county or tribe materially false
13.15 information on the provider's billing forms, provided false attendance records to a county,
13.16 tribe, or the commissioner, or committed financial misconduct as described in section
13.17 245E.01, subdivision 8, the county or tribal agency may suspend a provider's payment
13.18 pursuant to chapter 245E, or deny or revoke a provider's authorization pursuant to section
13.19 119B.13, subdivision 6, paragraph (d), clause (2), prior to pursuing other available remedies.
13.20 The county or tribe must send notice in accordance with the requirements of section
13.21 119B.161, subdivision 2. If a provider's payment is suspended under this section, the payment
13.22 suspension shall remain in effect until: (1) the commissioner, county, tribe, or a law
13.23 enforcement authority determines that there is insufficient evidence warranting the action
13.24 and a county, tribe, or the commissioner does not pursue an additional administrative remedy
13.25 under chapter 119B or 245E, or section 256.046 or 256.98; or (2) all criminal, civil, and
13.26 administrative proceedings related to the provider's alleged misconduct conclude and any
13.27 appeal rights are exhausted.

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

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

14.1 **Sec. 13. [256B.0371] ADMINISTRATION OF DENTAL SERVICES.**

14.2 (a) Effective January 1, 2023, the commissioner shall contract with a dental administrator
 14.3 to administer dental services for all recipients of medical assistance and MinnesotaCare,
 14.4 including persons enrolled in managed care as described in section 256B.69.

14.5 (b) The dental administrator must provide administrative services, including but not
 14.6 limited to:

14.7 (1) provider recruitment, contracting, and assistance;

14.8 (2) recipient outreach and assistance;

14.9 (3) utilization management and reviews of medical necessity for dental services;

14.10 (4) dental claims processing;

14.11 (5) coordination of dental care with other services;

14.12 (6) management of fraud and abuse;

14.13 (7) monitoring access to dental services;

14.14 (8) performance measurement;

14.15 (9) quality improvement and evaluation; and

14.16 (10) management of third-party liability requirements.

14.17 (c) Payments to contracted dental providers must be at the rates established under section
 14.18 256B.76.

14.19 **EFFECTIVE DATE.** This section is effective January 1, 2023.

14.20 Sec. 14. Minnesota Statutes 2020, section 256B.04, subdivision 12, is amended to read:

14.21 Subd. 12. **Limitation on services.** ~~(a) Place limits on the types of services covered by~~
 14.22 ~~medical assistance, the frequency with which the same or similar services may be covered~~
 14.23 ~~by medical assistance for an individual recipient, and the amount paid for each covered~~
 14.24 ~~service. The state agency shall promulgate rules establishing maximum reimbursement rates~~
 14.25 ~~for emergency and nonemergency transportation.~~

14.26 ~~The rules shall provide:~~

14.27 ~~(1) an opportunity for all recognized transportation providers to be reimbursed for~~
 14.28 ~~nonemergency transportation consistent with the maximum rates established by the agency;~~
 14.29 ~~and~~

15.1 ~~(2) reimbursement of public and private nonprofit providers serving the population with~~
 15.2 ~~a disability generally at reasonable maximum rates that reflect the cost of providing the~~
 15.3 ~~service regardless of the fare that might be charged by the provider for similar services to~~
 15.4 ~~individuals other than those receiving medical assistance or medical care under this chapter.~~

15.5 ~~(b) The commissioner shall encourage providers reimbursed under this chapter to~~
 15.6 ~~coordinate their operation with similar services that are operating in the same community.~~
 15.7 ~~To the extent practicable, the commissioner shall encourage eligible individuals to utilize~~
 15.8 ~~less expensive providers capable of serving their needs.~~

15.9 ~~(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective~~
 15.10 ~~on January 1, 1981, "recognized provider of transportation services" means an operator of~~
 15.11 ~~special transportation service as defined in section 174.29 that has been issued a current~~
 15.12 ~~certificate of compliance with operating standards of the commissioner of transportation~~
 15.13 ~~or, if those standards do not apply to the operator, that the agency finds is able to provide~~
 15.14 ~~the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized~~
 15.15 ~~transportation provider" includes an operator of special transportation service that the agency~~
 15.16 ~~finds is able to provide the required transportation in a safe and reliable manner.~~

15.17 Sec. 15. Minnesota Statutes 2020, section 256B.04, subdivision 14, is amended to read:

15.18 Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and
 15.19 feasible, the commissioner may utilize volume purchase through competitive bidding and
 15.20 negotiation under the provisions of chapter 16C, to provide items under the medical assistance
 15.21 program including but not limited to the following:

15.22 (1) eyeglasses;

15.23 (2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation
 15.24 on a short-term basis, until the vendor can obtain the necessary supply from the contract
 15.25 dealer;

15.26 (3) hearing aids and supplies; ~~and~~

15.27 (4) durable medical equipment, including but not limited to:

15.28 (i) hospital beds;

15.29 (ii) commodes;

15.30 (iii) glide-about chairs;

15.31 (iv) patient lift apparatus;

16.1 (v) wheelchairs and accessories;

16.2 (vi) oxygen administration equipment;

16.3 (vii) respiratory therapy equipment;

16.4 (viii) electronic diagnostic, therapeutic and life-support systems; and

16.5 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,

16.6 paragraph (c) or (d);

16.7 (5) nonemergency medical transportation ~~level-of-need determinations, disbursement of~~

16.8 ~~public transportation passes and tokens, and volunteer and recipient mileage and parking~~

16.9 ~~reimbursements; and~~

16.10 (6) drugs.

16.11 (b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not

16.12 affect contract payments under this subdivision unless specifically identified.

16.13 (c) The commissioner may not utilize volume purchase through competitive bidding

16.14 and negotiation under the provisions of chapter 16C for ~~special transportation services or~~

16.15 incontinence products and related supplies.

16.16 Sec. 16. Minnesota Statutes 2020, section 256B.055, subdivision 6, is amended to read:

16.17 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for

16.18 a pregnant woman who meets the other eligibility criteria of this section and whose unborn

16.19 child would be eligible as a needy child under subdivision 10 if born and living with the

16.20 woman. In accordance with Code of Federal Regulations, title 42, section 435.956, the

16.21 commissioner must accept self-attestation of pregnancy unless the agency has information

16.22 that is not reasonably compatible with such attestation. For purposes of this subdivision, a

16.23 woman is considered pregnant for ~~60 days~~ six months postpartum.

16.24 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,

16.25 whichever is later. The commissioner shall notify the revisor of statutes when federal

16.26 approval has been obtained.

16.27 Sec. 17. Minnesota Statutes 2020, section 256B.056, subdivision 10, is amended to read:

16.28 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who are

16.29 applying for the continuation of medical assistance coverage following the end of the ~~60-day~~

16.30 six-month postpartum period to update their income and asset information and to submit

16.31 any required income or asset verification.

17.1 (b) The commissioner shall determine the eligibility of private-sector health care coverage
17.2 for infants less than one year of age eligible under section 256B.055, subdivision 10, or
17.3 256B.057, subdivision 1, paragraph (c), and shall pay for private-sector coverage if this is
17.4 determined to be cost-effective.

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

17.7 (d) The commissioner shall utilize information obtained through the electronic service
17.8 established by the secretary of the United States Department of Health and Human Services
17.9 and other available electronic data sources in Code of Federal Regulations, title 42, sections
17.10 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish
17.11 standards to define when information obtained electronically is reasonably compatible with
17.12 information provided by applicants and enrollees, including use of self-attestation, to
17.13 accomplish real-time eligibility determinations and maintain program integrity.

17.14 (e) Each person applying for or receiving medical assistance under section 256B.055,
17.15 subdivision 7, and any other person whose resources are required by law to be disclosed to
17.16 determine the applicant's or recipient's eligibility must authorize the commissioner to obtain
17.17 information from financial institutions to identify unreported accounts as required in section
17.18 256.01, subdivision 18f. If a person refuses or revokes the authorization, the commissioner
17.19 may determine that the applicant or recipient is ineligible for medical assistance. For purposes
17.20 of this paragraph, an authorization to identify unreported accounts meets the requirements
17.21 of the Right to Financial Privacy Act, United States Code, title 12, chapter 35, and need not
17.22 be furnished to the financial institution.

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

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

17.29 Sec. 18. Minnesota Statutes 2020, section 256B.057, subdivision 3, is amended to read:

17.30 Subd. 3. **Qualified Medicare beneficiaries.** ~~(a) A person who is entitled to Part A~~
17.31 ~~Medicare benefits, whose income is equal to or less than 100 percent of the federal poverty~~
17.32 ~~guidelines, and whose assets are no more than \$10,000 for a single individual and \$18,000~~
17.33 ~~for a married couple or family of two or more, is eligible for medical assistance~~

18.1 reimbursement of Medicare Part A and Part B premiums, Part A and Part B coinsurance
18.2 and deductibles, and cost-effective premiums for enrollment with a health maintenance
18.3 organization or a competitive medical plan under section 1876 of the Social Security Act;
18.4 if:

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

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

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

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

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

18.19 Sec. 19. Minnesota Statutes 2020, section 256B.06, subdivision 4, is amended to read:

18.20 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to
18.21 citizens of the United States, qualified noncitizens as defined in this subdivision, and other
18.22 persons residing lawfully in the United States. Citizens or nationals of the United States
18.23 must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
18.24 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
18.25 109-171.

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

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

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

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

19.1 (4) granted withholding of deportation according to United States Code, title 8, section
19.2 1253(h);

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

19.5 (6) granted conditional entrant status according to United States Code, title 8, section
19.6 1153(a)(7);

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

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

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

19.16 (c) All qualified noncitizens who were residing in the United States before August 22,
19.17 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical
19.18 assistance with federal financial participation.

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

19.23 (1) refugees admitted to the United States according to United States Code, title 8, section
19.24 1157;

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

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

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

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

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

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

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

20.15 (g) For purposes of this subdivision, the term "emergency medical condition" means a
20.16 medical condition that meets the requirements of United States Code, title 42, section
20.17 1396b(v).

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

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

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

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

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

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

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

20.31 (iii) services for routine prenatal care;

- 21.1 (iv) continuing care, including long-term care, nursing facility services, home health
21.2 care, adult day care, day training, or supportive living services;
- 21.3 (v) elective surgery;
- 21.4 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part
21.5 of an emergency room visit;
- 21.6 (vii) preventative health care and family planning services;
- 21.7 (viii) rehabilitation services;
- 21.8 (ix) physical, occupational, or speech therapy;
- 21.9 (x) transportation services;
- 21.10 (xi) case management;
- 21.11 (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 21.12 (xiii) dental services;
- 21.13 (xiv) hospice care;
- 21.14 (xv) audiology services and hearing aids;
- 21.15 (xvi) podiatry services;
- 21.16 (xvii) chiropractic services;
- 21.17 (xviii) immunizations;
- 21.18 (xix) vision services and eyeglasses;
- 21.19 (xx) waiver services;
- 21.20 (xxi) individualized education programs; or
- 21.21 (xxii) chemical dependency treatment.
- 21.22 (i) Pregnant noncitizens who are ineligible for federally funded medical assistance
21.23 because of immigration status, are not covered by a group health plan or health insurance
21.24 coverage according to Code of Federal Regulations, title 42, section 457.310, and who
21.25 otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance
21.26 through the period of pregnancy, including labor and delivery, and ~~60 days~~ six months
21.27 postpartum, ~~to the extent federal funds are available under title XXI of the Social Security~~
21.28 ~~Act, and the state children's health insurance program.~~

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

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

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

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

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

22.25 (l) Effective July 1, 2013, recipients of emergency medical assistance under this
22.26 subdivision are eligible for coverage of the elderly waiver services provided under chapter
22.27 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit
22.28 for elderly waiver services does not apply. In order to qualify for coverage, a recipient of
22.29 emergency medical assistance is subject to the assessment and reassessment requirements
22.30 of section 256B.0911. Initial and continued enrollment under this paragraph is subject to
22.31 the limits of available funding.

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

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

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

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

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

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

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

23.33 (4) the development of dental delivery models; and

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

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

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

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

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

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

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

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

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

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

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

25.9 ~~(5)~~ (6) the commissioner's medical director who shall serve as a nonvoting member.

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

25.14 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 3e, is amended to read:

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

25.23 Sec. 23. Minnesota Statutes 2020, section 256B.0625, subdivision 9, is amended to read:

25.24 Subd. 9. **Dental services.** (a) Medical assistance covers dental services. The commissioner
 25.25 shall contract with a dental administrator for the administration of dental services. The
 25.26 contract shall include the administration of dental services for persons enrolled in managed
 25.27 care as described in section 256B.69.

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

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

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

- 26.1 (3) limited exams;
- 26.2 (4) bitewing x-rays, limited to one per year;
- 26.3 (5) periapical x-rays;
- 26.4 (6) panoramic x-rays, limited to one every five years except (1) when medically necessary
- 26.5 for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once
- 26.6 every two years for patients who cannot cooperate for intraoral film due to a developmental
- 26.7 disability or medical condition that does not allow for intraoral film placement;
- 26.8 (7) prophylaxis, limited to one per year;
- 26.9 (8) application of fluoride varnish, limited to one per year;
- 26.10 (9) posterior fillings, all at the amalgam rate;
- 26.11 (10) anterior fillings;
- 26.12 (11) endodontics, limited to root canals on the anterior and premolars only;
- 26.13 (12) removable prostheses, each dental arch limited to one every six years;
- 26.14 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;
- 26.15 (14) palliative treatment and sedative fillings for relief of pain; ~~and~~
- 26.16 (15) full-mouth debridement, limited to one every five years; and
- 26.17 (16) nonsurgical treatment for periodontal disease, including scaling and root planing
- 26.18 once every two years for each quadrant, and routine periodontal maintenance procedures.
- 26.19 (c) In addition to the services specified in paragraph (b), medical assistance covers the
- 26.20 following services for adults, if provided in an outpatient hospital setting or freestanding
- 26.21 ambulatory surgical center as part of outpatient dental surgery:
- 26.22 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 26.23 (2) general anesthesia; and
- 26.24 (3) full-mouth survey once every five years.
- 26.25 (d) Medical assistance covers medically necessary dental services for children and
- 26.26 pregnant women. The following guidelines apply:
- 26.27 (1) posterior fillings are paid at the amalgam rate;
- 26.28 (2) application of sealants are covered once every five years per permanent molar for
- 26.29 children only;

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

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

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

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

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

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

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

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

27.17 **EFFECTIVE DATE.** This section is effective July 1, 2021, except that the amendments
27.18 to paragraphs (a) and (f) are effective January 1, 2023.

27.19 Sec. 24. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

27.20 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
27.21 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
27.22 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
27.23 dispensing physician, or by a physician, a physician assistant, or an advanced practice
27.24 registered nurse employed by or under contract with a community health board as defined
27.25 in section 145A.02, subdivision 5, for the purposes of communicable disease control.

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

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

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

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

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

28.15 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
28.16 a licensed practitioner or by a licensed pharmacist who meets standards established by the
28.17 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
28.18 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
28.19 with documented vitamin deficiencies, vitamins for children under the age of seven and
28.20 pregnant or nursing women, and any other over-the-counter drug identified by the
28.21 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
28.22 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
28.23 disorders, and this determination shall not be subject to the requirements of chapter 14. A
28.24 pharmacist may prescribe over-the-counter medications as provided under this paragraph
28.25 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
28.26 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
28.27 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
28.28 and make referrals as needed to other health care professionals.

28.29 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
28.30 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
28.31 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
28.32 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
28.33 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
28.34 individuals, medical assistance may cover drugs from the drug classes listed in United States

29.1 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
29.2 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
29.3 not be covered.

29.4 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
29.5 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
29.6 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
29.7 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.
29.8 By March 1 of each year, each 340B covered entity and ambulatory pharmacy under common
29.9 ownership of the 340B covered entity must report to the commissioner its reimbursements
29.10 for the previous calendar year from each managed care and county-based purchasing plan,
29.11 or the pharmacy benefit manager contracted with the managed care or county-based
29.12 purchasing plan. The report must include:

29.13 (1) the National Provider Identification (NPI) number for each 340B covered entity or
29.14 ambulatory pharmacy under common ownership of the 340B covered entity;

29.15 (2) the name of each 340B covered entity;

29.16 (3) the servicing address of each 340B covered entity;

29.17 (4) the aggregate cost of drugs purchased during the prior calendar year through the
29.18 340B program;

29.19 (5) the aggregate cost of drugs purchased during the prior calendar year outside of the
29.20 340B program;

29.21 (6) the total reimbursement received by the 340B covered entity from all payers, including
29.22 uninsured patients, for all drugs during the prior calendar year; and

29.23 (7) either: (i) the number of outpatient 340B pharmacy claims and reimbursement amounts
29.24 from each managed care and county-based purchasing plan, or pharmacy benefit manager
29.25 contracted with the managed care or county-based purchasing plan; or (ii) the number of
29.26 professional or facility 340B claim lines and reimbursement amounts during the prior
29.27 calendar year from each managed care and county-based purchasing plan.

29.28 The commissioner shall submit a copy of the reports to the chairs and ranking minority
29.29 members of the legislative committees with jurisdiction over health care policy and finance
29.30 by April 1 of each year. Drugs acquired through the federal 340B Drug Pricing Program
29.31 and dispensed by a 340B covered entity or ambulatory pharmacy under common ownership
29.32 of the 340B covered entity are not eligible for coverage if the 340B covered entity or

30.1 ambulatory pharmacy under common ownership of the 340B covered entity fails to submit
30.2 a report to the commissioner containing the information required under clauses (1) to (7).

30.3 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
30.4 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
30.5 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
30.6 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
30.7 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
30.8 pharmacist in accordance with section 151.37, subdivision 16.

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

30.11 Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations
30.12 from professional medical associations and professional pharmacy associations, and consumer
30.13 groups shall designate a Formulary Committee to carry out duties as described in subdivisions
30.14 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively
30.15 engaged in the practice of medicine in Minnesota, one of whom must be actively engaged
30.16 in the treatment of persons with mental illness; at least three licensed pharmacists actively
30.17 engaged in the practice of pharmacy in Minnesota; and one consumer representative; the
30.18 remainder to be made up of health care professionals who are licensed in their field and
30.19 have recognized knowledge in the clinically appropriate prescribing, dispensing, and
30.20 monitoring of covered outpatient drugs. Members of the Formulary Committee shall not
30.21 be employed by the Department of Human Services, but the committee shall be staffed by
30.22 an employee of the department who shall serve as an ex officio, nonvoting member of the
30.23 committee. The department's medical director shall also serve as an ex officio, nonvoting
30.24 member for the committee. Committee members shall serve three-year terms and may be
30.25 reappointed by the commissioner. The Formulary Committee shall meet at least twice per
30.26 year. The commissioner may require more frequent Formulary Committee meetings as
30.27 needed. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid
30.28 to each committee member in attendance. ~~The Formulary Committee expires June 30, 2022.~~
30.29 Notwithstanding section 15.059, subdivision 6, the Formulary Committee does not expire.

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

30.32 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its
30.33 establishment and publication shall not be subject to the requirements of the Administrative

31.1 Procedure Act, but the Formulary Committee shall review and comment on the formulary
31.2 contents.

31.3 (b) The formulary shall not include:

31.4 (1) drugs, active pharmaceutical ingredients, or products for which there is no federal
31.5 funding;

31.6 (2) over-the-counter drugs, except as provided in subdivision 13;

31.7 ~~(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically~~
31.8 ~~necessary lipase inhibitors may be covered for a recipient with type II diabetes;~~

31.9 ~~(4)~~ (3) drugs or active pharmaceutical ingredients when used for the treatment of
31.10 impotence or erectile dysfunction;

31.11 ~~(5)~~ (4) drugs or active pharmaceutical ingredients for which medical value has not been
31.12 established;

31.13 ~~(6)~~ (5) drugs from manufacturers who have not signed a rebate agreement with the
31.14 Department of Health and Human Services pursuant to section 1927 of title XIX of the
31.15 Social Security Act; and

31.16 ~~(7)~~ (6) medical cannabis as defined in section 152.22, subdivision 6.

31.17 (c) If a single-source drug used by at least two percent of the fee-for-service medical
31.18 assistance recipients is removed from the formulary due to the failure of the manufacturer
31.19 to sign a rebate agreement with the Department of Health and Human Services, the
31.20 commissioner shall notify prescribing practitioners within 30 days of receiving notification
31.21 from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was
31.22 not signed.

31.23 Sec. 27. Minnesota Statutes 2020, section 256B.0625, subdivision 17, is amended to read:

31.24 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
31.25 means motor vehicle transportation provided by a public or private person that serves
31.26 Minnesota health care program beneficiaries who do not require emergency ambulance
31.27 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

31.28 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
31.29 emergency medical care or transportation costs incurred by eligible persons in obtaining
31.30 emergency or nonemergency medical care when paid directly to an ambulance company,
31.31 nonemergency medical transportation company, or other recognized providers of
31.32 transportation services. Medical transportation must be provided by:

32.1 (1) nonemergency medical transportation providers who meet the requirements of this
32.2 subdivision;

32.3 (2) ambulances, as defined in section 144E.001, subdivision 2;

32.4 (3) taxicabs that meet the requirements of this subdivision;

32.5 (4) public transit, as defined in section 174.22, subdivision 7; or

32.6 (5) not-for-hire vehicles, including volunteer drivers.

32.7 (c) Medical assistance covers nonemergency medical transportation provided by
32.8 nonemergency medical transportation providers enrolled in the Minnesota health care
32.9 programs. All nonemergency medical transportation providers must comply with the
32.10 operating standards for special transportation service as defined in sections 174.29 to 174.30
32.11 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
32.12 commissioner and reported on the claim as the individual who provided the service. All
32.13 nonemergency medical transportation providers shall bill for nonemergency medical
32.14 transportation services in accordance with Minnesota health care programs criteria. Publicly
32.15 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
32.16 requirements outlined in this paragraph.

32.17 (d) An organization may be terminated, denied, or suspended from enrollment if:

32.18 (1) the provider has not initiated background studies on the individuals specified in
32.19 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

32.20 (2) the provider has initiated background studies on the individuals specified in section
32.21 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

32.22 (i) the commissioner has sent the provider a notice that the individual has been
32.23 disqualified under section 245C.14; and

32.24 (ii) the individual has not received a disqualification set-aside specific to the special
32.25 transportation services provider under sections 245C.22 and 245C.23.

32.26 (e) The administrative agency of nonemergency medical transportation must:

32.27 (1) adhere to the policies defined by the commissioner ~~in consultation with the~~
32.28 ~~Nonemergency Medical Transportation Advisory Committee;~~

32.29 (2) pay nonemergency medical transportation providers for services provided to
32.30 Minnesota health care programs beneficiaries to obtain covered medical services; and

33.1 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
33.2 trips, and number of trips by mode; ~~and.~~

33.3 ~~(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single~~
33.4 ~~administrative structure assessment tool that meets the technical requirements established~~
33.5 ~~by the commissioner, reconciles trip information with claims being submitted by providers,~~
33.6 ~~and ensures prompt payment for nonemergency medical transportation services.~~

33.7 ~~(f) Until the commissioner implements the single administrative structure and delivery~~
33.8 ~~system under subdivision 18e, clients shall obtain their level of service certificate from the~~
33.9 ~~commissioner or an entity approved by the commissioner that does not dispatch rides for~~
33.10 ~~clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).~~

33.11 ~~(g)~~ (f) The commissioner may use an order by the recipient's attending physician,
33.12 advanced practice registered nurse, or a medical or mental health professional to certify that
33.13 the recipient requires nonemergency medical transportation services. Nonemergency medical
33.14 transportation providers shall perform driver-assisted services for eligible individuals, when
33.15 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
33.16 residence or place of business, assistance with admittance of the individual to the medical
33.17 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
33.18 or stretchers in the vehicle.

33.19 Nonemergency medical transportation providers must take clients to the health care
33.20 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
33.21 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
33.22 authorization from the ~~local agency administrator~~.

33.23 Nonemergency medical transportation providers may not bill for separate base rates for
33.24 the continuation of a trip beyond the original destination. Nonemergency medical
33.25 transportation providers must maintain trip logs, which include pickup and drop-off times,
33.26 signed by the medical provider or client, whichever is deemed most appropriate, attesting
33.27 to mileage traveled to obtain covered medical services. Clients requesting client mileage
33.28 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
33.29 services.

33.30 ~~(h)~~ (g) The administrative agency shall use the level of service process established by
33.31 the commissioner ~~in consultation with the Nonemergency Medical Transportation Advisory~~
33.32 ~~Committee~~ to determine the client's most appropriate mode of transportation. If public transit
33.33 or a certified transportation provider is not available to provide the appropriate service mode
33.34 for the client, the client may receive a onetime service upgrade.

34.1 ~~(j)~~ (h) The covered modes of transportation are:

34.2 (1) client reimbursement, which includes client mileage reimbursement provided to
34.3 clients who have their own transportation, or to family or an acquaintance who provides
34.4 transportation to the client;

34.5 (2) volunteer transport, which includes transportation by volunteers using their own
34.6 vehicle;

34.7 (3) unassisted transport, which includes transportation provided to a client by a taxicab
34.8 or public transit. If a taxicab or public transit is not available, the client can receive
34.9 transportation from another nonemergency medical transportation provider;

34.10 (4) assisted transport, which includes transport provided to clients who require assistance
34.11 by a nonemergency medical transportation provider;

34.12 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
34.13 dependent on a device and requires a nonemergency medical transportation provider with
34.14 a vehicle containing a lift or ramp;

34.15 (6) protected transport, which includes transport provided to a client who has received
34.16 a prescreening that has deemed other forms of transportation inappropriate and who requires
34.17 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
34.18 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
34.19 the vehicle driver; and (ii) who is certified as a protected transport provider; and

34.20 (7) stretcher transport, which includes transport for a client in a prone or supine position
34.21 and requires a nonemergency medical transportation provider with a vehicle that can transport
34.22 a client in a prone or supine position.

34.23 ~~(j) The local agency shall be the single administrative agency and shall administer and~~
34.24 ~~reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the~~
34.25 ~~commissioner has developed, made available, and funded the web-based single administrative~~
34.26 ~~structure, assessment tool, and level of need assessment under subdivision 18c. The local~~
34.27 ~~agency's financial obligation is limited to funds provided by the state or federal government.~~

34.28 ~~(k)~~ (i) The commissioner shall:

34.29 (1) ~~in consultation with the Nonemergency Medical Transportation Advisory Committee,~~
34.30 verify that the mode and use of nonemergency medical transportation is appropriate;

34.31 (2) verify that the client is going to an approved medical appointment; and

34.32 (3) investigate all complaints and appeals.

35.1 ~~(l) The administrative agency shall pay for the services provided in this subdivision and~~
35.2 ~~seek reimbursement from the commissioner, if appropriate. As vendors of medical care,~~
35.3 ~~local agencies are subject to the provisions in section 256B.041, the sanctions and monetary~~
35.4 ~~recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.~~

35.5 ~~(m) (j)~~ Payments for nonemergency medical transportation must be paid based on the
35.6 client's assessed mode under paragraph ~~(h)~~ (g), not the type of vehicle used to provide the
35.7 service. ~~The medical assistance reimbursement rates for nonemergency medical transportation~~
35.8 ~~services that are payable by or on behalf of the commissioner for nonemergency medical~~
35.9 ~~transportation services are:~~

35.10 ~~(1) \$0.22 per mile for client reimbursement;~~

35.11 ~~(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer~~
35.12 ~~transport;~~

35.13 ~~(3) equivalent to the standard fare for unassisted transport when provided by public~~
35.14 ~~transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency~~
35.15 ~~medical transportation provider;~~

35.16 ~~(4) \$13 for the base rate and \$1.30 per mile for assisted transport;~~

35.17 ~~(5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;~~

35.18 ~~(6) \$75 for the base rate and \$2.40 per mile for protected transport; and~~

35.19 ~~(7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for~~
35.20 ~~an additional attendant if deemed medically necessary.~~

35.21 ~~(n) The base rate for nonemergency medical transportation services in areas defined~~
35.22 ~~under RUCA to be super rural is equal to 111.3 percent of the respective base rate in~~
35.23 ~~paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation~~
35.24 ~~services in areas defined under RUCA to be rural or super rural areas is:~~

35.25 ~~(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage~~
35.26 ~~rate in paragraph (m), clauses (1) to (7); and~~

35.27 ~~(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage~~
35.28 ~~rate in paragraph (m), clauses (1) to (7).~~

35.29 ~~(o) For purposes of reimbursement rates for nonemergency medical transportation~~
35.30 ~~services under paragraphs (m) and (n), the zip code of the recipient's place of residence~~
35.31 ~~shall determine whether the urban, rural, or super rural reimbursement rate applies.~~

36.1 ~~(p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means~~
36.2 ~~a census tract based classification system under which a geographical area is determined~~
36.3 ~~to be urban, rural, or super rural.~~

36.4 ~~(q)~~ (k) The commissioner, when determining reimbursement rates for nonemergency
36.5 medical transportation ~~under paragraphs (m) and (n)~~, shall exempt all modes of transportation
36.6 listed under paragraph ~~(i)~~ (h) from Minnesota Rules, part 9505.0445, item R, subitem (2).

36.7 **EFFECTIVE DATE.** This section is effective January 1, 2023.

36.8 Sec. 28. Minnesota Statutes 2020, section 256B.0625, subdivision 17b, is amended to
36.9 read:

36.10 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
36.11 medical transportation providers must document each occurrence of a service provided to
36.12 a recipient according to this subdivision. Providers must maintain odometer and other records
36.13 sufficient to distinguish individual trips with specific vehicles and drivers. The documentation
36.14 may be collected and maintained using electronic systems or software or in paper form but
36.15 must be made available and produced upon request. Program funds paid for transportation
36.16 that is not documented according to this subdivision shall be recovered by the nonemergency
36.17 medical transportation vendor or department.

36.18 (b) A nonemergency medical transportation provider must compile transportation records
36.19 that meet the following requirements:

36.20 (1) the record must be in English and must be legible according to the standard of a
36.21 reasonable person;

36.22 (2) the recipient's name must be on each page of the record; and

36.23 (3) each entry in the record must document:

36.24 (i) the date on which the entry is made;

36.25 (ii) the date or dates the service is provided;

36.26 (iii) the printed last name, first name, and middle initial of the driver;

36.27 (iv) the signature of the driver attesting to the following: "I certify that I have accurately
36.28 reported in this record the trip miles I actually drove and the dates and times I actually drove
36.29 them. I understand that misreporting the miles driven and hours worked is fraud for which
36.30 I could face criminal prosecution or civil proceedings.";

37.1 (v) the signature of the recipient or authorized party attesting to the following: "I certify
37.2 that I received the reported transportation service.", or the signature of the provider of
37.3 medical services certifying that the recipient was delivered to the provider;

37.4 (vi) the address, or the description if the address is not available, of both the origin and
37.5 destination, and the mileage for the most direct route from the origin to the destination;

37.6 (vii) the mode of transportation in which the service is provided;

37.7 (viii) the license plate number of the vehicle used to transport the recipient;

37.8 (ix) whether the service was ambulatory or nonambulatory;

37.9 (x) the time of the pickup and the time of the drop-off with "a.m." and "p.m."

37.10 designations;

37.11 (xi) the name of the extra attendant when an extra attendant is used to provide special
37.12 transportation service; and

37.13 (xii) the electronic source documentation used to calculate driving directions and mileage.

37.14 **EFFECTIVE DATE.** This section is effective January 1, 2023.

37.15 Sec. 29. Minnesota Statutes 2020, section 256B.0625, subdivision 18, is amended to read:

37.16 Subd. 18. **Bus Public transit or taxicab transportation.** (a) To the extent authorized
37.17 by rule of the state agency, medical assistance covers the most appropriate and cost-effective
37.18 form of transportation incurred by any ambulatory eligible person for obtaining
37.19 nonemergency medical care.

37.20 (b) The commissioner may provide a monthly public transit pass to recipients who are
37.21 well-served by public transit for the recipient's nonemergency medical transportation needs.
37.22 Any recipient who is eligible for one public transit trip for a medically necessary covered
37.23 service may select to receive a transit pass for that month. Recipients who do not have any
37.24 transportation needs for a medically necessary service in any given month or who have
37.25 received a transit pass for that month through another program administered by a county or
37.26 Tribe are not eligible for a transit pass that month. The commissioner shall not require
37.27 recipients to select a monthly transit pass if the recipient's transportation needs cannot be
37.28 served by public transit systems. Recipients who receive a monthly transit pass are not
37.29 eligible for other modes of transportation, unless an unexpected need arises that cannot be
37.30 accessed through public transit.

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

38.1 Sec. 30. Minnesota Statutes 2020, section 256B.0625, subdivision 18b, is amended to
38.2 read:

38.3 Subd. 18b. ~~Broker dispatching prohibition~~ **Administration of nonemergency medical**
38.4 **transportation.** ~~Except for establishing level of service process, the commissioner shall~~
38.5 ~~not use a broker or coordinator for any purpose related to nonemergency medical~~
38.6 ~~transportation services under subdivision 18.~~ The commissioner shall contract either statewide
38.7 or regionally for the administration of the nonemergency medical transportation program
38.8 in compliance with the provisions of this chapter. The contract shall include the
38.9 administration of all covered modes under the nonemergency medical transportation benefit
38.10 for those enrolled in managed care as described in section 256B.69.

38.11 **EFFECTIVE DATE.** This section is effective January 1, 2023.

38.12 Sec. 31. Minnesota Statutes 2020, section 256B.0625, subdivision 30, is amended to read:

38.13 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,
38.14 federally qualified health center services, nonprofit community health clinic services, and
38.15 public health clinic services. Rural health clinic services and federally qualified health center
38.16 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and
38.17 (C). Payment for rural health clinic and federally qualified health center services shall be
38.18 made according to applicable federal law and regulation.

38.19 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
38.20 submit an estimate of budgeted costs and visits for the initial reporting period in the form
38.21 and detail required by the commissioner. An FQHC that is already in operation shall submit
38.22 an initial report using actual costs and visits for the initial reporting period. Within 90 days
38.23 of the end of its reporting period, an FQHC shall submit, in the form and detail required by
38.24 the commissioner, a report of its operations, including allowable costs actually incurred for
38.25 the period and the actual number of visits for services furnished during the period, and other
38.26 information required by the commissioner. FQHCs that file Medicare cost reports shall
38.27 provide the commissioner with a copy of the most recent Medicare cost report filed with
38.28 the Medicare program intermediary for the reporting year which support the costs claimed
38.29 on their cost report to the state.

38.30 (c) In order to continue cost-based payment under the medical assistance program
38.31 according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation
38.32 as an essential community provider within six months of final adoption of rules by the
38.33 Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and
38.34 rural health clinics that have applied for essential community provider status within the

39.1 six-month time prescribed, medical assistance payments will continue to be made according
39.2 to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural
39.3 health clinics that either do not apply within the time specified above or who have had
39.4 essential community provider status for three years, medical assistance payments for health
39.5 services provided by these entities shall be according to the same rates and conditions
39.6 applicable to the same service provided by health care providers that are not FQHCs or rural
39.7 health clinics.

39.8 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural
39.9 health clinic to make application for an essential community provider designation in order
39.10 to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

39.11 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall
39.12 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

39.13 (f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health
39.14 clinic may elect to be paid either under the prospective payment system established in United
39.15 States Code, title 42, section 1396a(aa), or under an alternative payment methodology
39.16 consistent with the requirements of United States Code, title 42, section 1396a(aa), and
39.17 approved by the Centers for Medicare and Medicaid Services. The alternative payment
39.18 methodology shall be 100 percent of cost as determined according to Medicare cost
39.19 principles.

39.20 (g) Effective for services provided on or after January 1, 2021, all claims for payment
39.21 of clinic services provided by FQHCs and rural health clinics shall be paid by the
39.22 commissioner, according to an annual election by the FQHC or rural health clinic, under
39.23 the current prospective payment system described in paragraph (f) or the alternative payment
39.24 methodology described in paragraph (l).

39.25 (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

39.26 (1) has nonprofit status as specified in chapter 317A;

39.27 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

39.28 (3) is established to provide health services to low-income population groups, uninsured,
39.29 high-risk and special needs populations, underserved and other special needs populations;

39.30 (4) employs professional staff at least one-half of which are familiar with the cultural
39.31 background of their clients;

39.32 (5) charges for services on a sliding fee scale designed to provide assistance to
39.33 low-income clients based on current poverty income guidelines and family size; and

40.1 (6) does not restrict access or services because of a client's financial limitations or public
40.2 assistance status and provides no-cost care as needed.

40.3 (i) Effective for services provided on or after January 1, 2015, all claims for payment
40.4 of clinic services provided by FQHCs and rural health clinics shall be paid by the
40.5 commissioner. the commissioner shall determine the most feasible method for paying claims
40.6 from the following options:

40.7 (1) FQHCs and rural health clinics submit claims directly to the commissioner for
40.8 payment, and the commissioner provides claims information for recipients enrolled in a
40.9 managed care or county-based purchasing plan to the plan, on a regular basis; or

40.10 (2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed
40.11 care or county-based purchasing plan to the plan, and those claims are submitted by the
40.12 plan to the commissioner for payment to the clinic.

40.13 (j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate
40.14 and pay monthly the proposed managed care supplemental payments to clinics, and clinics
40.15 shall conduct a timely review of the payment calculation data in order to finalize all
40.16 supplemental payments in accordance with federal law. Any issues arising from a clinic's
40.17 review must be reported to the commissioner by January 1, 2017. Upon final agreement
40.18 between the commissioner and a clinic on issues identified under this subdivision, and in
40.19 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
40.20 for managed care plan or county-based purchasing plan claims for services provided prior
40.21 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
40.22 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
40.23 arbitration process under section 14.57.

40.24 (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the
40.25 Social Security Act, to obtain federal financial participation at the 100 percent federal
40.26 matching percentage available to facilities of the Indian Health Service or tribal organization
40.27 in accordance with section 1905(b) of the Social Security Act for expenditures made to
40.28 organizations dually certified under Title V of the Indian Health Care Improvement Act,
40.29 Public Law 94-437, and as a federally qualified health center under paragraph (a) that
40.30 provides services to American Indian and Alaskan Native individuals eligible for services
40.31 under this subdivision.

40.32 (l) All claims for payment of clinic services provided by FQHCs and rural health clinics,
40.33 that have elected to be paid under this paragraph, shall be paid by the commissioner according
40.34 to the following requirements:

41.1 (1) the commissioner shall establish a single medical and single dental organization
41.2 encounter rate for each FQHC and rural health clinic when applicable;

41.3 (2) each FQHC and rural health clinic is eligible for same day reimbursement of one
41.4 medical and one dental organization encounter rate if eligible medical and dental visits are
41.5 provided on the same day;

41.6 (3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance
41.7 with current applicable Medicare cost principles, their allowable costs, including direct
41.8 patient care costs and patient-related support services. Nonallowable costs include, but are
41.9 not limited to:

41.10 (i) general social services and administrative costs;

41.11 (ii) retail pharmacy;

41.12 (iii) patient incentives, food, housing assistance, and utility assistance;

41.13 (iv) external lab and x-ray;

41.14 (v) navigation services;

41.15 (vi) health care taxes;

41.16 (vii) advertising, public relations, and marketing;

41.17 (viii) office entertainment costs, food, alcohol, and gifts;

41.18 (ix) contributions and donations;

41.19 (x) bad debts or losses on awards or contracts;

41.20 (xi) fines, penalties, damages, or other settlements;

41.21 (xii) fund-raising, investment management, and associated administrative costs;

41.22 (xiii) research and associated administrative costs;

41.23 (xiv) nonpaid workers;

41.24 (xv) lobbying;

41.25 (xvi) scholarships and student aid; and

41.26 (xvii) nonmedical assistance covered services;

41.27 (4) the commissioner shall review the list of nonallowable costs in the years between
41.28 the rebasing process established in clause (5), in consultation with the Minnesota Association

42.1 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
42.2 publish the list and any updates in the Minnesota health care programs provider manual;

42.3 (5) the initial applicable base year organization encounter rates for FQHCs and rural
42.4 health clinics shall be computed for services delivered on or after January 1, 2021, and:

42.5 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
42.6 from 2017 and 2018;

42.7 (ii) must be according to current applicable Medicare cost principles as applicable to
42.8 FQHCs and rural health clinics without the application of productivity screens and upper
42.9 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
42.10 payment limit;

42.11 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
42.12 reports that are three and four years prior to the rebasing year. Years in which organizational
42.13 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health
42.14 emergency shall not be used as part of a base year when the base year includes more than
42.15 one year. The commissioner may use the Medicare cost reports of a year unaffected by a
42.16 pandemic, disease, or other public health emergency, or previous two consecutive years,
42.17 inflated to the base year as established under item (iv);

42.18 (iv) must be inflated to the base year using the inflation factor described in clause (6);
42.19 and

42.20 (v) the commissioner must provide for a 60-day appeals process under section 14.57;

42.21 (6) the commissioner shall annually inflate the applicable organization encounter rates
42.22 for FQHCs and rural health clinics from the base year payment rate to the effective date by
42.23 using the CMS FQHC Market Basket inflator established under United States Code, title
42.24 42, section 1395m(o), less productivity;

42.25 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
42.26 under this paragraph shall submit all necessary documentation required by the commissioner
42.27 to compute the rebased organization encounter rates no later than six months following the
42.28 date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid
42.29 Services;

42.30 (8) the commissioner shall reimburse FQHCs and rural health clinics an additional
42.31 amount relative to their medical and dental organization encounter rates that is attributable
42.32 to the tax required to be paid according to section 295.52, if applicable;

43.1 (9) FQHCs and rural health clinics may submit change of scope requests to the
43.2 commissioner if the change of scope would result in an increase or decrease of 2.5 percent
43.3 or higher in the medical or dental organization encounter rate currently received by the
43.4 FQHC or rural health clinic;

43.5 (10) for FQHCs and rural health clinics seeking a change in scope with the commissioner
43.6 under clause (9) that requires the approval of the scope change by the federal Health
43.7 Resources Services Administration:

43.8 (i) FQHCs and rural health clinics shall submit the change of scope request, including
43.9 the start date of services, to the commissioner within seven business days of submission of
43.10 the scope change to the federal Health Resources Services Administration;

43.11 (ii) the commissioner shall establish the effective date of the payment change as the
43.12 federal Health Resources Services Administration date of approval of the FQHC's or rural
43.13 health clinic's scope change request, or the effective start date of services, whichever is
43.14 later; and

43.15 (iii) within 45 days of one year after the effective date established in item (ii), the
43.16 commissioner shall conduct a retroactive review to determine if the actual costs established
43.17 under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in
43.18 the medical or dental organization encounter rate, and if this is the case, the commissioner
43.19 shall revise the rate accordingly and shall adjust payments retrospectively to the effective
43.20 date established in item (ii);

43.21 (11) for change of scope requests that do not require federal Health Resources Services
43.22 Administration approval, the FQHC and rural health clinic shall submit the request to the
43.23 commissioner before implementing the change, and the effective date of the change is the
43.24 date the commissioner received the FQHC's or rural health clinic's request, or the effective
43.25 start date of the service, whichever is later. The commissioner shall provide a response to
43.26 the FQHC's or rural health clinic's request within 45 days of submission and provide a final
43.27 approval within 120 days of submission. This timeline may be waived at the mutual
43.28 agreement of the commissioner and the FQHC or rural health clinic if more information is
43.29 needed to evaluate the request;

43.30 (12) the commissioner, when establishing organization encounter rates for new FQHCs
43.31 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
43.32 health clinics in a 60-mile radius for organizations established outside of the seven-county
43.33 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan

44.1 area. If this information is not available, the commissioner may use Medicare cost reports
44.2 or audited financial statements to establish base rate;

44.3 (13) the commissioner shall establish a quality measures workgroup that includes
44.4 representatives from the Minnesota Association of Community Health Centers, FQHCs,
44.5 and rural health clinics, to evaluate clinical and nonclinical measures; and

44.6 (14) the commissioner shall not disallow or reduce costs that are related to an FQHC's
44.7 or rural health clinic's participation in health care educational programs to the extent that
44.8 the costs are not accounted for in the alternative payment methodology encounter rate
44.9 established in this paragraph.

44.10 Sec. 32. Minnesota Statutes 2020, section 256B.0625, subdivision 31, is amended to read:

44.11 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
44.12 supplies and equipment. Separate payment outside of the facility's payment rate shall be
44.13 made for wheelchairs and wheelchair accessories for recipients who are residents of
44.14 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
44.15 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
44.16 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
44.17 purchased outside of the facility's payment rate is the property of the recipient.

44.18 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
44.19 must enroll as a Medicare provider.

44.20 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,
44.21 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment
44.22 requirement if:

44.23 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,
44.24 or medical supply;

44.25 (2) the vendor serves ten or fewer medical assistance recipients per year;

44.26 (3) the commissioner finds that other vendors are not available to provide same or similar
44.27 durable medical equipment, prosthetics, orthotics, or medical supplies; and

44.28 (4) the vendor complies with all screening requirements in this chapter and Code of
44.29 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
44.30 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
44.31 and Medicaid Services approved national accreditation organization as complying with the

45.1 Medicare program's supplier and quality standards and the vendor serves primarily pediatric
45.2 patients.

45.3 (d) Durable medical equipment means a device or equipment that:

45.4 (1) can withstand repeated use;

45.5 (2) is generally not useful in the absence of an illness, injury, or disability; and

45.6 (3) is provided to correct or accommodate a physiological disorder or physical condition
45.7 or is generally used primarily for a medical purpose.

45.8 (e) Electronic tablets may be considered durable medical equipment if the electronic
45.9 tablet will be used as an augmentative and alternative communication system as defined
45.10 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must
45.11 be locked in order to prevent use not related to communication.

45.12 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
45.13 locked to prevent use not as an augmentative communication device, a recipient of waiver
45.14 services may use an electronic tablet for a use not related to communication when the
45.15 recipient has been authorized under the waiver to receive one or more additional applications
45.16 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
45.17 the purchase of a separate electronic tablet with waiver funds.

45.18 (g) An order or prescription for medical supplies, equipment, or appliances must meet
45.19 the requirements in Code of Federal Regulations, title 42, part 440.70.

45.20 (h) Allergen-reducing products provided according to subdivision 67, paragraph (c) or
45.21 (d), shall be considered durable medical equipment.

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

45.25 Sec. 33. Minnesota Statutes 2020, section 256B.0625, subdivision 58, is amended to read:

45.26 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical
45.27 assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT).
45.28 In administering the EPSDT program, the commissioner shall, at a minimum:

45.29 (1) provide information to children and families, using the most effective mode identified,
45.30 regarding:

45.31 (i) the benefits of preventative health care visits;

46.1 (ii) the services available as part of the EPSDT program; and

46.2 (iii) assistance finding a provider, transportation, or interpreter services;

46.3 (2) maintain an up-to-date periodicity schedule published in the department policy
46.4 manual, taking into consideration the most up-to-date community standard of care; and

46.5 (3) maintain up-to-date policies for providers on the delivery of EPSDT services that
46.6 are in the provider manual on the department website.

46.7 (b) The commissioner may contract for the administration of the outreach services as
46.8 required within the EPSDT program.

46.9 (c) The commissioner may contract for the required EPSDT outreach services, including
46.10 but not limited to children enrolled or attributed to an integrated health partnership
46.11 demonstration project described in section 256B.0755. Integrated health partnerships that
46.12 choose to include the EPSDT outreach services within the integrated health partnership's
46.13 contracted responsibilities must receive compensation from the commissioner on a
46.14 per-member per-month basis for each included child. Integrated health partnerships must
46.15 accept responsibility for the effectiveness of outreach services it delivers. For children who
46.16 are not a part of the demonstration project, the commissioner may contract for the
46.17 administration of the outreach services.

46.18 (d) The payment amount for a complete EPSDT screening shall not include charges for
46.19 health care services and products that are available at no cost to the provider and shall not
46.20 exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October
46.21 1, 2010.

46.22 **EFFECTIVE DATE.** This section is effective July 1, 2021, except that paragraph (c)
46.23 is effective January 1, 2022.

46.24 Sec. 34. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
46.25 to read:

46.26 Subd. 67. **Enhanced asthma care services.** (a) Medical assistance covers enhanced
46.27 asthma care services and related products to be provided in the children's homes for children
46.28 with poorly controlled asthma. To be eligible for services and products under this subdivision,
46.29 a child must:

46.30 (1) have poorly controlled asthma defined by having received health care for the child's
46.31 asthma from a hospital emergency department at least one time in the past year or have
46.32 been hospitalized for the treatment of asthma at least one time in the past year; and

47.1 (2) receive a referral for services and products under this subdivision from a treating
47.2 health care provider.

47.3 (b) Covered services include home visits provided by a registered environmental health
47.4 specialist or lead risk assessor currently credentialed by the Department of Health or a
47.5 healthy homes specialist credentialed by the Building Performance Institute.

47.6 (c) Covered products include the following allergen-reducing products that are identified
47.7 as needed and recommended for the child by a registered environmental health specialist,
47.8 healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse,
47.9 or other health care professional providing asthma care for the child, and proven to reduce
47.10 asthma triggers:

47.11 (1) allergen encasements for mattresses, box springs, and pillows;

47.12 (2) an allergen-rated vacuum cleaner, filters, and bags;

47.13 (3) a dehumidifier and filters;

47.14 (4) HEPA single-room air cleaners and filters;

47.15 (5) integrated pest management, including traps and starter packages of food storage
47.16 containers;

47.17 (6) a damp mopping system;

47.18 (7) if the child does not have access to a bed, a waterproof hospital-grade mattress; and

47.19 (8) for homeowners only, furnace filters.

47.20 (d) The commissioner shall determine additional products that may be covered as new
47.21 best practices for asthma care are identified.

47.22 (e) A home assessment is a home visit to identify asthma triggers in the home and to
47.23 provide education on trigger-reducing products. A child is limited to two home assessments
47.24 except that a child may receive an additional home assessment if the child moves to a new
47.25 home; if a new asthma trigger, including tobacco smoke, enters the home; or if the child's
47.26 health care provider identifies a new allergy for the child, including an allergy to mold,
47.27 pests, pets, or dust mites. The commissioner shall determine the frequency with which a
47.28 child may receive a product under paragraph (c) or (d) based on the reasonable expected
47.29 lifetime of the product.

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

48.1 Sec. 35. Minnesota Statutes 2020, section 256B.0631, subdivision 1, is amended to read:

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

48.5 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
48.6 subdivision, a visit means an episode of service which is required because of a recipient's
48.7 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
48.8 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
48.9 practice nurse, audiologist, optician, or optometrist;

48.10 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
48.11 co-payment shall be increased to \$20 upon federal approval;

48.12 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject
48.13 to a \$12 per month maximum for prescription drug co-payments. No co-payments shall
48.14 apply to antipsychotic drugs when used for the treatment of mental illness. No co-payments
48.15 shall apply to medications when used for the prevention or treatment of the human
48.16 immunodeficiency virus (HIV);

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

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

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

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

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

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

49.8 EFFECTIVE DATE. This section is effective January 1, 2022, subject to federal
49.9 approval. The commissioner of human services shall notify the revisor of statutes when
49.10 federal approval is obtained.

49.11 Sec. 36. Minnesota Statutes 2020, section 256B.0638, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

50.1 (9) one member of the Health Services Policy Committee established under section
50.2 256B.0625, subdivisions 3c to 3e;

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

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

50.7 (12) one member representing Minnesota law enforcement; and

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

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

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

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

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

50.14 (4) a member representing the Minnesota Department of Health.

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

50.17 Sec. 37. Minnesota Statutes 2020, section 256B.0638, subdivision 5, is amended to read:

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

50.25 (b) The commissioner shall notify an opioid prescriber and all provider groups with
50.26 which the opioid prescriber is employed or affiliated when the opioid prescriber's prescribing
50.27 pattern exceeds the opioid quality improvement standard thresholds. An opioid prescriber
50.28 and any provider group that receives a notice under this paragraph shall submit to the
50.29 commissioner a quality improvement plan for review and approval by the commissioner
50.30 with the goal of bringing the opioid prescriber's prescribing practices into alignment with
50.31 community standards. A quality improvement plan must include:

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

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

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

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

51.10 (1) monitor prescribing practices more frequently than annually;

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

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

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

51.19 Sec. 38. Minnesota Statutes 2020, section 256B.0638, subdivision 6, is amended to read:

51.20 Subd. 6. **Data practices.** (a) Reports and data identifying an opioid prescriber are private
51.21 data on individuals as defined under section 13.02, subdivision 12, until an opioid prescriber
51.22 is subject to termination as a medical assistance provider under this section. Notwithstanding
51.23 this data classification, the commissioner shall share with all of the provider groups with
51.24 which an opioid prescriber is employed, contracted, or affiliated, ~~a report identifying an~~
51.25 ~~opioid prescriber who is subject to quality improvement activities~~ the data under subdivision
51.26 5, paragraph (a), (b), or (c).

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

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

52.1 Sec. 39. Minnesota Statutes 2020, section 256B.0659, subdivision 13, is amended to read:

52.2 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must
52.3 work for a personal care assistance provider agency, meet the definition of qualified
52.4 professional under section 256B.0625, subdivision 19c, ~~and enroll with the department as~~
52.5 ~~a qualified professional after clearing~~ clear a background study, and meet provider training
52.6 requirements. Before a qualified professional provides services, the personal care assistance
52.7 provider agency must initiate a background study on the qualified professional under chapter
52.8 245C, and the personal care assistance provider agency must have received a notice from
52.9 the commissioner that the qualified professional:

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

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

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

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

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

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

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

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

52.25 (c) ~~Effective July 1, 2011,~~ The qualified professional shall complete the provider training
52.26 with basic information about the personal care assistance program approved by the
52.27 commissioner. Newly hired qualified professionals must complete the training within six
52.28 months of the date hired by a personal care assistance provider agency. Qualified
52.29 professionals who have completed the required training as a worker from a personal care
52.30 assistance provider agency do not need to repeat the required training if they are hired by
52.31 another agency, if they have completed the training within the last three years. The required
52.32 training must be available with meaningful access according to title VI of the Civil Rights
52.33 Act and federal regulations adopted under that law or any guidance from the United States

53.1 Health and Human Services Department. The required training must be available online or
53.2 by electronic remote connection. The required training must provide for competency testing
53.3 to demonstrate an understanding of the content without attending in-person training. A
53.4 qualified professional is allowed to be employed and is not subject to the training requirement
53.5 until the training is offered online or through remote electronic connection. A qualified
53.6 professional employed by a personal care assistance provider agency certified for
53.7 participation in Medicare as a home health agency is exempt from the training required in
53.8 this subdivision. When available, the qualified professional working for a Medicare-certified
53.9 home health agency must successfully complete the competency test. The commissioner
53.10 shall ensure there is a mechanism in place to verify the identity of persons completing the
53.11 competency testing electronically.

53.12 Sec. 40. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

53.13 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
53.14 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
53.15 payment limit for nonstate government hospitals. The commissioner shall then determine
53.16 the amount of a supplemental payment to Hennepin County Medical Center and Regions
53.17 Hospital for these services that would increase medical assistance spending in this category
53.18 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
53.19 In making this determination, the commissioner shall allot the available increases between
53.20 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
53.21 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
53.22 shall adjust this allotment as necessary based on federal approvals, the amount of
53.23 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
53.24 in order to maximize the additional total payments. The commissioner shall inform Hennepin
53.25 County and Ramsey County of the periodic intergovernmental transfers necessary to match
53.26 federal Medicaid payments available under this subdivision in order to make supplementary
53.27 medical assistance payments to Hennepin County Medical Center and Regions Hospital
53.28 equal to an amount that when combined with existing medical assistance payments to
53.29 nonstate governmental hospitals would increase total payments to hospitals in this category
53.30 for outpatient services to the aggregate upper payment limit for all hospitals in this category
53.31 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
53.32 supplementary payments to Hennepin County Medical Center and Regions Hospital.

53.33 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
53.34 determine an upper payment limit for physicians and other billing professionals affiliated
53.35 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit

54.1 shall be based on the average commercial rate or be determined using another method
54.2 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
54.3 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
54.4 necessary to match the federal Medicaid payments available under this subdivision in order
54.5 to make supplementary payments to physicians and other billing professionals affiliated
54.6 with Hennepin County Medical Center and to make supplementary payments to physicians
54.7 and other billing professionals affiliated with Regions Hospital through HealthPartners
54.8 Medical Group equal to the difference between the established medical assistance payment
54.9 for physician and other billing professional services and the upper payment limit. Upon
54.10 receipt of these periodic transfers, the commissioner shall make supplementary payments
54.11 to physicians and other billing professionals affiliated with Hennepin County Medical Center
54.12 and shall make supplementary payments to physicians and other billing professionals
54.13 affiliated with Regions Hospital through HealthPartners Medical Group.

54.14 (c) Beginning January 1, 2010, ~~Hennepin County and Ramsey County~~ may make monthly
54.15 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
54.16 ~~\$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.~~
54.17 The commissioner shall increase the medical assistance capitation payments to any licensed
54.18 health plan under contract with the medical assistance program that agrees to make enhanced
54.19 payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be
54.20 in an amount equal to the annual value of the monthly transfers plus federal financial
54.21 participation, with each health plan receiving its pro rata share of the increase based on the
54.22 pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~
54.23 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"
54.24 means the total annual value of increased medical assistance capitation payments, including
54.25 the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For
54.26 managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce
54.27 the total annual value of increased medical assistance capitation payments under this
54.28 paragraph by an amount equal to ten percent of the base amount, and by an additional ten
54.29 percent of the base amount for each subsequent contract year until December 31, 2025.
54.30 Upon the request of the commissioner, health plans shall submit individual-level cost data
54.31 for verification purposes. The commissioner may ratably reduce these payments on a pro
54.32 rata basis in order to satisfy federal requirements for actuarial soundness. If payments are
54.33 reduced, transfers shall be reduced accordingly. Any licensed health plan that receives
54.34 increased medical assistance capitation payments under the intergovernmental transfer
54.35 described in this paragraph shall increase its medical assistance payments to ~~Hennepin~~
54.36 ~~County Medical Center and~~ Regions Hospital by the same amount as the increased payments

55.1 received in the capitation payment described in this paragraph. This paragraph expires
55.2 January 1, 2026.

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

55.19 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
55.20 determine an upper payment limit for physicians, dentists, and other billing professionals
55.21 affiliated with the University of Minnesota and University of Minnesota Physicians. The
55.22 upper payment limit shall be based on the average commercial rate or be determined using
55.23 another method acceptable to the Centers for Medicare and Medicaid Services. The
55.24 commissioner shall inform the University of Minnesota Medical School and University of
55.25 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
55.26 match the federal Medicaid payments available under this subdivision in order to make
55.27 supplementary payments to physicians, dentists, and other billing professionals affiliated
55.28 with the University of Minnesota and the University of Minnesota Physicians equal to the
55.29 difference between the established medical assistance payment for physician, dentist, and
55.30 other billing professional services and the upper payment limit. Upon receipt of these periodic
55.31 transfers, the commissioner shall make supplementary payments to physicians, dentists,
55.32 and other billing professionals affiliated with the University of Minnesota and the University
55.33 of Minnesota Physicians.

55.34 (f) The commissioner shall inform the transferring governmental entities on an ongoing
55.35 basis of the need for any changes needed in the intergovernmental transfers in order to

56.1 continue the payments under paragraphs (a) to (e), at their maximum level, including
56.2 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

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

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

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

56.11 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval
56.12 of both this section and Minnesota Statutes, section 256B.1973, whichever is later. The
56.13 commissioner of human services shall notify the revisor of statutes when federal approval
56.14 is obtained.

56.15 Sec. 41. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

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

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

56.24 (d) "High medical assistance utilization" means a medical assistance utilization rate
56.25 equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause
56.26 (6).

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

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

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

57.9 Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For
57.10 each federally approved directed payment arrangement that is a state-directed fee schedule
57.11 requirement, the commissioner shall determine a uniform adjustment factor to be applied
57.12 to each claim submitted by an eligible provider to a health plan. The uniform adjustment
57.13 factor shall be determined using the average commercial payer rate or using another method
57.14 acceptable to the Centers for Medicare and Medicaid Services if the average commercial
57.15 payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities
57.16 under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The
57.17 commissioner shall ensure that the application of the uniform adjustment factor maximizes
57.18 the allowable directed payments and does not result in payments exceeding federal limits,
57.19 and may use an annual settle-up process. The directed payment shall be specific to each
57.20 health plan and prospectively incorporated into capitation payments for that plan.

57.21 (b) For each federally approved directed payment arrangement that is a state-directed
57.22 fee schedule requirement, the commissioner shall develop a plan for the initial
57.23 implementation of the state-directed fee schedule requirement to ensure that the eligible
57.24 provider receives the entire permissible value of the federally approved directed payment
57.25 arrangement. If federal approval of a directed payment arrangement under this subdivision
57.26 is retroactive, the commissioner shall make a onetime pro rata increase to the uniform
57.27 adjustment factor and the initial payments in order to include claims submitted between the
57.28 retroactive federal approval date and the period captured by the initial payments.

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

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

58.1 Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee
58.2 schedule requirement must align the state quality goals to Hennepin Healthcare medical
58.3 assistance patients, including unstably housed individuals, those with higher levels of social
58.4 and clinical risk, limited English proficiency (LEP) patients, adults with serious chronic
58.5 conditions, and individuals of color. The directed payment arrangement must maintain
58.6 quality and access to a full range of health care delivery mechanisms for these patients that
58.7 may include behavioral health, emergent care, preventive care, hospitalization, transportation,
58.8 interpreter services, and pharmaceutical services. The commissioner, in consultation with
58.9 Hennepin Healthcare, shall submit to the Centers for Medicare and Medicaid Services a
58.10 methodology to measure access to care and the achievement of state quality goals.

58.11 **EFFECTIVE DATE.** This section is effective January 1, 2022, or upon federal approval,
58.12 whichever is later, unless the federal approval provides for an effective date that is before
58.13 the date the federal approval was issued, including a retroactive effective date, in which
58.14 case this section is effective retroactively from the federally approved effective date. The
58.15 commissioner of human services shall notify the revisor of statutes when federal approval
58.16 is obtained.

58.17 Sec. 42. Minnesota Statutes 2020, section 256B.69, subdivision 6d, is amended to read:

58.18 Subd. 6d. **Prescription drugs.** The commissioner ~~may~~ shall exclude ~~or modify~~ coverage
58.19 for outpatient prescription drugs dispensed by a pharmacy to a member eligible for medical
58.20 assistance under this chapter from the prepaid managed care contracts entered into under
58.21 this section ~~in order to increase savings to the state by collecting additional prescription~~
58.22 ~~drug rebates. The contracts must maintain incentives for the managed care plan to manage~~
58.23 ~~drug costs and utilization and may require that the managed care plans maintain an open~~
58.24 ~~drug formulary. In order to manage drug costs and utilization, the contracts may authorize~~
58.25 ~~the managed care plans to use preferred drug lists and prior authorization. This subdivision~~
58.26 ~~is contingent on federal approval of the managed care contract changes and the collection~~
58.27 ~~of additional prescription drug rebates.~~

58.28 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon completion of
58.29 the Medicaid Management Information System pharmacy module modernization project,
58.30 whichever is later. The commissioner shall notify the revisor of statutes when the project
58.31 is completed.

59.1 Sec. 43. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision
59.2 to read:

59.3 Subd. 9f. **Annual report on provider reimbursement rates.** (a) The commissioner,
59.4 by December 15 of each year, shall submit to the chairs and ranking minority members of
59.5 the legislative committees with jurisdiction over health care policy and finance a report on
59.6 managed care and county-based purchasing plan provider reimbursement rates. The report
59.7 must comply with sections 3.195 and 3.197.

59.8 (b) The report must include, for each managed care and county-based purchasing plan,
59.9 the mean and median provider reimbursement rates by county for the calendar year preceding
59.10 the reporting year, for the five most common billing codes statewide across all plans, in
59.11 each of the following provider service categories:

59.12 (1) physician services - prenatal and preventive;

59.13 (2) physician services - nonprenatal and nonpreventive;

59.14 (3) dental services;

59.15 (4) inpatient hospital services;

59.16 (5) outpatient hospital services; and

59.17 (6) mental health services.

59.18 (c) The commissioner shall also include in the report:

59.19 (1) the mean and median reimbursement rates across all plans by county for the calendar
59.20 year preceding the reporting year for the billing codes and provider service categories
59.21 described in paragraph (b); and

59.22 (2) the mean and median fee-for-service reimbursement rates by county for the calendar
59.23 year preceding the reporting year for the billing codes and provider service categories
59.24 described in paragraph (b).

59.25 Sec. 44. Minnesota Statutes 2020, section 256B.69, is amended by adding a subdivision
59.26 to read:

59.27 Subd. 9g. **Annual report on prepaid health plan reimbursement to 340B covered**
59.28 **entities.** (a) By March 1 of each year, each managed care and county-based purchasing plan
59.29 shall report to the commissioner its reimbursement to 340B covered entities for the previous
59.30 calendar year. The report must include:

59.31 (1) the National Provider Identification (NPI) number for each 340B covered entity;

60.1 (2) the name of each 340B covered entity;

60.2 (3) the servicing address of each 340B covered entity; and

60.3 (4) either: (i) the number of outpatient 340B pharmacy claims and reimbursement
60.4 amounts; or (ii) the number of professional or facility 340B claim lines and reimbursement
60.5 amounts.

60.6 (b) The commissioner shall submit a copy of the reports to the chairs and ranking minority
60.7 members of the legislative committees with jurisdiction over health care policy and finance
60.8 by April 1 of each year.

60.9 Sec. 45. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

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

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

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

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

60.23 (b) Any managed care contract that directs managed care organization expenditures as
60.24 permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with
60.25 Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial
60.26 soundness and generally accepted actuarial principles and practices; and have written
60.27 approval from the Centers for Medicare and Medicaid Services before implementation. To
60.28 obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

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

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

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

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

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

61.7 (6) is not renewed automatically.

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

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

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

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

61.17 Sec. 46. Minnesota Statutes 2020, section 256B.75, is amended to read:

61.18 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

61.19 (a) For outpatient hospital facility fee payments for services rendered on or after October
61.20 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
61.21 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
61.22 which there is a federal maximum allowable payment. Effective for services rendered on
61.23 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
61.24 emergency room facility fees shall be increased by eight percent over the rates in effect on
61.25 December 31, 1999, except for those services for which there is a federal maximum allowable
61.26 payment. Services for which there is a federal maximum allowable payment shall be paid
61.27 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
61.28 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
61.29 upper limit. If it is determined that a provision of this section conflicts with existing or
61.30 future requirements of the United States government with respect to federal financial
61.31 participation in medical assistance, the federal requirements prevail. The commissioner

62.1 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
62.2 participation resulting from rates that are in excess of the Medicare upper limitations.

62.3 (b) (1) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
62.4 surgery hospital facility fee services for critical access hospitals designated under section
62.5 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
62.6 cost-finding methods and allowable costs of the Medicare program. Effective for services
62.7 provided on or after July 1, 2015, rates established for critical access hospitals under this
62.8 paragraph for the applicable payment year shall be the final payment and shall not be settled
62.9 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
62.10 year ending in 2017, the rate for outpatient hospital services shall be computed using
62.11 information from each hospital's Medicare cost report as filed with Medicare for the year
62.12 that is two years before the year that the rate is being computed. Rates shall be computed
62.13 using information from Worksheet C series until the department finalizes the medical
62.14 assistance cost reporting process for critical access hospitals. After the cost reporting process
62.15 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
62.16 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
62.17 related to rural health clinics and federally qualified health clinics, divided by ancillary
62.18 charges plus outpatient charges, excluding charges related to rural health clinics and federally
62.19 qualified health clinics.

62.20 (2) Effective for services provided on or after January 1, 2023, the rate described in
62.21 clause (1) shall be increased for hospitals providing high levels of high-cost drugs or 340B
62.22 drugs. The rate adjustment shall be based on each hospital's share of the total reimbursement
62.23 for 340B drugs to all critical access hospitals, but shall not exceed three percentage points.

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

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

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

63.6 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
63.7 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
63.8 hospital facility services before third-party liability and spenddown, is reduced three percent
63.9 from the current statutory rates. Mental health services and facilities defined under section
63.10 256.969, subdivision 16, are excluded from this paragraph.

63.11 Sec. 47. Minnesota Statutes 2020, section 256B.76, subdivision 2, is amended to read:

63.12 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
63.13 1, 1992, through December 31, 2022, the commissioner shall make payments for dental
63.14 services as follows:

63.15 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
63.16 above the rate in effect on June 30, 1992; and

63.17 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
63.18 of 1989, less the percent in aggregate necessary to equal the above increases.

63.19 (b) Beginning October 1, 1999, through December 31, 2022, the payment for tooth
63.20 sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent
63.21 of median 1997 charges.

63.22 (c) Effective for services rendered on or after January 1, 2000, through December 31,
63.23 2022, payment rates for dental services shall be increased by three percent over the rates in
63.24 effect on December 31, 1999.

63.25 (d) Effective for services provided on or after January 1, 2002, through December 31,
63.26 2022, payment for diagnostic examinations and dental x-rays provided to children under
63.27 age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999
63.28 charges.

63.29 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
63.30 for managed care.

63.31 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
63.32 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare

64.1 principles of reimbursement. This payment shall be effective for services rendered on or
64.2 after January 1, 2011, to recipients enrolled in managed care plans or county-based
64.3 purchasing plans.

64.4 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
64.5 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
64.6 supplemental state payment equal to the difference between the total payments in paragraph
64.7 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
64.8 operation of the dental clinics.

64.9 (h) If the cost-based payment system for state-operated dental clinics described in
64.10 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
64.11 designated as critical access dental providers under subdivision 4, paragraph (b), and shall
64.12 receive the critical access dental reimbursement rate as described under subdivision 4,
64.13 paragraph (a).

64.14 ~~(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,~~
64.15 ~~payment rates for dental services shall be reduced by three percent. This reduction does not~~
64.16 ~~apply to state-operated dental clinics in paragraph (f).~~

64.17 ~~(j)~~ (i) Effective for services rendered on or after January 1, 2014, through December 31,
64.18 2022, payment rates for dental services shall be increased by five percent from the rates in
64.19 effect on December 31, 2013. This increase does not apply to state-operated dental clinics
64.20 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
64.21 services. Effective January 1, 2014, payments made to managed care plans and county-based
64.22 purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment
64.23 increase described in this paragraph.

64.24 ~~(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,~~
64.25 ~~the commissioner shall increase payment rates for services furnished by dental providers~~
64.26 ~~located outside of the seven-county metropolitan area by the maximum percentage possible~~
64.27 ~~above the rates in effect on June 30, 2015, while remaining within the limits of funding~~
64.28 ~~appropriated for this purpose. This increase does not apply to state-operated dental clinics~~
64.29 ~~in paragraph (f), federally qualified health centers, rural health centers, and Indian health~~
64.30 ~~services. Effective January 1, 2016, through December 31, 2016, payments to managed care~~
64.31 ~~plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect~~
64.32 ~~the payment increase described in this paragraph. The commissioner shall require managed~~
64.33 ~~care and county-based purchasing plans to pass on the full amount of the increase, in the~~

65.1 ~~form of higher payment rates to dental providers located outside of the seven-county~~
65.2 ~~metropolitan area.~~

65.3 ~~(h)~~ (j) Effective for services provided on or after January 1, 2017, through December 31,
65.4 2022, the commissioner shall increase payment rates by 9.65 percent for dental services
65.5 provided outside of the seven-county metropolitan area. This increase does not apply to
65.6 state-operated dental clinics in paragraph (f), federally qualified health centers, rural health
65.7 centers, or Indian health services. Effective January 1, 2017, payments to managed care
65.8 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
65.9 the payment increase described in this paragraph.

65.10 ~~(m)~~ (k) Effective for services provided on or after July 1, 2017, through December 31,
65.11 2022, the commissioner shall increase payment rates by 23.8 percent for dental services
65.12 provided to enrollees under the age of 21. This rate increase does not apply to state-operated
65.13 dental clinics in paragraph (f), federally qualified health centers, rural health centers, or
65.14 Indian health centers. This rate increase does not apply to managed care plans and
65.15 county-based purchasing plans.

65.16 (l) Effective for services provided on or after January 1, 2023, payment for dental services
65.17 shall be the lower of the submitted charge, or the percentile of 2018 submitted charges
65.18 from claims paid by the commissioner. This paragraph does not apply to federally qualified
65.19 health centers, rural health centers, state-operated dental clinics, or Indian health centers.

65.20 (m) Beginning January 1, 2026, and every four years thereafter, the commissioner shall
65.21 rebase payment rates for dental services to the first percentile of submitted charges for the
65.22 applicable base year using charge data from paid claims submitted by providers. The
65.23 commissioner shall increase this payment amount by 20 percent for providers designated
65.24 as critical access dental providers under medical assistance and MinnesotaCare. The critical
65.25 access dental provider payment add-on shall be calculated to be specific to each individual
65.26 clinic location within a larger system. The base year used for each rebasing shall be the
65.27 calendar year that is two years prior to the effective date of the rebasing.

65.28 Sec. 48. Minnesota Statutes 2020, section 256B.76, subdivision 4, is amended to read:

65.29 Subd. 4. **Critical access dental providers.** (a) The commissioner shall increase
65.30 reimbursements to dentists and dental clinics deemed by the commissioner to be critical
65.31 access dental providers. For dental services rendered on or after July 1, 2016, through
65.32 December 31, 2022, the commissioner shall increase reimbursement by 37.5 percent above
65.33 the reimbursement rate that would otherwise be paid to the critical access dental provider,
65.34 except as specified under paragraph (b). The commissioner shall pay the managed care

66.1 plans and county-based purchasing plans in amounts sufficient to reflect increased
66.2 reimbursements to critical access dental providers as approved by the commissioner.

66.3 (b) For dental services rendered on or after July 1, 2016, through December 31, 2022,
66.4 by a dental clinic or dental group that meets the critical access dental provider designation
66.5 under paragraph (d), clause (4), and is owned and operated by a health maintenance
66.6 organization licensed under chapter 62D, the commissioner shall increase reimbursement
66.7 by 35 percent above the reimbursement rate that would otherwise be paid to the critical
66.8 access provider.

66.9 (c) Critical access dental payments made under paragraph (a) or (b) for dental services
66.10 provided by a critical access dental provider to an enrollee of a managed care plan or
66.11 county-based purchasing plan must not reflect any capitated payments or cost-based payments
66.12 from the managed care plan or county-based purchasing plan. The managed care plan or
66.13 county-based purchasing plan must base the additional critical access dental payment on
66.14 the amount that would have been paid for that service had the dental provider been paid
66.15 according to the managed care plan or county-based purchasing plan's fee schedule that
66.16 applies to dental providers that are not paid under a capitated payment or cost-based payment.

66.17 (d) The commissioner shall designate the following dentists and dental clinics as critical
66.18 access dental providers:

66.19 (1) nonprofit community clinics that:

66.20 (i) have nonprofit status in accordance with chapter 317A;

66.21 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
66.22 501(c)(3);

66.23 (iii) are established to provide oral health services to patients who are low income,
66.24 uninsured, have special needs, and are underserved;

66.25 (iv) have professional staff familiar with the cultural background of the clinic's patients;

66.26 (v) charge for services on a sliding fee scale designed to provide assistance to low-income
66.27 patients based on current poverty income guidelines and family size;

66.28 (vi) do not restrict access or services because of a patient's financial limitations or public
66.29 assistance status; and

66.30 (vii) have free care available as needed;

66.31 (2) federally qualified health centers, rural health clinics, and public health clinics;

67.1 (3) hospital-based dental clinics owned and operated by a city, county, or former state
67.2 hospital as defined in section 62Q.19, subdivision 1, paragraph (a), clause (4);

67.3 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
67.4 accordance with chapter 317A with more than 10,000 patient encounters per year with
67.5 patients who are uninsured or covered by medical assistance or MinnesotaCare;

67.6 (5) a dental clinic owned and operated by the University of Minnesota or the Minnesota
67.7 State Colleges and Universities system; and

67.8 (6) private practicing dentists if:

67.9 (i) the dentist's office is located within the seven-county metropolitan area and more
67.10 than 50 percent of the dentist's patient encounters per year are with patients who are uninsured
67.11 or covered by medical assistance or MinnesotaCare; or

67.12 (ii) the dentist's office is located outside the seven-county metropolitan area and more
67.13 than 25 percent of the dentist's patient encounters per year are with patients who are uninsured
67.14 or covered by medical assistance or MinnesotaCare.

67.15 Sec. 49. Minnesota Statutes 2020, section 256B.766, is amended to read:

67.16 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

67.17 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
67.18 services, shall be reduced by three percent, except that for the period July 1, 2009, through
67.19 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
67.20 and general assistance medical care programs, prior to third-party liability and spenddown
67.21 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
67.22 occupational therapy services, and speech-language pathology and related services as basic
67.23 care services. The reduction in this paragraph shall apply to physical therapy services,
67.24 occupational therapy services, and speech-language pathology and related services provided
67.25 on or after July 1, 2010.

67.26 (b) Payments made to managed care plans and county-based purchasing plans shall be
67.27 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
67.28 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
67.29 to reflect the reduction effective July 1, 2010.

67.30 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
67.31 total payments for outpatient hospital facility fees shall be reduced by five percent from the
67.32 rates in effect on August 31, 2011.

68.1 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
68.2 total payments for ambulatory surgery centers facility fees, medical supplies and durable
68.3 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
68.4 renal dialysis services, laboratory services, public health nursing services, physical therapy
68.5 services, occupational therapy services, speech therapy services, eyeglasses not subject to
68.6 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
68.7 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
68.8 2011.

68.9 (e) Effective for services provided on or after September 1, 2014, payments for
68.10 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
68.11 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
68.12 and hearing aids not subject to a volume purchase contract shall be increased by three percent
68.13 and payments for outpatient hospital facility fees shall be increased by three percent.
68.14 Payments made to managed care plans and county-based purchasing plans shall not be
68.15 adjusted to reflect payments under this paragraph.

68.16 (f) Payments for medical supplies and durable medical equipment not subject to a volume
68.17 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
68.18 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
68.19 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
68.20 provided on or after July 1, 2015, shall be increased by three percent from the rates as
68.21 determined under paragraphs (i) and (j).

68.22 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
68.23 hospital facility fees, medical supplies and durable medical equipment not subject to a
68.24 volume purchase contract, prosthetics, and orthotics to a hospital meeting the criteria specified
68.25 in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent
68.26 from the rates in effect on June 30, 2015. Payments made to managed care plans and
68.27 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

68.28 (h) This section does not apply to physician and professional services, inpatient hospital
68.29 services, family planning services, mental health services, dental services, prescription
68.30 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
68.31 health services, and Medicare cost-sharing.

68.32 (i) Effective for services provided on or after July 1, 2015, through June 30, 2021, the
68.33 following categories of medical supplies and durable medical equipment shall be individually
68.34 priced items: enteral nutrition and supplies, customized and other specialized tracheostomy

69.1 tubes and supplies, electric patient lifts, and durable medical equipment repair and service.
69.2 This paragraph does not apply to medical supplies and durable medical equipment subject
69.3 to a volume purchase contract, products subject to the preferred diabetic testing supply
69.4 program, and items provided to dually eligible recipients when Medicare is the primary
69.5 payer for the item. The commissioner shall not apply any medical assistance rate reductions
69.6 to durable medical equipment as a result of Medicare competitive bidding through June 30,
69.7 2021.

69.8 (j) Effective for services provided on or after July 1, 2015, through June 30, 2021,
69.9 medical assistance payment rates for durable medical equipment, prosthetics, orthotics, or
69.10 supplies shall be increased as follows:

69.11 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
69.12 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
69.13 increased by 9.5 percent; and

69.14 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
69.15 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
69.16 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
69.17 being applied after calculation of any increased payment rate under clause (1).

69.18 This paragraph does not apply to medical supplies and durable medical equipment subject
69.19 to a volume purchase contract, products subject to the preferred diabetic testing supply
69.20 program, items provided to dually eligible recipients when Medicare is the primary payer
69.21 for the item, and individually priced items identified in paragraph (i). Payments made to
69.22 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
69.23 rate increases in this paragraph.

69.24 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
69.25 through June 30, 2021, the rate shall be the lower of the submitted charge or the Medicare
69.26 fee schedule rate. Effective for pressure support ventilators provided on or after January 1,
69.27 2016, through June 30, 2021, the rate shall be the lower of the submitted charge or 47 percent
69.28 above the Medicare fee schedule rate. For payments made in accordance with this paragraph,
69.29 if, and to the extent that, the commissioner identifies that the state has received federal
69.30 financial participation for ventilators in excess of the amount allowed effective January 1,
69.31 2018, under United States Code, title 42, section 1396b(i)(27), the state shall repay the
69.32 excess amount to the Centers for Medicare and Medicaid Services with state funds and
69.33 maintain the full payment rate under this paragraph.

70.1 (l) Payment rates for durable medical equipment, prosthetics, orthotics or supplies, that
70.2 are subject to the upper payment limit in accordance with section 1903(i)(27) of the Social
70.3 Security Act, shall be paid the Medicare rate. Rate increases provided in this chapter shall
70.4 not be applied to the items listed in this paragraph.

70.5 (m) Effective July 1, 2021, the payment rates for all durable medical equipment,
70.6 prosthetics, orthotics, or supplies, except pressure support ventilators, shall be the lesser of
70.7 the provider's submitted charges or the Medicare fee schedule amount, with no increases
70.8 or decreases described in paragraphs (a) to (k) applied. Pressure support ventilators shall
70.9 be paid the Medicare rate plus 47 percent.

70.10 (n) Effective July 1, 2021, the payment rates for durable medical equipment, prosthetics,
70.11 orthotics, or supplies for which Medicare has not established a payment amount shall be
70.12 the lesser of the provider's submitted charges, or the alternative payment methodology rate
70.13 described in clauses (1) to (4) with no increases or decreases described in paragraphs (a) to
70.14 (k) applied.

70.15 (1) The alternate payment methodology rate is calculated from either:

70.16 (i) at least 100 paid claim lines, as priced under paragraph (o), submitted by at least ten
70.17 different providers within one calendar month; or

70.18 (ii) at least 20 paid claim lines, as priced under paragraph (o), submitted by at least five
70.19 different providers within two consecutive quarters for services that are not paid 100 times
70.20 in a calendar month.

70.21 (2) The alternate payment methodology rate is the mean of the payment per unit of the
70.22 claim lines, with the top and bottom ten percent of claim lines, by payment per unit, excluded
70.23 from the calculation of the mean.

70.24 (3) The alternate payment methodology rate for the rate period will be added to the fee
70.25 schedule on the first day of a calendar month or the first day of a calendar quarter if claims
70.26 from more than one month were used to determine the rate. The alternate payment
70.27 methodology rates will be subject to Medicare's inflation or deflation factor on January 1
70.28 of each year unless the rate was calculated and posted to the fee schedule after July 1 of the
70.29 previous year.

70.30 (4) Not more than once every three years, the alternate payment methodology rates must
70.31 be evaluated by the commissioner for reasonableness by reviewing invoices from at least
70.32 20 paid claim lines and five different providers for claims paid during one calendar month
70.33 or one quarter if necessary to obtain the required sample. If the evaluation identifies that

71.1 the alternate payment methodology rate is more than five percent higher or lower than the
71.2 provider's actual acquisition cost plus 20 percent, then the commissioner shall recalculate
71.3 and update the fee schedule according to clauses (1) to (3). If the evaluation does not show
71.4 that the alternate payment methodology fee schedule rate is five percent higher or lower
71.5 than the provider's actual acquisition cost plus 20 percent or a sufficient sample cannot be
71.6 collected due to low utilization as defined in clause (1), then the commissioner shall maintain
71.7 the previously calculated alternate payment methodology rate on the fee schedule.

71.8 (o) Until sufficient data is available to calculate the alternative payment methodology,
71.9 the payment shall be based on the provider's actual acquisition cost plus 20 percent as
71.10 documented on an invoice submitted by the provider. The payment may be based on a quote
71.11 the provider received from a vendor showing the provider's actual acquisition cost only if
71.12 the durable medical equipment, prosthetic, orthotic, or supply requires authorization and
71.13 the rate is required to complete the authorization.

71.14 (p) Notwithstanding paragraph (n), durable medical equipment and supplies billed using
71.15 miscellaneous codes, and for which no Medicare rate is available, shall be paid the provider's
71.16 actual acquisition cost plus ten percent.

71.17 Sec. 50. Minnesota Statutes 2020, section 256B.767, is amended to read:

71.18 **256B.767 MEDICARE PAYMENT LIMIT.**

71.19 (a) Effective for services rendered on or after July 1, 2010, fee-for-service payment rates
71.20 for physician and professional services under section 256B.76, subdivision 1, and basic care
71.21 services subject to the rate reduction specified in section 256B.766, shall not exceed the
71.22 Medicare payment rate for the applicable service, as adjusted for any changes in Medicare
71.23 payment rates after July 1, 2010. The commissioner shall implement this section after any
71.24 other rate adjustment that is effective July 1, 2010, and shall reduce rates under this section
71.25 by first reducing or eliminating provider rate add-ons.

71.26 (b) This section does not apply to services provided by advanced practice certified nurse
71.27 midwives licensed under chapter 148 or traditional midwives licensed under chapter 147D.
71.28 Notwithstanding this exemption, medical assistance fee-for-service payment rates for
71.29 advanced practice certified nurse midwives and licensed traditional midwives shall equal
71.30 and shall not exceed the medical assistance payment rate to physicians for the applicable
71.31 service.

71.32 (c) This section does not apply to mental health services or physician services billed by
71.33 a psychiatrist or an advanced practice registered nurse with a specialty in mental health.

72.1 ~~(d) Effective July 1, 2015, this section shall not apply to durable medical equipment,~~
72.2 ~~prosthetics, orthotics, or supplies.~~

72.3 ~~(e)~~ (d) This section does not apply to physical therapy, occupational therapy, speech
72.4 pathology and related services, and basic care services provided by a hospital meeting the
72.5 criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4).

72.6 Sec. 51. Minnesota Statutes 2020, section 256B.79, subdivision 1, is amended to read:

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

72.9 (b) "Adverse outcomes" means maternal opiate addiction, other reportable prenatal
72.10 substance abuse, low birth weight, or preterm birth.

72.11 (c) "Qualified integrated perinatal care collaborative" or "collaborative" means a
72.12 combination of (1) members of community-based organizations that represent communities
72.13 within the identified targeted populations, and (2) local or tribally based service entities,
72.14 including health care, public health, social services, mental health, chemical dependency
72.15 treatment, and community-based providers, determined by the commissioner to meet the
72.16 criteria for the provision of integrated care and enhanced services for enrollees within
72.17 targeted populations.

72.18 (d) "Targeted populations" means pregnant medical assistance enrollees residing in
72.19 ~~geographic areas~~ communities identified by the commissioner as being at above-average
72.20 risk for adverse outcomes.

72.21 Sec. 52. Minnesota Statutes 2020, section 256B.79, subdivision 3, is amended to read:

72.22 Subd. 3. **Grant awards.** The commissioner shall award grants to qualifying applicants
72.23 to support interdisciplinary, integrated perinatal care. Grant funds must be distributed through
72.24 a request for proposals process to a designated lead agency within an entity that has been
72.25 determined to be a qualified integrated perinatal care collaborative or within an entity in
72.26 the process of meeting the qualifications to become a qualified integrated perinatal care
72.27 collaborative, ~~and priority shall be given to qualified integrated perinatal care collaboratives~~
72.28 ~~that received grants under this section prior to January 1, 2019.~~ Grant awards must be used
72.29 to support interdisciplinary, team-based needs assessments, planning, and implementation
72.30 of integrated care and enhanced services for targeted populations. In determining grant
72.31 award amounts, the commissioner shall consider the identified health and social risks linked
72.32 to adverse outcomes and attributed to enrollees within the identified targeted population.

73.1 Sec. 53. Minnesota Statutes 2020, section 256L.01, subdivision 5, is amended to read:

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

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

73.7 Sec. 54. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

73.8 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
73.9 children under the age of 21 ~~and~~₂ to American Indians as defined in Code of Federal
73.10 Regulations, title 42, section 600.5, or to pre-exposure prophylaxis (PrEP) and postexposure
73.11 prophylaxis (PEP) medications when used for the prevention or treatment of the human
73.12 immunodeficiency virus (HIV).

73.13 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
73.14 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
73.15 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
73.16 services exempt from cost-sharing under state law. The cost-sharing changes described in
73.17 this paragraph shall not be implemented prior to January 1, 2016.

73.18 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
73.19 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
73.20 title 42, sections 600.510 and 600.520.

73.21 **EFFECTIVE DATE.** This section is effective January 1, 2022, subject to federal
73.22 approval. The commissioner of human services shall notify the revisor of statutes when
73.23 federal approval is obtained.

73.24 Sec. 55. Minnesota Statutes 2020, section 256L.04, subdivision 7b, is amended to read:

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

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

73.29 Sec. 56. Minnesota Statutes 2020, section 256L.05, subdivision 3a, is amended to read:

73.30 Subd. 3a. **Redetermination of eligibility.** (a) An enrollee's eligibility must be
73.31 redetermined on an annual basis, ~~in accordance with Code of Federal Regulations, title 42,~~

74.1 ~~section 435.916 (a). The 12-month eligibility period begins the month of application.~~
74.2 ~~Beginning July 1, 2017, the commissioner shall adjust the eligibility period for enrollees to~~
74.3 ~~implement renewals throughout the year according to guidance from the Centers for Medicare~~
74.4 ~~and Medicaid Services. The period of eligibility is the entire calendar year following the~~
74.5 ~~year in which eligibility is redetermined. Eligibility redeterminations shall occur during the~~
74.6 ~~open enrollment period for qualified health plans as specified in Code of Federal Regulations,~~
74.7 ~~title 45, section 155.410(e)(3).~~

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

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

74.11 Sec. 57. Minnesota Statutes 2020, section 256L.11, subdivision 6a, is amended to read:

74.12 Subd. 6a. **Dental providers.** Effective for dental services provided to MinnesotaCare
74.13 enrollees on or after January 1, 2018, through December 31, 2022, the commissioner shall
74.14 increase payment rates to dental providers by 54 percent. Payments made to prepaid health
74.15 plans under section 256L.12 shall reflect the payment increase described in this subdivision.
74.16 The prepaid health plans under contract with the commissioner shall provide payments to
74.17 dental providers that are at least equal to a rate that includes the payment rate specified in
74.18 this subdivision, and if applicable to the provider, the rates described under subdivision 7.

74.19 Sec. 58. Minnesota Statutes 2020, section 256L.11, subdivision 7, is amended to read:

74.20 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
74.21 MinnesotaCare enrollees on or after July 1, 2017, through December 31, 2022, the
74.22 commissioner shall increase payment rates to dentists and dental clinics deemed by the
74.23 commissioner to be critical access providers under section 256B.76, subdivision 4, by 20
74.24 percent above the payment rate that would otherwise be paid to the provider. The
74.25 commissioner shall pay the prepaid health plans under contract with the commissioner
74.26 amounts sufficient to reflect this rate increase. The prepaid health plan must pass this rate
74.27 increase to providers who have been identified by the commissioner as critical access dental
74.28 providers under section 256B.76, subdivision 4.

74.29 Sec. 59. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

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

- 75.1 (1) payments received by a health care provider or the wholly owned subsidiary of a
75.2 health care provider for care provided outside Minnesota;
- 75.3 (2) government payments received by the commissioner of human services for
75.4 state-operated services;
- 75.5 (3) payments received by a health care provider for hearing aids and related equipment
75.6 or prescription eyewear delivered outside of Minnesota; and
- 75.7 (4) payments received by an educational institution from student tuition, student activity
75.8 fees, health care service fees, government appropriations, donations, or grants, and for
75.9 services identified in and provided under an individualized education program as defined
75.10 in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee
75.11 for service payments and payments for extended coverage are taxable.
- 75.12 (b) The following payments are exempted from the gross revenues subject to hospital,
75.13 surgical center, or health care provider taxes under sections 295.50 to 295.59:
- 75.14 (1) payments received for services provided under the Medicare program, including
75.15 payments received from the government and organizations governed by sections 1833,
75.16 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title
75.17 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid
75.18 by the Medicare enrollee, by Medicare supplemental coverage as described in section
75.19 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal
75.20 Social Security Act. Payments for services not covered by Medicare are taxable;
- 75.21 (2) payments received for home health care services;
- 75.22 (3) payments received from hospitals or surgical centers for goods and services on which
75.23 liability for tax is imposed under section 295.52 or the source of funds for the payment is
75.24 exempt under clause (1), (6), (9), (10), or (11);
- 75.25 (4) payments received from the health care providers for goods and services on which
75.26 liability for tax is imposed under this chapter or the source of funds for the payment is
75.27 exempt under clause (1), (6), (9), (10), or (11);
- 75.28 (5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax
75.29 under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs
75.30 otherwise exempt under this chapter;
- 75.31 (6) payments received from the chemical dependency fund under chapter 254B;

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

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

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

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

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

76.18 (12) supplemental ~~or~~, enhanced, or uniform adjustment factor payments authorized under
76.19 section 256B.196 ~~or~~, 256B.197, or 256B.1973.

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

76.23 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
76.24 31, 2021.

76.25 **Sec. 60. COURT RULING ON AFFORDABLE CARE ACT.**

76.26 In the event the United States Supreme Court reverses, in whole or in part, Public Law
76.27 111-148, as amended by Public Law 111-152, the commissioner of human services shall
76.28 take all actions necessary to maintain the current policies of the medical assistance and
76.29 MinnesotaCare programs, including but not limited to pursuing federal funds, or if federal
76.30 funding is not available, operating programs with state funding for at least one year following
76.31 the date of the Supreme Court decision or until the conclusion of the next regular legislative
76.32 session, whichever is later. Nothing in this section prohibits the commissioner from making

77.1 changes necessary to comply with federal or state requirements for the medical assistance
77.2 or MinnesotaCare programs that were not affected by the Supreme Court decision.

77.3 Sec. 61. **DELIVERY REFORM ANALYSIS REPORT.**

77.4 (a) The commissioner of human services shall present to the chairs and ranking minority
77.5 members of the legislative committees with jurisdiction over health care policy and finance,
77.6 by January 15, 2023, a report comparing service delivery and payment system models for
77.7 delivering services to Medical Assistance enrollees for whom income eligibility is determined
77.8 using the modified adjusted gross income methodology under Minnesota Statutes, section
77.9 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
77.10 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
77.11 model with at least two alternative models. The alternative models must include a state-based
77.12 model in which the state holds the plan risk as the insurer and may contract with a third-party
77.13 administrator for claims processing and plan administration. The alternative models may
77.14 include but are not limited to:

77.15 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
77.16 256B.0755;

77.17 (2) delivering care under fee-for-service through a primary care case management system;
77.18 and

77.19 (3) continuing to contract with managed care and county-based purchasing plans for
77.20 some or all enrollees under modified contracts.

77.21 (b) The report must include:

77.22 (1) a description of how each model would address:

77.23 (i) racial and other inequities in the delivery of health care and health care outcomes;

77.24 (ii) geographic inequities in the delivery of health care;

77.25 (iii) the provision of incentives for preventive care and other best practices;

77.26 (iv) reimbursing providers for high-quality, value-based care at levels sufficient to sustain
77.27 or increase enrollee access to care; and

77.28 (v) transparency and simplicity for enrollees, health care providers, and policymakers;

77.29 (2) a comparison of the projected cost of each model; and

78.1 (3) an implementation timeline for each model, that includes the earliest date by which
78.2 each model could be implemented if authorized during the 2023 legislative session, and a
78.3 discussion of barriers to implementation.

78.4 Sec. 62. **DENTAL HOME DEMONSTRATION PROJECT.**

78.5 (a) The Dental Services Advisory Committee, in collaboration with stakeholders, shall
78.6 design a dental home demonstration project and present recommendations by February 1,
78.7 2022, to the commissioner and the chairs and ranking minority members of the legislative
78.8 committees with jurisdiction over health finance and policy.

78.9 (b) The Dental Services Advisory Committee, at a minimum, shall engage with the
78.10 following stakeholders: the Minnesota Department of Health, the Minnesota Dental
78.11 Association, the Minnesota Dental Hygienists' Association, the University of Minnesota
78.12 School of Dentistry, dental programs operated by the Minnesota State Colleges and
78.13 Universities system, and representatives of each of the following dental provider types
78.14 serving medical assistance and MinnesotaCare enrollees:

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

78.17 (2) private practice dental clinics for which medical assistance and MinnesotaCare
78.18 enrollees comprise 25 percent or less of the clinic's patient load;

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

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

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

78.23 (6) nonprofit dental clinics providing services within the seven-county metropolitan
78.24 area;

78.25 (7) nonprofit dental clinics providing services outside of the seven-county metropolitan
78.26 area; and

78.27 (8) multispecialty hospital-based dental clinics.

78.28 (c) The dental home demonstration project shall give incentives for qualified providers
78.29 that provide high-quality, patient-centered, comprehensive, and coordinated oral health
78.30 services. The demonstration project shall seek to increase the number of new dental providers
78.31 serving medical assistance and MinnesotaCare enrollees and increase the capacity of existing

79.1 providers. The demonstration project must test payment methods that establish value-based
 79.2 incentives to:

79.3 (1) increase the extent to which current dental providers serve medical assistance and
 79.4 MinnesotaCare enrollees across their lifespan;

79.5 (2) develop service models that create equity and reduce disparities in access to dental
 79.6 services for high-risk and medically and socially complex enrollees;

79.7 (3) advance alternative delivery models of care within community settings using
 79.8 evidence-based approaches and innovative workforce teams; and

79.9 (4) improve the quality of dental care by meeting dental home goals.

79.10 **Sec. 63. DIRECTION TO COMMISSIONER; INCOME AND ASSET EXCLUSION**
 79.11 **FOR ST. PAUL GUARANTEED INCOME DEMONSTRATION PROJECT.**

79.12 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this
 79.13 subdivision have the meanings given.

79.14 (b) "Commissioner" means the commissioner of human services unless specified
 79.15 otherwise.

79.16 (c) "Guaranteed income demonstration project" means a demonstration project in St.
 79.17 Paul to evaluate how unconditional cash payments have a causal effect on income volatility,
 79.18 financial well-being, and early childhood development in infants and toddlers.

79.19 Subd. 2. **Commissioner; income and asset exclusion.** (a) During the duration of the
 79.20 guaranteed income demonstration project, the commissioner shall not count payments made
 79.21 to families by the guaranteed income demonstration project as income or assets for purposes
 79.22 of determining or redetermining eligibility for the following programs:

79.23 (1) child care assistance programs under Minnesota Statutes, chapter 119B; and

79.24 (2) the Minnesota family investment program, work benefit program, or diversionary
 79.25 work program under Minnesota Statutes, chapter 256J.

79.26 (b) During the duration of the guaranteed income demonstration project, the commissioner
 79.27 shall not count payments made to families by the guaranteed income demonstration project
 79.28 as income or assets for purposes of determining or redetermining eligibility for the following
 79.29 programs:

79.30 (1) medical assistance under Minnesota Statutes, chapter 256B; and

79.31 (2) MinnesotaCare under Minnesota Statutes, chapter 256L.

80.1 Subd. 3. **Report.** The city of St. Paul shall provide a report to the chairs and ranking
80.2 minority members of the legislative committees with jurisdiction over human services policy
80.3 and finance by February 15, 2023, with information on the progress and outcomes of the
80.4 guaranteed income demonstration project under this section.

80.5 Subd. 4. **Expiration.** This section expires June 30, 2023.

80.6 **EFFECTIVE DATE.** This section is effective July 1, 2021, except for subdivision 2,
80.7 paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later.

80.8 Sec. 64. **EXPANSION OF OUTPATIENT DRUG CARVE OUT; PRESCRIPTION**
80.9 **DRUG PURCHASING PROGRAM.**

80.10 The commissioner of human services, in consultation with the commissioners of
80.11 commerce and health, shall assess the feasibility of, and develop recommendations for: (1)
80.12 expanding the outpatient prescription drug carve out under Minnesota Statutes, section
80.13 256B.69, subdivision 6d, to include MinnesotaCare enrollees; and (2) establishing a
80.14 prescription drug purchasing program to serve nonpublic program enrollees of health plan
80.15 companies. The recommendations must address the process and terms by which the
80.16 commissioner would contract with health plan companies to administer prescription drug
80.17 benefits for the companies' enrollees and develop and manage a formulary. The commissioner
80.18 shall present recommendations to the chairs and ranking minority members of the legislative
80.19 committees with jurisdiction over commerce and health and human services policy and
80.20 finance by December 15, 2023.

80.21 Sec. 65. **FEDERAL APPROVAL; EXTENSION OF POSTPARTUM COVERAGE.**

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

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

80.26 Sec. 66. **PROPOSAL FOR A PUBLIC OPTION.**

80.27 (a) The commissioner of human services shall consult with the Centers for Medicare
80.28 and Medicaid Services, the Internal Revenue Service, and other relevant federal agencies
80.29 to develop a proposal for a public option program. The proposal may consider multiple
80.30 public option structures, at least one of which must be through expanded enrollment into
80.31 MinnesotaCare. Each option must:

81.1 (1) allow individuals with incomes above the maximum income eligibility limit under
81.2 Minnesota Statutes, section 256L.04, subdivision 1 or 7, the option of purchasing coverage
81.3 through the public option;

81.4 (2) allow undocumented noncitizens, and individuals with access to subsidized employer
81.5 health coverage who are subject to the family glitch, the option of purchasing through the
81.6 public option;

81.7 (3) establish a small employer public option that allows employers with 50 or fewer
81.8 employees to offer the public option to the employer's employees and contribute to the
81.9 employees' premiums;

81.10 (4) allow the state to:

81.11 (i) receive the maximum pass through of federal dollars that would otherwise be used
81.12 to provide coverage for eligible public option enrollees if the enrollees were instead covered
81.13 through qualified health plans with premium tax credits, emergency medical assistance, or
81.14 other relevant programs; and

81.15 (ii) continue to receive basic health program payments for eligible MinnesotaCare
81.16 enrollees; and

81.17 (5) be administered in coordination with the existing MinnesotaCare program to maximize
81.18 efficiency and improve continuity of care, consistent with the requirements of Minnesota
81.19 Statutes, sections 256L.06, 256L.10, and 256L.11.

81.20 (b) Each public option proposal must include:

81.21 (1) a premium scale for public option enrollees that at least meets the Affordable Care
81.22 Act affordability standard for each income level;

81.23 (2) an analysis of the impact of the public option on MNsure enrollment and the consumer
81.24 assistance program and, if necessary, a proposal to ensure that the public option has an
81.25 adequate enrollment infrastructure and consumer assistance capacity;

81.26 (3) actuarial and financial analyses necessary to project program enrollment and costs;
81.27 and

81.28 (4) an analysis of the cost of implementing the public option using current eligibility
81.29 and enrollment technology systems, and at the option of the commissioner, an analysis of
81.30 alternative eligibility and enrollment systems that may reduce initial and ongoing costs and
81.31 improve functionality and accessibility.

82.1 (c) The commissioner shall incorporate into the design of the public option mechanisms
82.2 to ensure the long-term financial sustainability of MinnesotaCare and mitigate any adverse
82.3 financial impacts to MNsure. These mechanisms must minimize: (i) adverse selection; (ii)
82.4 state financial risk and expenditures; and (iii) potential impacts on premiums in the individual
82.5 and group insurance markets.

82.6 (d) The commissioner shall present the proposal to the chairs and ranking minority
82.7 members of the legislative committees with jurisdiction over health care policy and finance
82.8 by December 15, 2021. The proposal must include recommendations on any legislative
82.9 changes necessary to implement the public option. Any implementation of the proposal that
82.10 requires a state financial contribution must be contingent on legislative approval.

82.11 **Sec. 67. RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**

82.12 (a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06,
82.13 subdivision 3, or any other provision to the contrary, the commissioner shall not collect any
82.14 unpaid premium for a coverage month that occurred during the COVID-19 public health
82.15 emergency declared by the United States Secretary of Health and Human Services.

82.16 (b) Notwithstanding any provision to the contrary, periodic data matching under
82.17 Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to six
82.18 months following the last day of the COVID-19 public health emergency declared by the
82.19 United States Secretary of Health and Human Services.

82.20 (c) Notwithstanding any provision to the contrary, the requirement for the commissioner
82.21 of human services to issue an annual report on periodic data matching under Minnesota
82.22 Statutes, section 256B.0561, is suspended for one year following the last day of the
82.23 COVID-19 public health emergency declared by the United States Secretary of Health and
82.24 Human Services.

82.25 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
82.26 paragraph (a) related to MinnesotaCare premiums is effective upon federal approval. The
82.27 commissioner shall notify the revisor of statutes when federal approval is received.

82.28 **Sec. 68. REVISOR INSTRUCTION.**

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

83.1 Sec. 69. **REPEALER.**

83.2 (a) Minnesota Rules, parts 9505.0275; 9505.1693; 9505.1696, subparts 1, 2, 3, 4, 5, 6,
83.3 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 22; 9505.1699; 9505.1701; 9505.1703;
83.4 9505.1706; 9505.1712; 9505.1715; 9505.1718; 9505.1724; 9505.1727; 9505.1730;
83.5 9505.1733; 9505.1736; 9505.1739; 9505.1742; 9505.1745; and 9505.1748, are repealed.

83.6 (b) Minnesota Statutes 2020, section 256B.0625, subdivisions 18c, 18d, 18e, and 18h,
83.7 are repealed.

83.8 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2021, and paragraph (b) is
83.9 effective January 1, 2023.

83.10 ARTICLE 2

83.11 DHS LICENSING AND BACKGROUND STUDIES

83.12 Section 1. Minnesota Statutes 2020, section 62V.05, is amended by adding a subdivision
83.13 to read:

83.14 **Subd. 4a. Background study required.** (a) The board must initiate background studies
83.15 under section 245C.031 of:

83.16 (1) each navigator;

83.17 (2) each in-person assister; and

83.18 (3) each certified application counselor.

83.19 (b) The board may initiate the background studies required by paragraph (a) using the
83.20 online NETStudy 2.0 system operated by the commissioner of human services.

83.21 (c) The board shall not permit any individual to provide any service or function listed
83.22 in paragraph (a) until the board has received notification from the commissioner of human
83.23 services indicating that the individual:

83.24 (1) is not disqualified under chapter 245C; or

83.25 (2) is disqualified, but has received a set aside from the board of that disqualification
83.26 according to sections 245C.22 and 245C.23.

83.27 (d) The board or its delegate shall review a reconsideration request of an individual in
83.28 paragraph (a), including granting a set aside, according to the procedures and criteria in
83.29 chapter 245C. The board shall notify the individual and the Department of Human Services
83.30 of the board's decision.

84.1 Sec. 2. Minnesota Statutes 2020, section 122A.18, subdivision 8, is amended to read:

84.2 Subd. 8. **Background ~~checks~~ studies.** (a) The Professional Educator Licensing and
84.3 Standards Board and the Board of School Administrators must ~~obtain a~~ initiate criminal
84.4 history background ~~check on~~ studies of all first-time ~~teaching~~ applicants for educator licenses
84.5 under their jurisdiction. Applicants must include with their licensure applications:

84.6 (1) an executed criminal history consent form, including fingerprints; and

84.7 (2) payment to conduct the background ~~check~~ study. The Professional Educator Licensing
84.8 and Standards Board must deposit payments received under this subdivision in an account
84.9 in the special revenue fund. Amounts in the account are annually appropriated to the
84.10 Professional Educator Licensing and Standards Board to pay for the costs of background
84.11 ~~checks~~ studies on applicants for licensure.

84.12 (b) The background ~~check~~ study for all first-time teaching applicants for licenses must
84.13 include a review of information from the Bureau of Criminal Apprehension, including
84.14 criminal history data as defined in section 13.87, and must also include a review of the
84.15 national criminal records repository. The superintendent of the Bureau of Criminal
84.16 Apprehension is authorized to exchange fingerprints with the Federal Bureau of Investigation
84.17 for purposes of the criminal history check. ~~The superintendent shall recover the cost to the~~
84.18 ~~bureau of a background check through the fee charged to the applicant under paragraph (a).~~

84.19 (c) The Professional Educator Licensing and Standards Board ~~must contract with~~ may
84.20 initiate criminal history background studies through the commissioner of human services
84.21 according to section 245C.031 to conduct background checks and obtain background ~~check~~
84.22 study data required under this chapter.

84.23 Sec. 3. Minnesota Statutes 2020, section 245A.05, is amended to read:

84.24 **245A.05 DENIAL OF APPLICATION.**

84.25 (a) The commissioner may deny a license if an applicant or controlling individual:

84.26 (1) fails to submit a substantially complete application after receiving notice from the
84.27 commissioner under section 245A.04, subdivision 1;

84.28 (2) fails to comply with applicable laws or rules;

84.29 (3) knowingly withholds relevant information from or gives false or misleading
84.30 information to the commissioner in connection with an application for a license or during
84.31 an investigation;

85.1 (4) has a disqualification that has not been set aside under section 245C.22 and no
85.2 variance has been granted;

85.3 (5) has an individual living in the household who received a background study under
85.4 section 245C.03, subdivision 1, paragraph (a), clause (2), who has a disqualification that
85.5 has not been set aside under section 245C.22, and no variance has been granted;

85.6 (6) is associated with an individual who received a background study under section
85.7 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
85.8 children or vulnerable adults, and who has a disqualification that has not been set aside
85.9 under section 245C.22, and no variance has been granted;

85.10 (7) fails to comply with section 245A.04, subdivision 1, paragraph (f) or (g);

85.11 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
85.12 6;

85.13 (9) has a history of noncompliance as a license holder or controlling individual with
85.14 applicable laws or rules, including but not limited to this chapter and chapters 119B and
85.15 245C; ~~or~~

85.16 (10) is prohibited from holding a license according to section 245.095; or

85.17 (11) for a family foster setting, has nondisqualifying background study information, as
85.18 described in section 245C.05, subdivision 4, that reflects on the individual's ability to safely
85.19 provide care to foster children.

85.20 (b) An applicant whose application has been denied by the commissioner must be given
85.21 notice of the denial, which must state the reasons for the denial in plain language. Notice
85.22 must be given by certified mail or personal service. The notice must state the reasons the
85.23 application was denied and must inform the applicant of the right to a contested case hearing
85.24 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may
85.25 appeal the denial by notifying the commissioner in writing by certified mail or personal
85.26 service. If mailed, the appeal must be postmarked and sent to the commissioner within 20
85.27 calendar days after the applicant received the notice of denial. If an appeal request is made
85.28 by personal service, it must be received by the commissioner within 20 calendar days after
85.29 the applicant received the notice of denial. Section 245A.08 applies to hearings held to
85.30 appeal the commissioner's denial of an application.

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

86.1 Sec. 4. Minnesota Statutes 2020, section 245A.07, subdivision 1, is amended to read:

86.2 Subdivision 1. **Sanctions; appeals; license.** (a) In addition to making a license conditional
86.3 under section 245A.06, the commissioner may suspend or revoke the license, impose a fine,
86.4 or secure an injunction against the continuing operation of the program of a license holder
86.5 who does not comply with applicable law or rule, or who has nondisqualifying background
86.6 study information, as described in section 245C.05, subdivision 4, that reflects on the license
86.7 holder's ability to safely provide care to foster children. When applying sanctions authorized
86.8 under this section, the commissioner shall consider the nature, chronicity, or severity of the
86.9 violation of law or rule and the effect of the violation on the health, safety, or rights of
86.10 persons served by the program.

86.11 (b) If a license holder appeals the suspension or revocation of a license and the license
86.12 holder continues to operate the program pending a final order on the appeal, the commissioner
86.13 shall issue the license holder a temporary provisional license. Unless otherwise specified
86.14 by the commissioner, variances in effect on the date of the license sanction under appeal
86.15 continue under the temporary provisional license. If a license holder fails to comply with
86.16 applicable law or rule while operating under a temporary provisional license, the
86.17 commissioner may impose additional sanctions under this section and section 245A.06, and
86.18 may terminate any prior variance. If a temporary provisional license is set to expire, a new
86.19 temporary provisional license shall be issued to the license holder upon payment of any fee
86.20 required under section 245A.10. The temporary provisional license shall expire on the date
86.21 the final order is issued. If the license holder prevails on the appeal, a new nonprovisional
86.22 license shall be issued for the remainder of the current license period.

86.23 (c) If a license holder is under investigation and the license issued under this chapter is
86.24 due to expire before completion of the investigation, the program shall be issued a new
86.25 license upon completion of the reapplication requirements and payment of any applicable
86.26 license fee. Upon completion of the investigation, a licensing sanction may be imposed
86.27 against the new license under this section, section 245A.06, or 245A.08.

86.28 (d) Failure to reapply or closure of a license issued under this chapter by the license
86.29 holder prior to the completion of any investigation shall not preclude the commissioner
86.30 from issuing a licensing sanction under this section or section 245A.06 at the conclusion
86.31 of the investigation.

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

87.1 Sec. 5. Minnesota Statutes 2020, section 245A.10, subdivision 4, is amended to read:

87.2 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall
 87.3 pay an annual nonrefundable license fee based on the following schedule:

87.4	Licensed Capacity	Child Care Center License Fee
87.5	1 to 24 persons	\$200
87.6	25 to 49 persons	\$300
87.7	50 to 74 persons	\$400
87.8	75 to 99 persons	\$500
87.9	100 to 124 persons	\$600
87.10	125 to 149 persons	\$700
87.11	150 to 174 persons	\$800
87.12	175 to 199 persons	\$900
87.13	200 to 224 persons	\$1,000
87.14	225 or more persons	\$1,100

87.16 (b)(1) A program licensed to provide one or more of the home and community-based
 87.17 services and supports identified under chapter 245D to persons with disabilities or age 65
 87.18 and older, shall pay an annual nonrefundable license fee based on revenues derived from
 87.19 the provision of services that would require licensure under chapter 245D during the calendar
 87.20 year immediately preceding the year in which the license fee is paid, according to the
 87.21 following schedule:

87.22	License Holder Annual Revenue	License Fee
87.23	less than or equal to \$10,000	\$200
87.24	greater than \$10,000 but less than or 87.25 equal to \$25,000	\$300
87.26	greater than \$25,000 but less than or 87.27 equal to \$50,000	\$400
87.28	greater than \$50,000 but less than or 87.29 equal to \$100,000	\$500
87.30	greater than \$100,000 but less than or 87.31 equal to \$150,000	\$600
87.32	greater than \$150,000 but less than or 87.33 equal to \$200,000	\$800
87.34	greater than \$200,000 but less than or 87.35 equal to \$250,000	\$1,000
87.36	greater than \$250,000 but less than or 87.37 equal to \$300,000	\$1,200
87.38	greater than \$300,000 but less than or 87.39 equal to \$350,000	\$1,400

88.1	greater than \$350,000 but less than or	
88.2	equal to \$400,000	\$1,600
88.3	greater than \$400,000 but less than or	
88.4	equal to \$450,000	\$1,800
88.5	greater than \$450,000 but less than or	
88.6	equal to \$500,000	\$2,000
88.7	greater than \$500,000 but less than or	
88.8	equal to \$600,000	\$2,250
88.9	greater than \$600,000 but less than or	
88.10	equal to \$700,000	\$2,500
88.11	greater than \$700,000 but less than or	
88.12	equal to \$800,000	\$2,750
88.13	greater than \$800,000 but less than or	
88.14	equal to \$900,000	\$3,000
88.15	greater than \$900,000 but less than or	
88.16	equal to \$1,000,000	\$3,250
88.17	greater than \$1,000,000 but less than or	
88.18	equal to \$1,250,000	\$3,500
88.19	greater than \$1,250,000 but less than or	
88.20	equal to \$1,500,000	\$3,750
88.21	greater than \$1,500,000 but less than or	
88.22	equal to \$1,750,000	\$4,000
88.23	greater than \$1,750,000 but less than or	
88.24	equal to \$2,000,000	\$4,250
88.25	greater than \$2,000,000 but less than or	
88.26	equal to \$2,500,000	\$4,500
88.27	greater than \$2,500,000 but less than or	
88.28	equal to \$3,000,000	\$4,750
88.29	greater than \$3,000,000 but less than or	
88.30	equal to \$3,500,000	\$5,000
88.31	greater than \$3,500,000 but less than or	
88.32	equal to \$4,000,000	\$5,500
88.33	greater than \$4,000,000 but less than or	
88.34	equal to \$4,500,000	\$6,000
88.35	greater than \$4,500,000 but less than or	
88.36	equal to \$5,000,000	\$6,500
88.37	greater than \$5,000,000 but less than or	
88.38	equal to \$7,500,000	\$7,000
88.39	greater than \$7,500,000 but less than or	
88.40	equal to \$10,000,000	\$8,500
88.41	greater than \$10,000,000 but less than or	
88.42	equal to \$12,500,000	\$10,000
88.43	greater than \$12,500,000 but less than or	
88.44	equal to \$15,000,000	\$14,000
88.45	greater than \$15,000,000	\$18,000

89.1 (2) If requested, the license holder shall provide the commissioner information to verify
 89.2 the license holder's annual revenues or other information as needed, including copies of
 89.3 documents submitted to the Department of Revenue.

89.4 (3) At each annual renewal, a license holder may elect to pay the highest renewal fee,
 89.5 and not provide annual revenue information to the commissioner.

89.6 (4) A license holder that knowingly provides the commissioner incorrect revenue amounts
 89.7 for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount
 89.8 of double the fee the provider should have paid.

89.9 (5) Notwithstanding clause (1), a license holder providing services under one or more
 89.10 licenses under chapter 245B that are in effect on May 15, 2013, shall pay an annual license
 89.11 fee for calendar years 2014, 2015, and 2016, equal to the total license fees paid by the license
 89.12 holder for all licenses held under chapter 245B for calendar year 2013. For calendar year
 89.13 2017 and thereafter, the license holder shall pay an annual license fee according to clause
 89.14 (1).

89.15 (c) A chemical dependency treatment program licensed under chapter 245G, to provide
 89.16 chemical dependency treatment shall pay an annual nonrefundable license fee based on the
 89.17 following schedule:

89.18	Licensed Capacity	License Fee
89.19	1 to 24 persons	\$600
89.20	25 to 49 persons	\$800
89.21	50 to 74 persons	\$1,000
89.22	75 to 99 persons	\$1,200
89.23	100 or more persons	\$1,400

89.24 (d) A ~~chemical dependency~~ detoxification program licensed under Minnesota Rules,
 89.25 parts 9530.6510 to 9530.6590, ~~to provide detoxification services~~ or a withdrawal management
 89.26 program licensed under chapter 245F shall pay an annual nonrefundable license fee based
 89.27 on the following schedule:

89.28	Licensed Capacity	License Fee
89.29	1 to 24 persons	\$760
89.30	25 to 49 persons	\$960
89.31	50 or more persons	\$1,160

89.32 A detoxification program that also operates a withdrawal management program at the same
 89.33 location shall only pay one fee based upon the licensed capacity of the program with the
 89.34 higher overall capacity.

90.1 (e) Except for child foster care, a residential facility licensed under Minnesota Rules,
 90.2 chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the
 90.3 following schedule:

90.4	Licensed Capacity	License Fee
90.5	1 to 24 persons	\$1,000
90.6	25 to 49 persons	\$1,100
90.7	50 to 74 persons	\$1,200
90.8	75 to 99 persons	\$1,300
90.9	100 or more persons	\$1,400

90.10 (f) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670,
 90.11 to serve persons with mental illness shall pay an annual nonrefundable license fee based on
 90.12 the following schedule:

90.13	Licensed Capacity	License Fee
90.14	1 to 24 persons	\$2,525
90.15	25 or more persons	\$2,725

90.16 (g) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 90.17 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 90.18 based on the following schedule:

90.19	Licensed Capacity	License Fee
90.20	1 to 24 persons	\$450
90.21	25 to 49 persons	\$650
90.22	50 to 74 persons	\$850
90.23	75 to 99 persons	\$1,050
90.24	100 or more persons	\$1,250

90.25 (h) A program licensed to provide independent living assistance for youth under section
 90.26 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

90.27 (i) A private agency licensed to provide foster care and adoption services under Minnesota
 90.28 Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of \$875.

90.29 (j) A program licensed as an adult day care center licensed under Minnesota Rules, parts
 90.30 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 90.31 following schedule:

90.32	Licensed Capacity	License Fee
90.33	1 to 24 persons	\$500
90.34	25 to 49 persons	\$700

91.1	50 to 74 persons	\$900
91.2	75 to 99 persons	\$1,100
91.3	100 or more persons	\$1,300

91.4 (k) A program licensed to provide treatment services to persons with sexual psychopathic
 91.5 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
 91.6 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

91.7 (l) A mental health center or mental health clinic requesting certification for purposes
 91.8 of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750
 91.9 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the mental health center or
 91.10 mental health clinic provides services at a primary location with satellite facilities, the
 91.11 satellite facilities shall be certified with the primary location without an additional charge.

91.12 Sec. 6. Minnesota Statutes 2020, section 245A.16, is amended by adding a subdivision to
 91.13 read:

91.14 Subd. 9. Licensed family foster settings. (a) Before recommending to grant a license,
 91.15 deny a license under section 245A.05, or revoke a license under section 245A.07 for
 91.16 nondisqualifying background study information received under section 245C.05, subdivision
 91.17 4, paragraph (a), clause (3), for a licensed family foster setting, a county agency or private
 91.18 agency that has been designated or licensed by the commissioner must review the following:

- 91.19 (1) the type of offenses;
- 91.20 (2) the number of offenses;
- 91.21 (3) the nature of the offenses;
- 91.22 (4) the age of the individual at the time of the offenses;
- 91.23 (5) the length of time that has elapsed since the last offense;
- 91.24 (6) the relationship of the offenses and the capacity to care for a child;
- 91.25 (7) evidence of rehabilitation;
- 91.26 (8) information or knowledge from community members regarding the individual's
 91.27 capacity to provide foster care;
- 91.28 (9) any available information regarding child maltreatment reports or child in need of
 91.29 protection or services petitions, or related cases, in which the individual has been involved
 91.30 or implicated, and documentation that the individual has remedied issues or conditions
 91.31 identified in child protection or court records that are relevant to safely caring for a child;

- 92.1 (10) a statement from the study subject;
- 92.2 (11) a statement from the license holder; and
- 92.3 (12) other aggravating and mitigating factors.
- 92.4 (b) For purposes of this section, "evidence of rehabilitation" includes but is not limited
92.5 to the following:
- 92.6 (1) maintaining a safe and stable residence;
- 92.7 (2) continuous, regular, or stable employment;
- 92.8 (3) successful participation in an education or job training program;
- 92.9 (4) positive involvement with the community or extended family;
- 92.10 (5) compliance with the terms and conditions of probation or parole following the
92.11 individual's most recent conviction;
- 92.12 (6) if the individual has had a substance use disorder, successful completion of a substance
92.13 use disorder assessment, substance use disorder treatment, and recommended continuing
92.14 care, if applicable, demonstrated abstinence from controlled substances, as defined in section
92.15 152.01, subdivision 4, or the establishment of a sober network;
- 92.16 (7) if the individual has had a mental illness or documented mental health issues,
92.17 demonstrated completion of a mental health evaluation, participation in therapy or other
92.18 recommended mental health treatment, or appropriate medication management, if applicable;
- 92.19 (8) if the individual's offense or conduct involved domestic violence, demonstrated
92.20 completion of a domestic violence or anger management program, and the absence of any
92.21 orders for protection or harassment restraining orders against the individual since the previous
92.22 offense or conduct;
- 92.23 (9) written letters of support from individuals of good repute, including but not limited
92.24 to employers, members of the clergy, probation or parole officers, volunteer supervisors,
92.25 or social services workers;
- 92.26 (10) demonstrated remorse for convictions or conduct, or demonstrated positive behavior
92.27 changes; and
- 92.28 (11) absence of convictions or arrests since the previous offense or conduct, including
92.29 any convictions that were expunged or pardoned.
- 92.30 (c) An applicant for a family foster setting license must sign all releases of information
92.31 requested by the county or private licensing agency.

93.1 (d) When licensing a relative for a family foster setting, the commissioner shall also
93.2 consider the importance of maintaining the child's relationship with relatives as an additional
93.3 significant factor in determining whether an application will be denied.

93.4 (e) When recommending that the commissioner deny or revoke a license, the county or
93.5 private licensing agency must send a summary of the review completed according to
93.6 paragraph (a), on a form developed by the commissioner, to the commissioner and include
93.7 any recommendation for licensing action.

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

93.9 Sec. 7. Minnesota Statutes 2020, section 245C.02, subdivision 4a, is amended to read:

93.10 Subd. 4a. **Authorized fingerprint collection vendor.** "Authorized fingerprint collection
93.11 vendor" means a qualified organization under a written contract with the commissioner to
93.12 provide services in accordance with section 245C.05, subdivision 5, paragraph (b). The
93.13 commissioner may retain the services of more than one authorized fingerprint collection
93.14 vendor.

93.15 Sec. 8. Minnesota Statutes 2020, section 245C.02, subdivision 5, is amended to read:

93.16 Subd. 5. **Background study.** "Background study" means:

93.17 (1) the collection and processing of a background study subject's fingerprints, including
93.18 the process of obtaining a background study subject's classifiable fingerprints and photograph
93.19 as required by section 245C.05, subdivision 5, paragraph (b); and

93.20 (2) the review of records conducted by the commissioner to determine whether a subject
93.21 is disqualified from direct contact with persons served by a program and, where specifically
93.22 provided in statutes, whether a subject is disqualified from having access to persons served
93.23 by a program and from working in a children's residential facility or foster residence setting.

93.24 Sec. 9. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision to
93.25 read:

93.26 Subd. 5b. **Alternative background study.** "Alternative background study" means:

93.27 (1) the collection and processing of a background study subject's fingerprints, including
93.28 the process of obtaining a background study subject's classifiable fingerprints and photograph
93.29 as required by section 245C.05, subdivision 5, paragraph (b); and

93.30 (2) a review of records conducted by the commissioner pursuant to section 245C.08 in
93.31 order to forward the background study investigating information to the entity that submitted

94.1 the alternative background study request under section 245C.031, subdivision 2. The
94.2 commissioner shall not make any eligibility determinations on background studies conducted
94.3 under section 245C.031.

94.4 Sec. 10. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision
94.5 to read:

94.6 Subd. 11c. **Entity.** "Entity" means any program, organization, or agency initiating a
94.7 background study.

94.8 Sec. 11. Minnesota Statutes 2020, section 245C.02, is amended by adding a subdivision
94.9 to read:

94.10 Subd. 16a. **Results.** "Results" means a determination that a study subject is eligible,
94.11 disqualified, set aside, granted a variance, or that more time is needed to complete the
94.12 background study.

94.13 Sec. 12. Minnesota Statutes 2020, section 245C.03, is amended to read:

94.14 **245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.**

94.15 Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background
94.16 study on:

94.17 (1) the person or persons applying for a license;

94.18 (2) an individual age 13 and over living in the household where the licensed program
94.19 will be provided who is not receiving licensed services from the program;

94.20 (3) current or prospective employees or contractors of the applicant who will have direct
94.21 contact with persons served by the facility, agency, or program;

94.22 (4) volunteers or student volunteers who will have direct contact with persons served
94.23 by the program to provide program services if the contact is not under the continuous, direct
94.24 supervision by an individual listed in clause (1) or (3);

94.25 (5) an individual age ten to 12 living in the household where the licensed services will
94.26 be provided when the commissioner has reasonable cause as defined in section 245C.02,
94.27 subdivision 15;

94.28 (6) an individual who, without providing direct contact services at a licensed program,
94.29 may have unsupervised access to children or vulnerable adults receiving services from a

95.1 program, when the commissioner has reasonable cause as defined in section 245C.02,
95.2 subdivision 15;

95.3 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

95.4 (8) notwithstanding the other requirements in this subdivision, child care background
95.5 study subjects as defined in section 245C.02, subdivision 6a; and

95.6 (9) notwithstanding clause (3), for children's residential facilities and foster residence
95.7 settings, any adult working in the facility, whether or not the individual will have direct
95.8 contact with persons served by the facility.

95.9 (b) For child foster care when the license holder resides in the home where foster care
95.10 services are provided, a short-term substitute caregiver providing direct contact services for
95.11 a child for less than 72 hours of continuous care is not required to receive a background
95.12 study under this chapter.

95.13 (c) This subdivision applies to the following programs that must be licensed under
95.14 chapter 245A:

95.15 (1) adult foster care;

95.16 (2) child foster care;

95.17 (3) children's residential facilities;

95.18 (4) family child care;

95.19 (5) licensed child care centers;

95.20 (6) licensed home and community-based services under chapter 245D;

95.21 (7) residential mental health programs for adults;

95.22 (8) substance use disorder treatment programs under chapter 245G;

95.23 (9) withdrawal management programs under chapter 245F;

95.24 (10) programs that provide treatment services to persons with sexual psychopathic
95.25 personalities or sexually dangerous persons;

95.26 (11) adult day care centers;

95.27 (12) family adult day services;

95.28 (13) independent living assistance for youth;

95.29 (14) detoxification programs;

96.1 (15) community residential settings; and

96.2 (16) intensive residential treatment services and residential crisis stabilization under
96.3 chapter 245I.

96.4 Subd. 1a. **Procedure.** (a) Individuals and organizations that are required under this
96.5 section to have or initiate background studies shall comply with the requirements of this
96.6 chapter.

96.7 (b) All studies conducted under this section shall be conducted according to sections
96.8 299C.60 to 299C.64. This requirement does not apply to subdivisions 1, paragraph (c),
96.9 clauses (2) to (5), and 6a.

96.10 Subd. 2. **Personal care provider organizations.** The commissioner shall conduct
96.11 background studies on any individual required under sections 256B.0651 to 256B.0654 and
96.12 256B.0659 to have a background study completed under this chapter.

96.13 Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct all
96.14 background studies required under this chapter and initiated by supplemental nursing services
96.15 agencies registered under section 144A.71, subdivision 1.

96.16 Subd. 3a. **Personal care assistance provider agency; background studies.** Personal
96.17 care assistance provider agencies enrolled to provide personal care assistance services under
96.18 the medical assistance program must meet the following requirements:

96.19 (1) owners who have a five percent interest or more and all managing employees are
96.20 subject to a background study as provided in this chapter. This requirement applies to
96.21 currently enrolled personal care assistance provider agencies and agencies seeking enrollment
96.22 as a personal care assistance provider agency. "Managing employee" has the same meaning
96.23 as Code of Federal Regulations, title 42, section 455.101. An organization is barred from
96.24 enrollment if:

96.25 (i) the organization has not initiated background studies of owners and managing
96.26 employees; or

96.27 (ii) the organization has initiated background studies of owners and managing employees
96.28 and the commissioner has sent the organization a notice that an owner or managing employee
96.29 of the organization has been disqualified under section 245C.14, and the owner or managing
96.30 employee has not received a set aside of the disqualification under section 245C.22; and

96.31 (2) a background study must be initiated and completed for all qualified professionals.

97.1 Subd. 3b. **Exception to personal care assistant; requirements.** The personal care
97.2 assistant for a recipient may be allowed to enroll with a different personal care assistance
97.3 provider agency upon initiation of a new background study according to this chapter if:

97.4 (1) the commissioner determines that a change in enrollment or affiliation of the personal
97.5 care assistant is needed in order to ensure continuity of services and protect the health and
97.6 safety of the recipient;

97.7 (2) the chosen agency has been continuously enrolled as a personal care assistance
97.8 provider agency for at least two years;

97.9 (3) the recipient chooses to transfer to the personal care assistance provider agency;

97.10 (4) the personal care assistant has been continuously enrolled with the former personal
97.11 care assistance provider agency since the last background study was completed; and

97.12 (5) the personal care assistant continues to meet requirements of section 256B.0659,
97.13 subdivision 11, notwithstanding paragraph (a), clause (3).

97.14 **Subd. 4. Personnel agencies; educational programs; professional services**
97.15 **agencies.** The commissioner also may conduct studies on individuals specified in subdivision
97.16 1, paragraph (a), clauses (3) and (4), when the studies are initiated by:

97.17 (1) personnel pool agencies;

97.18 (2) temporary personnel agencies;

97.19 (3) educational programs that train individuals by providing direct contact services in
97.20 licensed programs; and

97.21 (4) professional services agencies that are not licensed and which contract with licensed
97.22 programs to provide direct contact services or individuals who provide direct contact services.

97.23 **Subd. 5. Other state agencies.** The commissioner shall conduct background studies on
97.24 applicants and license holders under the jurisdiction of other state agencies who are required
97.25 in other statutory sections to initiate background studies under this chapter, including the
97.26 applicant's or license holder's employees, contractors, and volunteers when required under
97.27 other statutory sections.

97.28 **Subd. 5a. Facilities serving children or adults licensed or regulated by the**
97.29 **Department of Health.** (a) The commissioner shall conduct background studies of:

97.30 (1) individuals providing services who have direct contact, as defined under section
97.31 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes,
97.32 outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and

98.1 home care agencies licensed under chapter 144A; assisted living facilities and assisted living
98.2 facilities with dementia care licensed under chapter 144G; and board and lodging
98.3 establishments that are registered to provide supportive or health supervision services under
98.4 section 157.17;

98.5 (2) individuals specified in subdivision 2 who provide direct contact services in a nursing
98.6 home or a home care agency licensed under chapter 144A; an assisted living facility or
98.7 assisted living facility with dementia care licensed under chapter 144G; or a boarding care
98.8 home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides
98.9 outside of Minnesota, the study must include a check for substantiated findings of
98.10 maltreatment of adults and children in the individual's state of residence when the state
98.11 makes the information available;

98.12 (3) all other employees in assisted living facilities or assisted living facilities with
98.13 dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A,
98.14 and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of
98.15 an individual in this section shall disqualify the individual from positions allowing direct
98.16 contact with or access to patients or residents receiving services. "Access" means physical
98.17 access to a client or the client's personal property without continuous, direct supervision as
98.18 defined in section 245C.02, subdivision 8, when the employee's employment responsibilities
98.19 do not include providing direct contact services;

98.20 (4) individuals employed by a supplemental nursing services agency, as defined under
98.21 section 144A.70, who are providing services in health care facilities; and

98.22 (5) controlling persons of a supplemental nursing services agency, as defined by section
98.23 144A.70.

98.24 (b) If a facility or program is licensed by the Department of Human Services and the
98.25 Department of Health and is subject to the background study provisions of this chapter, the
98.26 Department of Human Services is solely responsible for the background studies of individuals
98.27 in the jointly licensed program.

98.28 (c) The commissioner of health shall review and make decisions regarding reconsideration
98.29 requests, including whether to grant variances, according to the procedures and criteria in
98.30 this chapter. The commissioner of health shall inform the requesting individual and the
98.31 Department of Human Services of the commissioner of health's decision regarding the
98.32 reconsideration. The commissioner of health's decision to grant or deny a reconsideration
98.33 of a disqualification is a final administrative agency action.

99.1 Subd. 5b. Facilities serving children or youth licensed by the Department of
99.2 Corrections. (a) The commissioner shall conduct background studies of individuals working
99.3 in secure and nonsecure children's residential facilities, juvenile detention facilities, and
99.4 foster residence settings, whether or not the individual will have direct contact, as defined
99.5 under section 245C.02, subdivision 11, with persons served in the facilities or settings.

99.6 (b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a
99.7 prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in
99.8 conducting background studies by providing the commissioner of human services or the
99.9 commissioner's representative all criminal conviction data available from local and state
99.10 criminal history record repositories related to applicants, operators, all persons living in a
99.11 household, and all staff of any facility subject to background studies under this subdivision.

99.12 (c) For the purpose of this subdivision, the term "secure and nonsecure residential facility
99.13 and detention facility" includes programs licensed or certified under section 241.021,
99.14 subdivision 2.

99.15 (d) If an individual is disqualified, the Department of Human Services shall notify the
99.16 disqualified individual and the facility in which the disqualified individual provides services
99.17 of the disqualification and shall inform the disqualified individual of the right to request a
99.18 reconsideration of the disqualification by submitting the request to the Department of
99.19 Corrections.

99.20 (e) The commissioner of corrections shall review and make decisions regarding
99.21 reconsideration requests, including whether to grant variances, according to the procedures
99.22 and criteria in this chapter. The commissioner of corrections shall inform the requesting
99.23 individual and the Department of Human Services of the commissioner of corrections'
99.24 decision regarding the reconsideration. The commissioner of corrections' decision to grant
99.25 or deny a reconsideration of a disqualification is the final administrative agency action.

99.26 Subd. 6. Unlicensed home and community-based waiver providers of service to
99.27 seniors and individuals with disabilities. (a) The commissioner shall conduct background
99.28 studies on of any individual required under section 256B.4912 to have a background study
99.29 completed under this chapter who provides direct contact, as defined in section 245C.02,
99.30 subdivision 11, for services specified in the federally approved home and community-based
99.31 waiver plans under section 256B.4912. The individual studied must meet the requirements
99.32 of this chapter prior to providing waiver services and as part of ongoing enrollment.

99.33 (b) The requirements in paragraph (a) apply to consumer-directed community supports
99.34 under section 256B.4911.

100.1 Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner
100.2 shall conduct background studies ~~on an individual~~ of the following individuals as required
100.3 ~~under~~ by sections 119B.125 and 245H.10 to complete a background study under this chapter:

100.4 (1) every individual who applies for certification;

100.5 (2) every member of a provider's household who is age 13 and older and lives in the
100.6 household where nonlicensed child care is provided; and

100.7 (3) an individual who is at least ten years of age and under 13 years of age and lives in
100.8 the household where the nonlicensed child care will be provided when the county has
100.9 reasonable cause as defined under section 245C.02, subdivision 15.

100.10 Subd. 7. **Children's therapeutic services and supports providers.** The commissioner
100.11 shall conduct background studies ~~according to this chapter when initiated by a children's~~
100.12 ~~therapeutic services and supports provider~~ of all direct service providers and volunteers for
100.13 children's therapeutic services and supports providers under section 256B.0943.

100.14 ~~Subd. 8. Self-initiated background studies. Upon implementation of NETStudy 2.0,~~
100.15 ~~the commissioner shall conduct background studies according to this chapter when initiated~~
100.16 ~~by an individual who is not on the master roster. A subject under this subdivision who is~~
100.17 ~~not disqualified must be placed on the inactive roster.~~

100.18 Subd. 9. **Community first services and supports and financial management services**
100.19 **organizations.** ~~The commissioner shall conduct background studies on any individual~~
100.20 ~~required under section 256B.85 to have a background study completed under this chapter.~~
100.21 Individuals affiliated with Community First Services and Supports (CFSS) agency-providers
100.22 and Financial Management Services (FMS) providers enrolled to provide CFSS services
100.23 under the medical assistance program must meet the following requirements:

100.24 (1) owners who have a five percent interest or more and all managing employees are
100.25 subject to a background study under this chapter. This requirement applies to currently
100.26 enrolled providers and agencies seeking enrollment. "Managing employee" has the meaning
100.27 given in Code of Federal Regulations, title 42, section 455.101. An organization is barred
100.28 from enrollment if:

100.29 (i) the organization has not initiated background studies of owners and managing
100.30 employees; or

100.31 (ii) the organization has initiated background studies of owners and managing employees
100.32 and the commissioner has sent the organization a notice that an owner or managing employee

101.1 of the organization has been disqualified under section 245C.14 and the owner or managing
101.2 employee has not received a set aside of the disqualification under section 245C.22;

101.3 (2) a background study must be initiated and completed for all staff who will have direct
101.4 contact with the participant to provide worker training and development; and

101.5 (3) a background study must be initiated and completed for all support workers.

101.6 Subd. 9a. **Exception to support worker requirements for continuity of services.** The
101.7 support worker for a participant may enroll with a different Community First Services and
101.8 Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon
101.9 initiation, rather than completion, of a new background study according to this chapter if:

101.10 (1) the commissioner determines that the support worker's change in enrollment or
101.11 affiliation is necessary to ensure continuity of services and to protect the health and safety
101.12 of the participant;

101.13 (2) the chosen agency-provider or FMS provider has been continuously enrolled as a
101.14 CFSS agency-provider or FMS provider for at least two years or since the inception of the
101.15 CFSS program, whichever is shorter;

101.16 (3) the participant served by the support worker chooses to transfer to the CFSS
101.17 agency-provider or the FMS provider to which the support worker is transferring;

101.18 (4) the support worker has been continuously enrolled with the former CFSS
101.19 agency-provider or FMS provider since the support worker's last background study was
101.20 completed; and

101.21 (5) the support worker continues to meet the requirements of section 256B.85, subdivision
101.22 16, notwithstanding paragraph (a), clause (1).

101.23 Subd. 10. **Providers of group residential housing or supplementary services.** (a) The
101.24 commissioner shall conduct background studies ~~on any individual required under section~~
101.25 ~~256I.04 to have a background study completed under this chapter.~~ of the following individuals
101.26 who provide services under section 256I.04:

101.27 (1) controlling individuals as defined in section 245A.02;

101.28 (2) managerial officials as defined in section 245A.02; and

101.29 (3) all employees and volunteers of the establishment who have direct contact with
101.30 recipients or who have unsupervised access to recipients, recipients' personal property, or
101.31 recipients' private data.

102.1 (b) The provider of housing support must comply with all requirements for entities
 102.2 initiating background studies under this chapter.

102.3 (c) A provider of housing support must demonstrate that all individuals who are required
 102.4 to have a background study according to paragraph (a) have a notice stating that:

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

102.6 (2) the individual is disqualified and the individual has been issued a set aside of the
 102.7 disqualification for the setting under section 245C.22.

102.8 ~~Subd. 11. **Child protection workers or social services staff having responsibility for**~~
 102.9 ~~**child protective duties.** (a) The commissioner must complete background studies, according~~
 102.10 ~~to paragraph (b) and section 245C.04, subdivision 10, when initiated by a county social~~
 102.11 ~~services agency or by a local welfare agency according to section 626.559, subdivision 1b.~~

102.12 ~~(b) For background studies completed by the commissioner under this subdivision, the~~
 102.13 ~~commissioner shall not make a disqualification decision, but shall provide the background~~
 102.14 ~~study information received to the county that initiated the study.~~

102.15 **Subd. 12. Providers of special transportation service.** (a) The commissioner shall
 102.16 conduct background studies on any individual required under section 174.30 to have a
 102.17 background study completed under this chapter. of the following individuals who provide
 102.18 special transportation services under section 174.30:

102.19 (1) each person with a direct or indirect ownership interest of five percent or higher in
 102.20 a transportation service provider;

102.21 (2) each controlling individual as defined under section 245A.02;

102.22 (3) a managerial official as defined in section 245A.02;

102.23 (4) each driver employed by the transportation service provider;

102.24 (5) each individual employed by the transportation service provider to assist a passenger
 102.25 during transport; and

102.26 (6) each employee of the transportation service agency who provides administrative
 102.27 support, including an employee who:

102.28 (i) may have face-to-face contact with or access to passengers, passengers' personal
 102.29 property, or passengers' private data;

102.30 (ii) performs any scheduling or dispatching tasks; or

102.31 (iii) performs any billing activities.

103.1 (b) When a local or contracted agency is authorizing a ride under section 256B.0625,
103.2 subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to
103.3 believe that the volunteer driver has a history that would disqualify the volunteer driver or
103.4 that may pose a risk to the health or safety of passengers, the agency may initiate a
103.5 background study that shall be completed according to this chapter using the commissioner
103.6 of human services' online NETStudy system, or by contacting the Department of Human
103.7 Services background study division for assistance. The agency that initiates the background
103.8 study under this paragraph shall be responsible for providing the volunteer driver with the
103.9 privacy notice required by section 245C.05, subdivision 2c, and with the payment for the
103.10 background study required by section 245C.10 before the background study is completed.

103.11 **Subd. 13. Providers of housing support services.** The commissioner shall conduct
103.12 background studies ~~on~~ of any individual provider of housing support services required under
103.13 by section 256B.051 to have a background study completed under this chapter.

103.14 **Subd. 14. Tribal nursing facilities.** For completed background studies to comply with
103.15 a Tribal organization's licensing requirements for individuals affiliated with a tribally licensed
103.16 nursing facility, the commissioner shall obtain state and national criminal history data.

103.17 **Subd. 15. Early intensive developmental and behavioral intervention providers.** The
103.18 commissioner shall conduct background studies according to this chapter when initiated by
103.19 an early intensive developmental and behavioral intervention provider under section
103.20 256B.0949.

103.21 **EFFECTIVE DATE.** This section is effective July 1, 2021, except subdivision 6,
103.22 paragraph (b), is effective upon federal approval and subdivision 15 is effective the day
103.23 following final enactment. The commissioner of human services shall notify the revisor of
103.24 statutes when federal approval is obtained.

103.25 **Sec. 13. [245C.031] BACKGROUND STUDY; ALTERNATIVE BACKGROUND**
103.26 **STUDIES.**

103.27 **Subdivision 1. Alternative background studies.** (a) The commissioner shall conduct
103.28 an alternative background study of individuals listed in this section.

103.29 (b) Notwithstanding other sections of this chapter, all alternative background studies
103.30 except subdivision 12 shall be conducted according to this section and with section 299C.60
103.31 to 299C.64.

103.32 (c) All terms in this section shall have the definitions provided in section 245C.02.

104.1 (d) The entity that submits an alternative background study request under this section
104.2 shall submit the request to the commissioner according to section 245C.05.

104.3 (e) The commissioner shall comply with the destruction requirements in section 245C.051.

104.4 (f) Background studies conducted under this section are subject to the provisions of
104.5 section 245C.32.

104.6 (g) The commissioner shall forward all information that the commissioner receives under
104.7 section 245C.08 to the entity that submitted the alternative background study request under
104.8 subdivision 2. The commissioner shall not make any eligibility determinations regarding
104.9 background studies conducted under this section.

104.10 Subd. 2. **Access to information.** Each entity that submits an alternative background
104.11 study request shall enter into an agreement with the commissioner before submitting requests
104.12 for alternative background studies under this section. As a part of the agreement, the entity
104.13 must agree to comply with state and federal law.

104.14 Subd. 3. **Child protection workers or social services staff having responsibility for**
104.15 **child protective duties.** The commissioner shall conduct an alternative background study
104.16 of any person who has responsibility for child protection duties when the background study
104.17 is initiated by a county social services agency or by a local welfare agency according to
104.18 section 260E.36, subdivision 3.

104.19 Subd. 4. **Applicants, licensees, and other occupations regulated by the commissioner**
104.20 **of health.** The commissioner shall conduct an alternative background study, including a
104.21 check of state data, and a national criminal history records check of the following individuals.
104.22 For studies under this section, the following persons shall complete a consent form:

104.23 (1) an applicant for initial licensure, temporary licensure, or relicensure after a lapse in
104.24 licensure as an audiologist or speech-language pathologist or an applicant for initial
104.25 certification as a hearing instrument dispenser who must submit to a background study
104.26 under section 144.0572.

104.27 (2) an applicant for a renewal license or certificate as an audiologist, speech-language
104.28 pathologist, or hearing instrument dispenser who was licensed or obtained a certificate
104.29 before January 1, 2018.

104.30 Subd. 5. **Guardians and conservators.** (a) The commissioner shall conduct an alternative
104.31 background study of:

104.32 (1) every court-appointed guardian and conservator, unless a background study has been
104.33 completed of the person under this section within the previous five years. The alternative

105.1 background study shall be completed prior to the appointment of the guardian or conservator,
105.2 unless a court determines that it would be in the best interests of the ward or protected person
105.3 to appoint a guardian or conservator before the alternative background study can be
105.4 completed. If the court appoints the guardian or conservator while the alternative background
105.5 study is pending, the alternative background study must be completed as soon as reasonably
105.6 possible after the guardian or conservator's appointment and no later than 30 days after the
105.7 guardian or conservator's appointment; and

105.8 (2) a guardian and a conservator once every five years after the guardian or conservator's
105.9 appointment if the person continues to serve as a guardian or conservator.

105.10 (b) An alternative background study is not required if the guardian or conservator is:

105.11 (1) a state agency or county;

105.12 (2) a parent or guardian of a proposed ward or protected person who has a developmental
105.13 disability if the parent or guardian has raised the proposed ward or protected person in the
105.14 family home until the time that the petition is filed, unless counsel appointed for the proposed
105.15 ward or protected person under section 524.5-205, paragraph (d); 524.5-304, paragraph (b);
105.16 524.5-405, paragraph (a); or 524.5-406, paragraph (b), recommends a background study;
105.17 or

105.18 (3) a bank with trust powers, a bank and trust company, or a trust company, organized
105.19 under the laws of any state or of the United States and regulated by the commissioner of
105.20 commerce or a federal regulator.

105.21 Subd. 6. **Guardians and conservators; required checks.** (a) An alternative background
105.22 study for a guardian or conservator pursuant to subdivision 5 shall include:

105.23 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal
105.24 history data obtained by the commissioner of human services;

105.25 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment
105.26 of a vulnerable adult under section 626.557 or a minor under chapter 260E. If the subject
105.27 of the study has been the perpetrator of substantiated maltreatment of a vulnerable adult or
105.28 a minor, the commissioner must include a copy of the public portion of the investigation
105.29 memorandum under section 626.557, subdivision 12b, or the public portion of the
105.30 investigation memorandum under section 260E.30. The commissioner shall provide the
105.31 court with information from a review of information according to subdivision 7 if the study
105.32 subject provided information that the study subject has a current or prior affiliation with a
105.33 state licensing agency;

106.1 (3) criminal history data from a national criminal history record check as defined in
106.2 section 245C.02, subdivision 13c; and

106.3 (4) state licensing agency data if a search of the database or databases of the agencies
106.4 listed in subdivision 7 shows that the proposed guardian or conservator has held a
106.5 professional license directly related to the responsibilities of a professional fiduciary from
106.6 an agency listed in subdivision 7 that was conditioned, suspended, revoked, or canceled.

106.7 (b) If the guardian or conservator is not an individual, the background study must be
106.8 completed of all individuals who are currently employed by the proposed guardian or
106.9 conservator who are responsible for exercising powers and duties under the guardianship
106.10 or conservatorship.

106.11 Subd. 7. **Guardians and conservators; state licensing data.** (a) Within 25 working
106.12 days of receiving the request for an alternative background study of a guardian or conservator,
106.13 the commissioner shall provide the court with licensing agency data for licenses directly
106.14 related to the responsibilities of a guardian or conservator if the study subject has a current
106.15 or prior affiliation with the:

106.16 (1) Lawyers Responsibility Board;

106.17 (2) State Board of Accountancy;

106.18 (3) Board of Social Work;

106.19 (4) Board of Psychology;

106.20 (5) Board of Nursing;

106.21 (6) Board of Medical Practice;

106.22 (7) Department of Education;

106.23 (8) Department of Commerce;

106.24 (9) Board of Chiropractic Examiners;

106.25 (10) Board of Dentistry;

106.26 (11) Board of Marriage and Family Therapy;

106.27 (12) Department of Human Services;

106.28 (13) Peace Officer Standards and Training (POST) Board; and

106.29 (14) Professional Educator Licensing and Standards Board.

107.1 (b) The commissioner and each of the agencies listed above, except for the Department
107.2 of Human Services, shall enter into a written agreement to provide the commissioner with
107.3 electronic access to the relevant licensing data and to provide the commissioner with a
107.4 quarterly list of new sanctions issued by the agency.

107.5 (c) The commissioner shall provide to the court the electronically available data
107.6 maintained in the agency's database, including whether the proposed guardian or conservator
107.7 is or has been licensed by the agency and whether a disciplinary action or a sanction against
107.8 the individual's license, including a condition, suspension, revocation, or cancellation, is in
107.9 the licensing agency's database.

107.10 (d) If the proposed guardian or conservator has resided in a state other than Minnesota
107.11 during the previous ten years, licensing agency data under this section shall also include
107.12 licensing agency data from any other state where the proposed guardian or conservator
107.13 reported to have resided during the previous ten years if the study subject has a current or
107.14 prior affiliation to the licensing agency. If the proposed guardian or conservator has or has
107.15 had a professional license in another state that is directly related to the responsibilities of a
107.16 guardian or conservator from one of the agencies listed under paragraph (a), state licensing
107.17 agency data shall also include data from the relevant licensing agency of the other state.

107.18 (e) The commissioner is not required to repeat a search for Minnesota or out-of-state
107.19 licensing data on an individual if the commissioner has provided this information to the
107.20 court within the prior five years.

107.21 (f) The commissioner shall review the information in paragraph (c) at least once every
107.22 four months to determine whether an individual who has been studied within the previous
107.23 five years:

- 107.24 (1) has any new disciplinary action or sanction against the individual's license; or
107.25 (2) did not disclose a prior or current affiliation with a Minnesota licensing agency.

107.26 (g) If the commissioner's review in paragraph (f) identifies new information, the
107.27 commissioner shall provide any new information to the court.

107.28 Subd. 8. **Guardians ad litem.** The commissioner shall conduct an alternative background
107.29 study of:

- 107.30 (1) a guardian ad litem appointed under section 518.165 if a background study of the
107.31 guardian ad litem has not been completed within the past three years. The background study
107.32 of the guardian ad litem must be completed before the court appoints the guardian ad litem,

108.1 unless the court determines that it is in the best interests of the child to appoint the guardian
108.2 ad litem before a background study is completed by the commissioner.

108.3 (2) a guardian ad litem once every three years after the guardian has been appointed, as
108.4 long as the individual continues to serve as a guardian ad litem.

108.5 Subd. 9. **Guardians ad litem; required checks.** (a) An alternative background study
108.6 for a guardian ad litem under subdivision 8 must include:

108.7 (1) criminal history data from the Bureau of Criminal Apprehension and other criminal
108.8 history data obtained by the commissioner of human services; and

108.9 (2) data regarding whether the person has been a perpetrator of substantiated maltreatment
108.10 of a minor or a vulnerable adult. If the study subject has been determined by the Department
108.11 of Human Services or the Department of Health to be the perpetrator of substantiated
108.12 maltreatment of a minor or a vulnerable adult in a licensed facility, the response must include
108.13 a copy of the public portion of the investigation memorandum under section 260E.30 or the
108.14 public portion of the investigation memorandum under section 626.557, subdivision 12b.
108.15 When the background study shows that the subject has been determined by a county adult
108.16 protection or child protection agency to have been responsible for maltreatment, the court
108.17 shall be informed of the county, the date of the finding, and the nature of the maltreatment
108.18 that was substantiated.

108.19 (b) For checks of records under paragraph (a), clauses (1) and (2), the commissioner
108.20 shall provide the records within 15 working days of receiving the request. The information
108.21 obtained under sections 245C.05 and 245C.08 from a national criminal history records
108.22 check shall be provided within three working days of the commissioner's receipt of the data.

108.23 (c) Notwithstanding section 260E.30 or 626.557, subdivision 12b, if the commissioner
108.24 or county lead agency or lead investigative agency has information that a person of whom
108.25 a background study was previously completed under this section has been determined to
108.26 be a perpetrator of maltreatment of a minor or vulnerable adult, the commissioner or the
108.27 county may provide this information to the court that requested the background study.

108.28 Subd. 10. **First-time applicants for educator licenses with the Professional Educator**
108.29 **Licensing and Standards Board.** The Professional Educator Licensing and Standards
108.30 Board shall make all eligibility determinations for alternative background studies conducted
108.31 under this section for the Professional Educator Licensing and Standards Board. The
108.32 commissioner may conduct an alternative background study of all first-time applicants for
108.33 educator licenses pursuant to section 122A.18, subdivision 8. The alternative background
108.34 study for all first-time applicants for educator licenses must include a review of information

109.1 from the Bureau of Criminal Apprehension, including criminal history data as defined in
109.2 section 13.87, and must also include a review of the national criminal records repository.

109.3 Subd. 11. **First-time applicants for administrator licenses with the Board of School**
109.4 **Administrators.** The Board of School Administrators shall make all eligibility determinations
109.5 for alternative background studies conducted under this section for the Board of School
109.6 Administrators. The commissioner may conduct an alternative background study of all
109.7 first-time applicants for administrator licenses pursuant to section 122A.18, subdivision 8.
109.8 The alternative background study for all first-time applicants for administrator licenses must
109.9 include a review of information from the Bureau of Criminal Apprehension, including
109.10 criminal history data as defined in section 13.87, and must also include a review of the
109.11 national criminal records repository.

109.12 Subd. 12. **Occupations regulated by MNsure.** (a) The commissioner shall conduct a
109.13 background study of any individual required under section 62V.05 to have a background
109.14 study completed under this chapter. Notwithstanding subdivision 1, paragraph (g), the
109.15 commissioner shall conduct a background study only based on Minnesota criminal records
109.16 of:

109.17 (1) each navigator;

109.18 (2) each in-person assister; and

109.19 (3) each certified application counselor.

109.20 (b) The MNsure board of directors may initiate background studies required by paragraph
109.21 (a) using the online NETStudy 2.0 system operated by the commissioner.

109.22 (c) The commissioner shall review information that the commissioner receives to
109.23 determine if the study subject has potentially disqualifying offenses. The commissioner
109.24 shall send a letter to the subject indicating any of the subject's potential disqualifications as
109.25 well as any relevant records. The commissioner shall send a copy of the letter indicating
109.26 any of the subject's potential disqualifications to the MNsure board.

109.27 (d) The MNsure board or its delegate shall review a reconsideration request of an
109.28 individual in paragraph (a), including granting a set aside, according to the procedures and
109.29 criteria in chapter 245C. The board shall notify the individual and the Department of Human
109.30 Services of the board's decision.

110.1 Sec. 14. Minnesota Statutes 2020, section 245C.05, subdivision 1, is amended to read:

110.2 Subdivision 1. **Individual studied.** (a) The individual who is the subject of the
110.3 background study must provide the applicant, license holder, or other entity under section
110.4 245C.04 with sufficient information to ensure an accurate study, including:

110.5 (1) the individual's first, middle, and last name and all other names by which the
110.6 individual has been known;

110.7 (2) current home address, city, and state of residence;

110.8 (3) current zip code;

110.9 (4) sex;

110.10 (5) date of birth;

110.11 (6) driver's license number or state identification number; and

110.12 (7) upon implementation of NETStudy 2.0, the home address, city, county, and state of
110.13 residence for the past five years.

110.14 (b) Every subject of a background study conducted or initiated by counties or private
110.15 agencies under this chapter must also provide the home address, city, county, and state of
110.16 residence for the past five years.

110.17 (c) Every subject of a background study related to private agency adoptions or related
110.18 to child foster care licensed through a private agency, who is 18 years of age or older, shall
110.19 also provide the commissioner a signed consent for the release of any information received
110.20 from national crime information databases to the private agency that initiated the background
110.21 study.

110.22 (d) The subject of a background study shall provide fingerprints and a photograph as
110.23 required in subdivision 5.

110.24 (e) The subject of a background study shall submit a completed criminal and maltreatment
110.25 history records check consent form for applicable national and state level record checks.

110.26 Sec. 15. Minnesota Statutes 2020, section 245C.05, subdivision 2, is amended to read:

110.27 Subd. 2. **Applicant, license holder, or other entity.** (a) The applicant, license holder,
110.28 or other ~~entities~~ entity initiating the background study as provided in this chapter shall verify
110.29 that the information collected under subdivision 1 about an individual who is the subject of
110.30 the background study is correct and must provide the information on forms or in a format
110.31 prescribed by the commissioner.

111.1 (b) The information collected under subdivision 1 about an individual who is the subject
111.2 of a completed background study may only be viewable by an entity that initiates a
111.3 subsequent background study on that individual under NETStudy 2.0 after the entity has
111.4 paid the applicable fee for the study and has provided the individual with the privacy notice
111.5 in subdivision 2c.

111.6 Sec. 16. Minnesota Statutes 2020, section 245C.05, subdivision 2a, is amended to read:

111.7 Subd. 2a. **County or private agency.** For background studies related to child foster care
111.8 when the applicant or license holder resides in the home where child foster care services
111.9 are provided, county and private agencies initiating the background study must collect the
111.10 information under subdivision 1 and forward it to the commissioner.

111.11 Sec. 17. Minnesota Statutes 2020, section 245C.05, subdivision 2b, is amended to read:

111.12 Subd. 2b. **County agency to collect and forward information to commissioner.** (a)
111.13 For background studies related to all family adult day services and to adult foster care when
111.14 the adult foster care license holder resides in the adult foster care residence, the county
111.15 agency or private agency initiating the background study must collect the information
111.16 required under subdivision 1 and forward it to the commissioner.

111.17 (b) Upon implementation of NETStudy 2.0, for background studies related to family
111.18 child care and legal nonlicensed child care authorized under chapter 119B, the county agency
111.19 initiating the background study must collect the information required under subdivision 1
111.20 and provide the information to the commissioner.

111.21 Sec. 18. Minnesota Statutes 2020, section 245C.05, subdivision 2c, is amended to read:

111.22 Subd. 2c. **Privacy notice to background study subject.** (a) Prior to initiating each
111.23 background study, the entity initiating the study must provide the commissioner's privacy
111.24 notice to the background study subject required under section 13.04, subdivision 2. The
111.25 notice must be available through the commissioner's electronic NETStudy and NETStudy
111.26 2.0 systems and shall include the information in paragraphs (b) and (c).

111.27 (b) The background study subject shall be informed that any previous background studies
111.28 that received a set-aside will be reviewed, and without further contact with the background
111.29 study subject, the commissioner may notify the agency that initiated the subsequent
111.30 background study:

111.31 (1) that the individual has a disqualification that has been set aside for the program or
111.32 agency that initiated the study;

- 112.1 (2) the reason for the disqualification; and
- 112.2 (3) that information about the decision to set aside the disqualification will be available
112.3 to the license holder upon request without the consent of the background study subject.
- 112.4 (c) The background study subject must also be informed that:
- 112.5 (1) the subject's fingerprints collected for purposes of completing the background study
112.6 under this chapter must not be retained by the Department of Public Safety, Bureau of
112.7 Criminal Apprehension, or by the commissioner. The Federal Bureau of Investigation will
112.8 ~~only retain fingerprints of subjects with a criminal history~~ not retain background study
112.9 subjects' fingerprints;
- 112.10 (2) effective upon implementation of NETStudy 2.0, the subject's photographic image
112.11 will be retained by the commissioner, and if the subject has provided the subject's Social
112.12 Security number for purposes of the background study, the photographic image will be
112.13 available to prospective employers and agencies initiating background studies under this
112.14 chapter to verify the identity of the subject of the background study;
- 112.15 (3) the commissioner's authorized fingerprint collection vendor or vendors shall, for
112.16 purposes of verifying the identity of the background study subject, be able to view the
112.17 identifying information entered into NETStudy 2.0 by the entity that initiated the background
112.18 study, but shall not retain the subject's fingerprints, photograph, or information from
112.19 NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more
112.20 than the subject's name and the date and time the subject's fingerprints were recorded and
112.21 sent, only as necessary for auditing and billing activities;
- 112.22 (4) the commissioner shall provide the subject notice, as required in section 245C.17,
112.23 subdivision 1, paragraph (a), when an entity initiates a background study on the individual;
- 112.24 (5) the subject may request in writing a report listing the entities that initiated a
112.25 background study on the individual as provided in section 245C.17, subdivision 1, paragraph
112.26 (b);
- 112.27 (6) the subject may request in writing that information used to complete the individual's
112.28 background study in NETStudy 2.0 be destroyed if the requirements of section 245C.051,
112.29 paragraph (a), are met; and
- 112.30 (7) notwithstanding clause (6), the commissioner shall destroy:
- 112.31 (i) the subject's photograph after a period of two years when the requirements of section
112.32 245C.051, paragraph (c), are met; and

113.1 (ii) any data collected on a subject under this chapter after a period of two years following
113.2 the individual's death as provided in section 245C.051, paragraph (d).

113.3 Sec. 19. Minnesota Statutes 2020, section 245C.05, subdivision 2d, is amended to read:

113.4 Subd. 2d. **Fingerprint data notification.** The commissioner of human services shall
113.5 notify all background study subjects under this chapter that the Department of Human
113.6 Services, Department of Public Safety, and the Bureau of Criminal Apprehension do not
113.7 retain fingerprint data after a background study is completed, and that the Federal Bureau
113.8 of Investigation ~~only retains the fingerprints of subjects who have a criminal history~~ does
113.9 not retain background study subjects' fingerprints.

113.10 Sec. 20. Minnesota Statutes 2020, section 245C.05, subdivision 4, is amended to read:

113.11 Subd. 4. **Electronic transmission.** (a) For background studies conducted by the
113.12 Department of Human Services, the commissioner shall implement a secure system for the
113.13 electronic transmission of:

113.14 (1) background study information to the commissioner;

113.15 (2) background study results to the license holder;

113.16 (3) background study ~~results~~ information obtained under this section and section 245C.08
113.17 to counties and private agencies for background studies conducted by the commissioner for
113.18 child foster care, including a summary of nondisqualifying results, except as prohibited by
113.19 law; and

113.20 (4) background study results to county agencies for background studies conducted by
113.21 the commissioner for adult foster care and family adult day services and, upon
113.22 implementation of NETStudy 2.0, family child care and legal nonlicensed child care
113.23 authorized under chapter 119B.

113.24 (b) Unless the commissioner has granted a hardship variance under paragraph (c), a
113.25 license holder or an applicant must use the electronic transmission system known as
113.26 NETStudy or NETStudy 2.0 to submit all requests for background studies to the
113.27 commissioner as required by this chapter.

113.28 (c) A license holder or applicant whose program is located in an area in which high-speed
113.29 Internet is inaccessible may request the commissioner to grant a variance to the electronic
113.30 transmission requirement.

114.1 (d) Section 245C.08, subdivision 3, paragraph (c), applies to results transmitted under
114.2 this subdivision.

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

114.4 Sec. 21. Minnesota Statutes 2020, section 245C.08, subdivision 3, is amended to read:

114.5 Subd. 3. **Arrest and investigative information.** (a) For any background study completed
114.6 under this section, if the commissioner has reasonable cause to believe the information is
114.7 pertinent to the disqualification of an individual, the commissioner also may review arrest
114.8 and investigative information from:

114.9 (1) the Bureau of Criminal Apprehension;

114.10 (2) the commissioners of health and human services;

114.11 (3) a county attorney;

114.12 (4) a county sheriff;

114.13 (5) a county agency;

114.14 (6) a local chief of police;

114.15 (7) other states;

114.16 (8) the courts;

114.17 (9) the Federal Bureau of Investigation;

114.18 (10) the National Criminal Records Repository; and

114.19 (11) criminal records from other states.

114.20 (b) Except when specifically required by law, the commissioner is not required to conduct
114.21 more than one review of a subject's records from the Federal Bureau of Investigation if a
114.22 review of the subject's criminal history with the Federal Bureau of Investigation has already
114.23 been completed by the commissioner and there has been no break in the subject's affiliation
114.24 with the entity that initiated the background study.

114.25 (c) If the commissioner conducts a national criminal history record check when required
114.26 by law and uses the information from the national criminal history record check to make a
114.27 disqualification determination, the data obtained is private data and cannot be shared with
114.28 ~~county agencies~~, private agencies, or prospective employers of the background study subject.

114.29 (d) If the commissioner conducts a national criminal history record check when required
114.30 by law and uses the information from the national criminal history record check to make a

115.1 disqualification determination, the license holder or entity that submitted the study is not
115.2 required to obtain a copy of the background study subject's disqualification letter under
115.3 section 245C.17, subdivision 3.

115.4 Sec. 22. Minnesota Statutes 2020, section 245C.08, is amended by adding a subdivision
115.5 to read:

115.6 Subd. 5. **Authorization.** The commissioner of human services shall be authorized to
115.7 receive information under this chapter.

115.8 Sec. 23. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
115.9 to read:

115.10 Subd. 1b. **Background study fees.** (a) The commissioner shall recover the cost of
115.11 background studies. Except as otherwise provided in subdivisions 1c and 1d, the fees
115.12 collected under this section shall be appropriated to the commissioner for the purpose of
115.13 conducting background studies under this chapter. Fees under this section are charges under
115.14 section 16A.1283, paragraph (b), clause (3).

115.15 (b) Background study fees may include:

115.16 (1) a fee to compensate the commissioner's authorized fingerprint collection vendor or
115.17 vendors for obtaining and processing a background study subject's classifiable fingerprints
115.18 and photograph pursuant to subdivision 1c; and

115.19 (2) a separate fee under subdivision 1c to complete a review of background-study-related
115.20 records as authorized under this chapter.

115.21 (c) Fees charged under paragraph (b) may be paid in whole or part when authorized by
115.22 law by a state agency or board; by state court administration; by a service provider, employer,
115.23 license holder, or other organization that initiates the background study; by the commissioner
115.24 or other organization with duly appropriated funds; by a background study subject; or by
115.25 some combination of these sources.

115.26 Sec. 24. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
115.27 to read:

115.28 Subd. 1c. **Fingerprint and photograph processing fees.** The commissioner shall enter
115.29 into a contract with a qualified vendor or vendors to obtain and process a background study
115.30 subject's classifiable fingerprints and photograph as required by section 245C.05. The
115.31 commissioner may, at their discretion, directly collect fees and reimburse the commissioner's

116.1 authorized fingerprint collection vendor for the vendor's services or require the vendor to
116.2 collect the fees. The authorized vendor is responsible for reimbursing the vendor's
116.3 subcontractors at a rate specified in the contract with the commissioner.

116.4 Sec. 25. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
116.5 to read:

116.6 Subd. 1d. **Background studies fee schedule.** (a) By March 1 each year, the commissioner
116.7 shall publish a schedule of fees sufficient to administer and conduct background studies
116.8 under this chapter. The published schedule of fees shall be effective on July 1 each year.

116.9 (b) Fees shall be based on the actual costs of administering and conducting background
116.10 studies, including payments to external agencies, department indirect cost payments under
116.11 section 16A.127, processing fees, and costs related to due process.

116.12 (c) The commissioner shall publish a notice of fees by posting fee amounts on the
116.13 department website. The notice shall specify the actual costs that comprise the fees including
116.14 the categories described in paragraph (b).

116.15 (d) The published schedule of fees shall remain in effect from July 1 to June 30 each
116.16 year.

116.17 (e) The fees collected under this subdivision are appropriated to the commissioner for
116.18 the purpose of conducting background studies, alternative background studies, and criminal
116.19 background checks.

116.20 **EFFECTIVE DATE.** This section is effective July 1, 2021. The commissioner of human
116.21 services shall publish the initial fee schedule on the Department of Human Services website
116.22 on July 1, 2021, and the initial fee schedule is effective September 1, 2021.

116.23 Sec. 26. Minnesota Statutes 2020, section 245C.10, subdivision 15, is amended to read:

116.24 ~~Subd. 15. **Guardians and conservators.** The commissioner shall recover the cost of~~
116.25 ~~conducting background studies for guardians and conservators under section 524.5-118~~
116.26 ~~through a fee of no more than \$110 per study. The fees collected under this subdivision are~~
116.27 ~~appropriated to the commissioner for the purpose of conducting background studies. fee~~
116.28 for conducting an alternative background study for appointment of a professional guardian
116.29 or conservator must be paid by the guardian or conservator. In other cases, the fee must be
116.30 paid as follows:

116.31 (1) if the matter is proceeding in forma pauperis, the fee must be paid as an expense for
116.32 purposes of section 524.5-502, paragraph (a);

117.1 (2) if there is an estate of the ward or protected person, the fee must be paid from the
117.2 estate; or

117.3 (3) in the case of a guardianship or conservatorship of a person that is not proceeding
117.4 in forma pauperis, the fee must be paid by the guardian, conservator, or the court.

117.5 Sec. 27. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
117.6 to read:

117.7 Subd. 17. **Early intensive developmental and behavioral intervention providers.** The
117.8 commissioner shall recover the cost of background studies required under section 245C.03,
117.9 subdivision 15, for the purposes of early intensive developmental and behavioral intervention
117.10 under section 256B.0949, through a fee of no more than \$20 per study charged to the enrolled
117.11 agency. The fees collected under this subdivision are appropriated to the commissioner for
117.12 the purpose of conducting background studies.

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

117.14 Sec. 28. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
117.15 to read:

117.16 Subd. 18. **Applicants, licensees, and other occupations regulated by commissioner**
117.17 **of health.** The applicant or license holder is responsible for paying to the Department of
117.18 Human Services all fees associated with the preparation of the fingerprints, the criminal
117.19 records check consent form, and the criminal background check.

117.20 Sec. 29. Minnesota Statutes 2020, section 245C.10, is amended by adding a subdivision
117.21 to read:

117.22 Subd. 19. **Occupations regulated by MNsure.** The commissioner shall set fees to
117.23 recover the cost of background studies and criminal background checks initiated by MNsure
117.24 under sections 62V.05 and 245C.031. The fee amount shall be established through
117.25 interagency agreement between the commissioner and the board of MNsure or its designee.
117.26 The fees collected under this subdivision shall be deposited in the special revenue fund and
117.27 are appropriated to the commissioner for the purpose of conducting background studies and
117.28 criminal background checks.

118.1 Sec. 30. Minnesota Statutes 2020, section 245C.13, subdivision 2, is amended to read:

118.2 Subd. 2. **Activities pending completion of background study.** The subject of a
118.3 background study may not perform any activity requiring a background study under
118.4 paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

118.5 (a) Notices from the commissioner required prior to activity under paragraph (c) include:

118.6 (1) a notice of the study results under section 245C.17 stating that:

118.7 (i) the individual is not disqualified; or

118.8 (ii) more time is needed to complete the study but the individual is not required to be
118.9 removed from direct contact or access to people receiving services prior to completion of
118.10 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
118.11 that more time is needed to complete the study must also indicate whether the individual is
118.12 required to be under continuous direct supervision prior to completion of the background
118.13 study. When more time is necessary to complete a background study of an individual
118.14 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
118.15 the individual may not work in the facility or setting regardless of whether or not the
118.16 individual is supervised;

118.17 (2) a notice that a disqualification has been set aside under section 245C.23; or

118.18 (3) a notice that a variance has been granted related to the individual under section
118.19 245C.30.

118.20 (b) For a background study affiliated with a licensed child care center or certified
118.21 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
118.22 must require the individual to be under continuous direct supervision prior to completion
118.23 of the background study except as permitted in subdivision 3.

118.24 (c) Activities prohibited prior to receipt of notice under paragraph (a) include:

118.25 (1) being issued a license;

118.26 (2) living in the household where the licensed program will be provided;

118.27 (3) providing direct contact services to persons served by a program unless the subject
118.28 is under continuous direct supervision;

118.29 (4) having access to persons receiving services if the background study was completed
118.30 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
118.31 (5), or (6), unless the subject is under continuous direct supervision;

119.1 (5) for licensed child care centers and certified license-exempt child care centers,
119.2 providing direct contact services to persons served by the program; ~~or~~

119.3 (6) for children's residential facilities or foster residence settings, working in the facility
119.4 or setting; or

119.5 (7) for background studies affiliated with a personal care provider organization, except
119.6 as provided in section 245C.03, subdivision 3b, before a personal care assistant provides
119.7 services, the personal care assistance provider agency must initiate a background study of
119.8 the personal care assistant under this chapter and the personal care assistance provider
119.9 agency must have received a notice from the commissioner that the personal care assistant
119.10 is:

119.11 (i) not disqualified under section 245C.14; or

119.12 (ii) disqualified, but the personal care assistant has received a set aside of the
119.13 disqualification under section 245C.22.

119.14 Sec. 31. Minnesota Statutes 2020, section 245C.14, subdivision 1, is amended to read:

119.15 Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall
119.16 disqualify an individual who is the subject of a background study from any position allowing
119.17 direct contact with persons receiving services from the license holder or entity identified in
119.18 section 245C.03, upon receipt of information showing, or when a background study
119.19 completed under this chapter shows any of the following:

119.20 (1) a conviction of, admission to, or Alford plea to one or more crimes listed in section
119.21 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor,
119.22 or misdemeanor level crime;

119.23 (2) a preponderance of the evidence indicates the individual has committed an act or
119.24 acts that meet the definition of any of the crimes listed in section 245C.15, regardless of
119.25 whether the preponderance of the evidence is for a felony, gross misdemeanor, or
119.26 misdemeanor level crime; or

119.27 (3) an investigation results in an administrative determination listed under section
119.28 245C.15, subdivision 4, paragraph (b).

119.29 (b) No individual who is disqualified following a background study under section
119.30 245C.03, subdivisions 1 and 2, may be retained in a position involving direct contact with
119.31 persons served by a program or entity identified in section 245C.03, unless the commissioner
119.32 has provided written notice under section 245C.17 stating that:

120.1 (1) the individual may remain in direct contact during the period in which the individual
120.2 may request reconsideration as provided in section 245C.21, subdivision 2;

120.3 (2) the commissioner has set aside the individual's disqualification for that program or
120.4 entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

120.5 (3) the license holder has been granted a variance for the disqualified individual under
120.6 section 245C.30.

120.7 (c) Notwithstanding paragraph (a), for the purposes of a background study affiliated
120.8 with a licensed family foster setting, the commissioner shall disqualify an individual who
120.9 is the subject of a background study from any position allowing direct contact with persons
120.10 receiving services from the license holder or entity identified in section 245C.03, upon
120.11 receipt of information showing or when a background study completed under this chapter
120.12 shows reason for disqualification under section 245C.15, subdivision 4a.

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

120.14 Sec. 32. Minnesota Statutes 2020, section 245C.14, is amended by adding a subdivision
120.15 to read:

120.16 **Subd. 4. Disqualification from working in licensed child care centers or certified**
120.17 **license-exempt child care centers.** (a) For a background study affiliated with a licensed
120.18 child care center or certified license-exempt child care center, if an individual is disqualified
120.19 from direct contact under subdivision 1, the commissioner must also disqualify the individual
120.20 from working in any position regardless of whether the individual would have direct contact
120.21 with or access to children served in the licensed child care center or certified license-exempt
120.22 child care center and from having access to a person receiving services from the center.

120.23 (b) Notwithstanding any other requirement of this chapter, for a background study
120.24 affiliated with a licensed child care center or a certified license-exempt child care center, if
120.25 an individual is disqualified, the individual may not work in the child care center until the
120.26 commissioner has issued a notice stating that:

120.27 (1) the individual is not disqualified;

120.28 (2) a disqualification has been set aside under section 245C.23; or

120.29 (3) a variance has been granted related to the individual under section 245C.30.

121.1 Sec. 33. Minnesota Statutes 2020, section 245C.15, is amended by adding a subdivision
121.2 to read:

121.3 Subd. 4a. Licensed family foster setting disqualifications. (a) Notwithstanding
121.4 subdivisions 1 to 4, for a background study affiliated with a licensed family foster setting,
121.5 regardless of how much time has passed, an individual is disqualified under section 245C.14
121.6 if the individual committed an act that resulted in a felony-level conviction for sections:
121.7 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder
121.8 in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in
121.9 the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first
121.10 degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse);
121.11 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense
121.12 under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or
121.13 neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325
121.14 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245
121.15 (aggravated robbery); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder
121.16 of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second
121.17 degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter
121.18 of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the
121.19 second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault
121.20 of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the
121.21 commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion
121.22 of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited
121.23 acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342
121.24 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second
121.25 degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual
121.26 conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree);
121.27 609.3453 (criminal sexual predatory conduct); 609.352 (solicitation of children to engage
121.28 in sexual conduct); 609.377 (malicious punishment of a child); 609.378 (neglect or
121.29 endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary
121.30 in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246
121.31 (use of minors in sexual performance prohibited); or 617.247 (possession of pictorial
121.32 representations of minors).

121.33 (b) Notwithstanding subdivisions 1 to 4, for the purposes of a background study affiliated
121.34 with a licensed family foster setting, an individual is disqualified under section 245C.14,
121.35 regardless of how much time has passed, if the individual:

- 122.1 (1) committed an action under paragraph (d) that resulted in death or involved sexual
122.2 abuse, as defined in section 260E.03, subdivision 20;
- 122.3 (2) committed an act that resulted in a gross misdemeanor-level conviction for section
122.4 609.3451 (criminal sexual conduct in the fifth degree);
- 122.5 (3) committed an act against or involving a minor that resulted in a felony-level conviction
122.6 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the
122.7 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);
122.8 or
- 122.9 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level
122.10 conviction for section 617.293 (dissemination and display of harmful materials to minors).
- 122.11 (c) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
122.12 family foster setting, an individual is disqualified under section 245C.14 if less than 20
122.13 years have passed since the termination of the individual's parental rights under section
122.14 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of
122.15 parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to
122.16 involuntarily terminate parental rights. An individual is disqualified under section 245C.14
122.17 if less than 20 years have passed since the termination of the individual's parental rights in
122.18 any other state or country, where the conditions for the individual's termination of parental
122.19 rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph
122.20 (b).
- 122.21 (d) Notwithstanding subdivisions 1 to 4, for a background study affiliated with a licensed
122.22 family foster setting, an individual is disqualified under section 245C.14 if less than five
122.23 years have passed since a felony-level violation for sections: 152.021 (controlled substance
122.24 crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023
122.25 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the
122.26 fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing
122.27 controlled substances across state borders); 152.0262, subdivision 1, paragraph (b)
122.28 (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision
122.29 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies
122.30 prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia;
122.31 prohibited conduct; criminal penalties; civil liabilities); 152.137 (methamphetamine-related
122.32 crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while
122.33 impaired); 243.166 (violation of predatory offender registration requirements); 609.2113
122.34 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn

123.1 child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal
123.2 abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal
123.3 neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery);
123.4 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex
123.5 trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the
123.6 first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562
123.7 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2
123.8 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration);
123.9 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or
123.10 stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or
123.11 624.713 (certain people not to possess firearms).

123.12 (e) Notwithstanding subdivisions 1 to 4, except as provided in paragraph (a), for a
123.13 background study affiliated with a licensed family child foster care license, an individual
123.14 is disqualified under section 245C.14 if less than five years have passed since:

123.15 (1) a felony-level violation for an act not against or involving a minor that constitutes:
123.16 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third
123.17 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the
123.18 fifth degree);

123.19 (2) a violation of an order for protection under section 518B.01, subdivision 14;

123.20 (3) a determination or disposition of the individual's failure to make required reports
123.21 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition
123.22 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment
123.23 was recurring or serious;

123.24 (4) a determination or disposition of the individual's substantiated serious or recurring
123.25 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or
123.26 serious or recurring maltreatment in any other state, the elements of which are substantially
123.27 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet
123.28 the definition of serious maltreatment or recurring maltreatment;

123.29 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in
123.30 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);
123.31 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);
123.32 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

123.33 (6) committing an act against or involving a minor that resulted in a misdemeanor-level
123.34 violation of section 609.224, subdivision 1 (assault in the fifth degree).

- 124.1 (f) For purposes of this subdivision, the disqualification begins from:
- 124.2 (1) the date of the alleged violation, if the individual was not convicted;
- 124.3 (2) the date of conviction, if the individual was convicted of the violation but not
- 124.4 committed to the custody of the commissioner of corrections; or
- 124.5 (3) the date of release from prison, if the individual was convicted of the violation and
- 124.6 committed to the custody of the commissioner of corrections.
- 124.7 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation
- 124.8 of the individual's supervised release, the disqualification begins from the date of release
- 124.9 from the subsequent incarceration.
- 124.10 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
- 124.11 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
- 124.12 Statutes, permanently disqualifies the individual under section 245C.14. An individual is
- 124.13 disqualified under section 245C.14 if less than five years have passed since the individual's
- 124.14 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs
- 124.15 (d) and (e).
- 124.16 (h) An individual's offense in any other state or country, where the elements of the
- 124.17 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),
- 124.18 permanently disqualifies the individual under section 245C.14. An individual is disqualified
- 124.19 under section 245C.14 if less than five years has passed since an offense in any other state
- 124.20 or country, the elements of which are substantially similar to the elements of any offense
- 124.21 listed in paragraphs (d) and (e).
- 124.22 **EFFECTIVE DATE.** This section is effective July 1, 2022.
- 124.23 Sec. 34. Minnesota Statutes 2020, section 245C.16, subdivision 1, is amended to read:
- 124.24 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines
- 124.25 that the individual studied has a disqualifying characteristic, the commissioner shall review
- 124.26 the information immediately available and make a determination as to the subject's immediate
- 124.27 risk of harm to persons served by the program where the individual studied will have direct
- 124.28 contact with, or access to, people receiving services.
- 124.29 (b) The commissioner shall consider all relevant information available, including the
- 124.30 following factors in determining the immediate risk of harm:
- 124.31 (1) the recency of the disqualifying characteristic;
- 124.32 (2) the recency of discharge from probation for the crimes;

- 125.1 (3) the number of disqualifying characteristics;
- 125.2 (4) the intrusiveness or violence of the disqualifying characteristic;
- 125.3 (5) the vulnerability of the victim involved in the disqualifying characteristic;
- 125.4 (6) the similarity of the victim to the persons served by the program where the individual
125.5 studied will have direct contact;
- 125.6 (7) whether the individual has a disqualification from a previous background study that
125.7 has not been set aside; ~~and~~
- 125.8 (8) if the individual has a disqualification which may not be set aside because it is a
125.9 permanent bar under section 245C.24, subdivision 1, or the individual is a child care
125.10 background study subject who has a felony-level conviction for a drug-related offense in
125.11 the last five years, the commissioner may order the immediate removal of the individual
125.12 from any position allowing direct contact with, or access to, persons receiving services from
125.13 the program and from working in a children's residential facility or foster residence setting;
125.14 and
- 125.15 (9) if the individual has a disqualification which may not be set aside because it is a
125.16 permanent bar under section 245C.24, subdivision 2, or the individual is a child care
125.17 background study subject who has a felony-level conviction for a drug-related offense during
125.18 the last five years, the commissioner may order the immediate removal of the individual
125.19 from any position allowing direct contact with or access to persons receiving services from
125.20 the center and from working in a licensed child care center or certified license-exempt child
125.21 care center.
- 125.22 (c) This section does not apply when the subject of a background study is regulated by
125.23 a health-related licensing board as defined in chapter 214, and the subject is determined to
125.24 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.
- 125.25 (d) This section does not apply to a background study related to an initial application
125.26 for a child foster family setting license.
- 125.27 (e) Except for paragraph (f), this section does not apply to a background study that is
125.28 also subject to the requirements under section 256B.0659, subdivisions 11 and 13, for a
125.29 personal care assistant or a qualified professional as defined in section 256B.0659,
125.30 subdivision 1.
- 125.31 (f) If the commissioner has reason to believe, based on arrest information or an active
125.32 maltreatment investigation, that an individual poses an imminent risk of harm to persons
125.33 receiving services, the commissioner may order that the person be continuously supervised

126.1 or immediately removed pending the conclusion of the maltreatment investigation or criminal
126.2 proceedings.

126.3 Sec. 35. Minnesota Statutes 2020, section 245C.16, subdivision 2, is amended to read:

126.4 Subd. 2. **Findings.** (a) After evaluating the information immediately available under
126.5 subdivision 1, the commissioner may have reason to believe one of the following:

126.6 (1) the individual poses an imminent risk of harm to persons served by the program
126.7 where the individual studied will have direct contact or access to persons served by the
126.8 program or where the individual studied will work;

126.9 (2) the individual poses a risk of harm requiring continuous, direct supervision while
126.10 providing direct contact services during the period in which the subject may request a
126.11 reconsideration; or

126.12 (3) the individual does not pose an imminent risk of harm or a risk of harm requiring
126.13 continuous, direct supervision while providing direct contact services during the period in
126.14 which the subject may request a reconsideration.

126.15 (b) After determining an individual's risk of harm under this section, the commissioner
126.16 must notify the subject of the background study and the applicant or license holder as
126.17 required under section 245C.17.

126.18 (c) For Title IV-E eligible children's residential facilities and foster residence settings,
126.19 the commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

126.20 (d) For licensed child care centers or certified license-exempt child care centers, the
126.21 commissioner is prohibited from making the findings in paragraph (a), clause (2) or (3).

126.22 Sec. 36. Minnesota Statutes 2020, section 245C.17, subdivision 1, is amended to read:

126.23 Subdivision 1. **Time frame for notice of study results and auditing system access.** (a)
126.24 Within three working days after the commissioner's receipt of a request for a background
126.25 study submitted through the commissioner's NETStudy or NETStudy 2.0 system, the
126.26 commissioner shall notify the background study subject and the license holder or other
126.27 entity as provided in this chapter in writing or by electronic transmission of the results of
126.28 the study or that more time is needed to complete the study. The notice to the individual
126.29 shall include the identity of the entity that initiated the background study.

126.30 (b) Before being provided access to NETStudy 2.0, the license holder or other entity
126.31 under section 245C.04 shall sign an acknowledgment of responsibilities form developed

127.1 by the commissioner that includes identifying the sensitive background study information
 127.2 person, who must be an employee of the license holder or entity. All queries to NETStudy
 127.3 2.0 are electronically recorded and subject to audit by the commissioner. The electronic
 127.4 record shall identify the specific user. A background study subject may request in writing
 127.5 to the commissioner a report listing the entities that initiated a background study on the
 127.6 individual.

127.7 (c) When the commissioner has completed a prior background study on an individual
 127.8 that resulted in an order for immediate removal and more time is necessary to complete a
 127.9 subsequent study, the notice that more time is needed that is issued under paragraph (a)
 127.10 shall include an order for immediate removal of the individual from any position allowing
 127.11 direct contact with or access to people receiving services and from working in a children's
 127.12 residential facility ~~or~~, foster residence setting, child care center, or certified license-exempt
 127.13 child care center pending completion of the background study.

127.14 Sec. 37. Minnesota Statutes 2020, section 245C.17, is amended by adding a subdivision
 127.15 to read:

127.16 **Subd. 8. Disqualification notice to child care centers and certified license-exempt**
 127.17 **child care centers.** (a) For child care centers and certified license-exempt child care centers,
 127.18 all notices under this section that order the license holder to immediately remove the
 127.19 individual studied from any position allowing direct contact with, or access to a person
 127.20 served by the center, must also order the license holder to immediately remove the individual
 127.21 studied from working in any position regardless of whether the individual would have direct
 127.22 contact with or access to children served in the center.

127.23 (b) For child care centers and certified license-exempt child care centers, notices under
 127.24 this section must not allow an individual to work in the center.

127.25 Sec. 38. Minnesota Statutes 2020, section 245C.18, is amended to read:

127.26 **245C.18 OBLIGATION TO REMOVE DISQUALIFIED INDIVIDUAL FROM**
 127.27 **DIRECT CONTACT AND FROM WORKING IN A PROGRAM, FACILITY, ~~OR~~**
 127.28 **SETTING, OR CENTER.**

127.29 (a) Upon receipt of notice from the commissioner, the license holder must remove a
 127.30 disqualified individual from direct contact with persons served by the licensed program if:

127.31 (1) the individual does not request reconsideration under section 245C.21 within the
 127.32 prescribed time;

128.1 (2) the individual submits a timely request for reconsideration, the commissioner does
128.2 not set aside the disqualification under section 245C.22, subdivision 4, and the individual
128.3 does not submit a timely request for a hearing under sections 245C.27 and 256.045, or
128.4 245C.28 and chapter 14; or

128.5 (3) the individual submits a timely request for a hearing under sections 245C.27 and
128.6 256.045, or 245C.28 and chapter 14, and the commissioner does not set aside or rescind the
128.7 disqualification under section 245A.08, subdivision 5, or 256.045.

128.8 (b) For children's residential facility and foster residence setting license holders, upon
128.9 receipt of notice from the commissioner under paragraph (a), the license holder must also
128.10 remove the disqualified individual from working in the program, facility, or setting and
128.11 from access to persons served by the licensed program.

128.12 (c) For Title IV-E eligible children's residential facility and foster residence setting
128.13 license holders, upon receipt of notice from the commissioner under paragraph (a), the
128.14 license holder must also remove the disqualified individual from working in the program
128.15 and from access to persons served by the program and must not allow the individual to work
128.16 in the facility or setting until the commissioner has issued a notice stating that:

128.17 (1) the individual is not disqualified;

128.18 (2) a disqualification has been set aside under section 245C.23; or

128.19 (3) a variance has been granted related to the individual under section 245C.30.

128.20 (d) For licensed child care center and certified license-exempt child care center license
128.21 holders, upon receipt of notice from the commissioner under paragraph (a), the license
128.22 holder must remove the disqualified individual from working in any position regardless of
128.23 whether the individual would have direct contact with or access to children served in the
128.24 center and from having access to persons served by the center and must not allow the
128.25 individual to work in the center until the commissioner has issued a notice stating that:

128.26 (1) the individual is not disqualified;

128.27 (2) a disqualification has been set aside under section 245C.23; or

128.28 (3) a variance has been granted related to the individual under section 245C.30.

128.29 Sec. 39. Minnesota Statutes 2020, section 245C.24, subdivision 2, is amended to read:

128.30 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
128.31 paragraphs (b) to ~~(e)~~ (f), the commissioner may not set aside the disqualification of any
128.32 individual disqualified pursuant to this chapter, regardless of how much time has passed,

129.1 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
129.2 1.

129.3 (b) For an individual in the chemical dependency or corrections field who was disqualified
129.4 for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification
129.5 was set aside prior to July 1, 2005, the commissioner must consider granting a variance
129.6 pursuant to section 245C.30 for the license holder for a program dealing primarily with
129.7 adults. A request for reconsideration evaluated under this paragraph must include a letter
129.8 of recommendation from the license holder that was subject to the prior set-aside decision
129.9 addressing the individual's quality of care to children or vulnerable adults and the
129.10 circumstances of the individual's departure from that service.

129.11 (c) If an individual who requires a background study for nonemergency medical
129.12 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
129.13 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
129.14 passed since the discharge of the sentence imposed, the commissioner may consider granting
129.15 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
129.16 paragraph must include a letter of recommendation from the employer. This paragraph does
129.17 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
129.18 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
129.19 clause (1); 617.246; or 617.247.

129.20 (d) When a licensed foster care provider adopts an individual who had received foster
129.21 care services from the provider for over six months, and the adopted individual is required
129.22 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause
129.23 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
129.24 to permit the adopted individual with a permanent disqualification to remain affiliated with
129.25 the license holder under the conditions of the variance when the variance is recommended
129.26 by the county of responsibility for each of the remaining individuals in placement in the
129.27 home and the licensing agency for the home.

129.28 (e) For an individual 18 years of age or older affiliated with a licensed family foster
129.29 setting, the commissioner must not set aside or grant a variance for the disqualification of
129.30 any individual disqualified pursuant to this chapter, regardless of how much time has passed,
129.31 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
129.32 4a, paragraphs (a) and (b).

130.1 (f) In connection with a family foster setting license, the commissioner may grant a
130.2 variance to the disqualification for an individual who is under 18 years of age at the time
130.3 the background study is submitted.

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

130.5 Sec. 40. Minnesota Statutes 2020, section 245C.24, subdivision 3, is amended to read:

130.6 Subd. 3. **Ten-year bar to set aside disqualification.** (a) The commissioner may not set
130.7 aside the disqualification of an individual in connection with a license to provide family
130.8 child care for children, ~~foster care for children in the provider's home~~, or foster care or day
130.9 care services for adults in the provider's home if: (1) less than ten years has passed since
130.10 the discharge of the sentence imposed, if any, for the offense; or (2) when disqualified based
130.11 on a preponderance of evidence determination under section 245C.14, subdivision 1,
130.12 paragraph (a), clause (2), or an admission under section 245C.14, subdivision 1, paragraph
130.13 (a), clause (1), and less than ten years has passed since the individual committed the act or
130.14 admitted to committing the act, whichever is later; and (3) the individual has committed a
130.15 violation of any of the following offenses: sections 609.165 (felon ineligible to possess
130.16 firearm); criminal vehicular homicide or criminal vehicular operation causing death under
130.17 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (aiding
130.18 suicide or aiding attempted suicide); felony violations under 609.223 or 609.2231 (assault
130.19 in the third or fourth degree); 609.229 (crimes committed for benefit of a gang); 609.713
130.20 (terroristic threats); 609.235 (use of drugs to injure or to facilitate crime); 609.24 (simple
130.21 robbery); 609.255 (false imprisonment); 609.562 (arson in the second degree); 609.71 (riot);
130.22 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a
130.23 witness); burglary in the first or second degree under 609.582 (burglary); 609.66 (dangerous
130.24 weapon); 609.665 (spring guns); 609.67 (machine guns and short-barreled shotguns);
130.25 609.749, subdivision 2 (gross misdemeanor harassment); 152.021 or 152.022 (controlled
130.26 substance crime in the first or second degree); 152.023, subdivision 1, clause (3) or (4) or
130.27 subdivision 2, clause (4) (controlled substance crime in the third degree); 152.024,
130.28 subdivision 1, clause (2), (3), or (4) (controlled substance crime in the fourth degree);
130.29 609.224, subdivision 2, paragraph (c) (fifth-degree assault by a caregiver against a vulnerable
130.30 adult); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or
130.31 patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a
130.32 vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure
130.33 to report); 609.265 (abduction); 609.2664 to 609.2665 (manslaughter of an unborn child in
130.34 the first or second degree); 609.267 to 609.2672 (assault of an unborn child in the first,
130.35 second, or third degree); 609.268 (injury or death of an unborn child in the commission of

131.1 a crime); repeat offenses under 617.23 (indecent exposure); 617.293 (disseminating or
131.2 displaying harmful material to minors); a felony-level conviction involving alcohol or drug
131.3 use, a gross misdemeanor offense under 609.324, subdivision 1 (other prohibited acts); a
131.4 gross misdemeanor offense under 609.378 (neglect or endangerment of a child); a gross
131.5 misdemeanor offense under 609.377 (malicious punishment of a child); 609.72, subdivision
131.6 3 (disorderly conduct against a vulnerable adult); or 624.713 (certain persons not to possess
131.7 firearms); or Minnesota Statutes 2012, section 609.21.

131.8 (b) The commissioner may not set aside the disqualification of an individual if less than
131.9 ten years have passed since the individual's aiding and abetting, attempt, or conspiracy to
131.10 commit any of the offenses listed in paragraph (a) as each of these offenses is defined in
131.11 Minnesota Statutes.

131.12 (c) The commissioner may not set aside the disqualification of an individual if less than
131.13 ten years have passed since the discharge of the sentence imposed for an offense in any
131.14 other state or country, the elements of which are substantially similar to the elements of any
131.15 of the offenses listed in paragraph (a).

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

131.17 Sec. 41. Minnesota Statutes 2020, section 245C.24, subdivision 4, is amended to read:

131.18 Subd. 4. **Seven-year bar to set aside disqualification.** The commissioner may not set
131.19 aside the disqualification of an individual in connection with a license to provide family
131.20 child care for children, ~~foster care for children in the provider's home,~~ or foster care or day
131.21 care services for adults in the provider's home if within seven years preceding the study:

131.22 (1) the individual committed an act that constitutes maltreatment of a child under sections
131.23 260E.24, subdivisions 1, 2, and 3, and 260E.30, subdivisions 1, 2, and 4, and the maltreatment
131.24 resulted in substantial bodily harm as defined in section 609.02, subdivision 7a, or substantial
131.25 mental or emotional harm as supported by competent psychological or psychiatric evidence;
131.26 or

131.27 (2) the individual was determined under section 626.557 to be the perpetrator of a
131.28 substantiated incident of maltreatment of a vulnerable adult that resulted in substantial
131.29 bodily harm as defined in section 609.02, subdivision 7a, or substantial mental or emotional
131.30 harm as supported by competent psychological or psychiatric evidence.

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

132.1 Sec. 42. Minnesota Statutes 2020, section 245C.24, is amended by adding a subdivision
132.2 to read:

132.3 Subd. 6. **Five-year bar to set aside disqualification; family foster setting.** (a) The
132.4 commissioner shall not set aside or grant a variance for the disqualification of an individual
132.5 18 years of age or older in connection with a foster family setting license if within five years
132.6 preceding the study the individual is convicted of a felony in section 245C.15, subdivision
132.7 4a, paragraph (d).

132.8 (b) In connection with a foster family setting license, the commissioner may set aside
132.9 or grant a variance to the disqualification for an individual who is under 18 years of age at
132.10 the time the background study is submitted.

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

132.12 Sec. 43. Minnesota Statutes 2020, section 245C.32, subdivision 1a, is amended to read:

132.13 Subd. 1a. **NETStudy 2.0 system.** (a) The commissioner shall design, develop, and test
132.14 the NETStudy 2.0 system and implement it no later than September 1, 2015.

132.15 (b) The NETStudy 2.0 system developed and implemented by the commissioner shall
132.16 incorporate and meet all applicable data security standards and policies required by the
132.17 Federal Bureau of Investigation (FBI), Department of Public Safety, Bureau of Criminal
132.18 Apprehension, and the Office of MN.IT Services. The system shall meet all required
132.19 standards for encryption of data at the database level as well as encryption of data that
132.20 travels electronically among agencies initiating background studies, the commissioner's
132.21 authorized fingerprint collection vendor or vendors, the commissioner, the Bureau of Criminal
132.22 Apprehension, and in cases involving national criminal record checks, the FBI.

132.23 (c) The data system developed and implemented by the commissioner shall incorporate
132.24 a system of data security that allows the commissioner to control access to the data field
132.25 level by the commissioner's employees. The commissioner shall establish that employees
132.26 have access to the minimum amount of private data on any individual as is necessary to
132.27 perform their duties under this chapter.

132.28 (d) The commissioner shall oversee regular quality and compliance audits of the
132.29 authorized fingerprint collection vendor or vendors.

133.1 Sec. 44. Minnesota Statutes 2020, section 256B.0949, is amended by adding a subdivision
133.2 to read:

133.3 Subd. 16a. **Background studies.** The requirements for background studies under this
133.4 section shall be met by an early intensive developmental and behavioral intervention services
133.5 agency through the commissioner's NETStudy system as provided under sections 245C.03,
133.6 subdivision 15, and 245C.10, subdivision 17.

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

133.8 Sec. 45. Minnesota Statutes 2020, section 260C.215, subdivision 4, is amended to read:

133.9 Subd. 4. **Duties of commissioner.** The commissioner of human services shall:

133.10 (1) provide practice guidance to responsible social services agencies and licensed
133.11 child-placing agencies that reflect federal and state laws and policy direction on placement
133.12 of children;

133.13 (2) develop criteria for determining whether a prospective adoptive or foster family has
133.14 the ability to understand and validate the child's cultural background;

133.15 (3) provide a standardized training curriculum for adoption and foster care workers and
133.16 administrators who work with children. Training must address the following objectives:

133.17 (i) developing and maintaining sensitivity to all cultures;

133.18 (ii) assessing values and their cultural implications;

133.19 (iii) making individualized placement decisions that advance the best interests of a
133.20 particular child under section 260C.212, subdivision 2; and

133.21 (iv) issues related to cross-cultural placement;

133.22 (4) provide a training curriculum for all prospective adoptive and foster families that
133.23 prepares them to care for the needs of adoptive and foster children taking into consideration
133.24 the needs of children outlined in section 260C.212, subdivision 2, paragraph (b), and, as
133.25 necessary, preparation is continued after placement of the child and includes the knowledge
133.26 and skills related to reasonable and prudent parenting standards for the participation of the
133.27 child in age or developmentally appropriate activities, according to section 260C.212,
133.28 subdivision 14;

133.29 (5) develop and provide to responsible social services agencies and licensed child-placing
133.30 agencies a home study format to assess the capacities and needs of prospective adoptive
133.31 and foster families. The format must address problem-solving skills; parenting skills; evaluate

134.1 the degree to which the prospective family has the ability to understand and validate the
134.2 child's cultural background, and other issues needed to provide sufficient information for
134.3 agencies to make an individualized placement decision consistent with section 260C.212,
134.4 subdivision 2. For a study of a prospective foster parent, the format must also address the
134.5 capacity of the prospective foster parent to provide a safe, healthy, smoke-free home
134.6 environment. If a prospective adoptive parent has also been a foster parent, any update
134.7 necessary to a home study for the purpose of adoption may be completed by the licensing
134.8 authority responsible for the foster parent's license. If a prospective adoptive parent with
134.9 an approved adoptive home study also applies for a foster care license, the license application
134.10 may be made with the same agency which provided the adoptive home study; ~~and~~

134.11 (6) consult with representatives reflecting diverse populations from the councils
134.12 established under sections 3.922 and 15.0145, and other state, local, and community
134.13 organizations; and

134.14 (7) establish family foster setting licensing guidelines for county agencies and private
134.15 agencies designated or licensed by the commissioner to perform licensing functions and
134.16 activities under section 245A.04. Guidelines that the commissioner establishes under this
134.17 clause shall be considered directives of the commissioner under section 245A.16.

134.18 **EFFECTIVE DATE.** This section is effective July 1, 2023.

134.19 Sec. 46. Laws 2020, First Special Session chapter 7, section 1, as amended by Laws 2020,
134.20 Third Special Session chapter 1, section 3, is amended by adding a subdivision to read:

134.21 **Subd. 5. Waivers and modifications; extension for 180 days.** When the peacetime
134.22 emergency declared by the governor in response to the COVID-19 outbreak expires, is
134.23 terminated, or is rescinded by the proper authority, waiver CV23: modifying background
134.24 study requirements, issued by the commissioner of human services pursuant to Executive
134.25 Orders 20-11 and 20-12, including any amendments to the modification issued before the
134.26 peacetime emergency expires, shall remain in effect for 180 days after the peacetime
134.27 emergency ends.

134.28 **EFFECTIVE DATE.** This section is effective the day following final enactment or
134.29 retroactively from the date the peacetime emergency declared by the governor in response
134.30 to the COVID-19 outbreak ends, whichever is earlier.

135.1 Sec. 47. **CHILD FOSTER CARE LICENSING GUIDELINES.**

135.2 By July 1, 2023, the commissioner of human services shall, in consultation with
135.3 stakeholders with expertise in child protection and children's behavioral health, develop
135.4 family foster setting licensing guidelines for county agencies and private agencies that
135.5 perform licensing functions. Stakeholders include but are not limited to child advocates,
135.6 representatives from community organizations, representatives of the state ethnic councils,
135.7 the ombudsperson for families, family foster setting providers, youth who have experienced
135.8 family foster setting placements, county child protection staff, and representatives of county
135.9 and private licensing agencies.

135.10 Sec. 48. **REVISOR INSTRUCTION.**

135.11 The revisor of statutes shall renumber Minnesota Statutes, section 245C.02, so that the
135.12 subdivisions are alphabetical. The revisor shall correct any cross-references that arise as a
135.13 result of the renumbering.

135.14 Sec. 49. **REPEALER.**

135.15 Minnesota Statutes 2020, section 245C.10, subdivisions 2, 2a, 3, 4, 5, 6, 7, 8, 9, 9a, 10,
135.16 11, 12, 13, 14, and 16, are repealed.

135.17 **ARTICLE 3**

135.18 **HEALTH DEPARTMENT**

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

135.20 Subdivision 1. **Implementation.** The commissioner of health, in consultation with the
135.21 e-Health Advisory Committee, shall develop uniform standards to be used for the
135.22 interoperable electronic health records system for sharing and synchronizing patient data
135.23 across systems. The standards must be compatible with federal efforts. The uniform standards
135.24 must be developed by January 1, 2009, and updated on an ongoing basis. ~~The commissioner~~
135.25 ~~shall include an update on standards development as part of an annual report to the legislature.~~
135.26 Individual health care providers in private practice with no other providers and health care
135.27 providers that do not accept reimbursement from a group purchaser, as defined in section
135.28 62J.03, subdivision 6, are excluded from the requirements of this section.

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

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

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

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

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

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

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

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

136.30 ~~(d)~~ This subdivision expires June 30, ~~2024~~ 2031.

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

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

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

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

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

137.13 (d) The electronic health record must meet the standards established according to section
137.14 3004 of the HITECH Act as applicable.

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

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

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

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

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

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

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

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

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

138.11 ~~(3)~~ (1) providing financial and technical support to Minnesota health care providers to
138.12 encourage implementation of admission, discharge and transfer alerts, and care summary
138.13 document exchange transactions and to evaluate the impact of health information technology
138.14 on cost and quality of care. Communications about available financial and technical support
138.15 shall include clear information about the interoperable health record requirements in
138.16 subdivision 1, including a separate statement in bold-face type clarifying the exceptions to
138.17 those requirements;

138.18 ~~(4)~~ (2) providing educational resources and technical assistance to health care providers
138.19 and patients related to state and national privacy, security, and consent laws governing
138.20 clinical health information, including the requirements in sections 144.291 to 144.298. In
138.21 carrying out these activities, the commissioner's technical assistance does not constitute
138.22 legal advice;

138.23 ~~(5)~~ (3) assessing Minnesota's legal, financial, and regulatory framework for health
138.24 information exchange, including the requirements in sections 144.291 to 144.298, and
138.25 making recommendations for modifications that would strengthen the ability of Minnesota
138.26 health care providers to securely exchange data in compliance with patient preferences and
138.27 in a way that is efficient and financially sustainable; and

138.28 ~~(6)~~ (4) seeking public input on both patient impact and costs associated with requirements
138.29 related to patient consent for release of health records for the purposes of treatment, payment,
138.30 and health care operations, as required in section 144.293, subdivision 2. The commissioner
138.31 shall provide a report to the legislature on the findings of this public input process no later
138.32 than February 1, 2017.

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

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

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

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

139.11 (3) ~~monitoring and responding to activity related to the development of quality measures~~
139.12 ~~and other measures as required by section 4101 of the HITECH Act. Any response related~~
139.13 ~~to quality measures shall consider and address the quality efforts required under chapter~~
139.14 ~~62U; and~~

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

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

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

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

139.29 Sec. 5. Minnesota Statutes 2020, section 62J.497, subdivision 1, is amended to read:

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

140.1 ~~(b) "Backward compatible" means that the newer version of a data transmission standard~~
140.2 ~~would retain, at a minimum, the full functionality of the versions previously adopted, and~~
140.3 ~~would permit the successful completion of the applicable transactions with entities that~~
140.4 ~~continue to use the older versions.~~

140.5 ~~(e)~~ (b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision
140.6 30. Dispensing does not include the direct administering of a controlled substance to a
140.7 patient by a licensed health care professional.

140.8 ~~(d)~~ (c) "Dispenser" means a person authorized by law to dispense a controlled substance,
140.9 pursuant to a valid prescription.

140.10 ~~(e)~~ (d) "Electronic media" has the meaning given under Code of Federal Regulations,
140.11 title 45, part 160.103.

140.12 ~~(f)~~ (e) "E-prescribing" means the transmission using electronic media of prescription or
140.13 prescription-related information between a prescriber, dispenser, pharmacy benefit manager,
140.14 or group purchaser, either directly or through an intermediary, including an e-prescribing
140.15 network. E-prescribing includes, but is not limited to, two-way transmissions between the
140.16 point of care and the dispenser and two-way transmissions related to eligibility, formulary,
140.17 and medication history information.

140.18 ~~(g)~~ (f) "Electronic prescription drug program" means a program that provides for
140.19 e-prescribing.

140.20 ~~(h)~~ (g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

140.21 ~~(i)~~ (h) "HL7 messages" means a standard approved by the standards development
140.22 organization known as Health Level Seven.

140.23 ~~(j)~~ (i) "National Provider Identifier" or "NPI" means the identifier described under Code
140.24 of Federal Regulations, title 45, part 162.406.

140.25 ~~(k)~~ (j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

140.26 ~~(l)~~ (k) "NCPDP Formulary and Benefits Standard" means the most recent version of the
140.27 National Council for Prescription Drug Programs Formulary and Benefits Standard;
140.28 Implementation Guide, Version 1, Release 0, October 2005 or the most recent standard
140.29 adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare
140.30 Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act and regulations
140.31 adopted under it. The standards shall be implemented according to the Centers for Medicare
140.32 and Medicaid Services schedule for compliance.

141.1 ~~(m)~~ (l) "NCPDP SCRIPT Standard" means the most recent version of the National
 141.2 Council for Prescription Drug Programs ~~Prescriber/Pharmacist Interface~~ SCRIPT Standard,
 141.3 ~~Implementation Guide Version 8, Release 1 (Version 8.1), October 2005,~~ or the most recent
 141.4 standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under
 141.5 Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and
 141.6 regulations adopted under it. The standards shall be implemented according to the Centers
 141.7 for Medicare and Medicaid Services schedule for compliance. ~~Subsequently released versions~~
 141.8 ~~of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard~~
 141.9 ~~is backward compatible to the current version adopted by the Centers for Medicare and~~
 141.10 ~~Medicaid Services.~~

141.11 ~~(n)~~ (m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

141.12 ~~(o)~~ (n) "Prescriber" means a licensed health care practitioner, other than a veterinarian,
 141.13 as defined in section 151.01, subdivision 23.

141.14 ~~(p)~~ (o) "Prescription-related information" means information regarding eligibility for
 141.15 drug benefits, medication history, or related health or drug information.

141.16 ~~(q)~~ (p) "Provider" or "health care provider" has the meaning given in section 62J.03,
 141.17 subdivision 8.

141.18 Sec. 6. Minnesota Statutes 2020, section 62J.497, subdivision 3, is amended to read:

141.19 Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use
 141.20 the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related
 141.21 information. ~~The NCPDP SCRIPT Standard shall be used to conduct the following~~
 141.22 ~~transactions:~~

141.23 ~~(1) get message transaction;~~

141.24 ~~(2) status response transaction;~~

141.25 ~~(3) error response transaction;~~

141.26 ~~(4) new prescription transaction;~~

141.27 ~~(5) prescription change request transaction;~~

141.28 ~~(6) prescription change response transaction;~~

141.29 ~~(7) refill prescription request transaction;~~

141.30 ~~(8) refill prescription response transaction;~~

141.31 ~~(9) verification transaction;~~

142.1 ~~(10) password change transaction;~~

142.2 ~~(11) cancel prescription request transaction; and~~

142.3 ~~(12) cancel prescription response transaction.~~

142.4 (b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT
142.5 Standard for communicating and transmitting medication history information.

142.6 (c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP
142.7 Formulary and Benefits Standard for communicating and transmitting formulary and benefit
142.8 information.

142.9 (d) Providers, group purchasers, prescribers, and dispensers must use the national provider
142.10 identifier to identify a health care provider in e-prescribing or prescription-related transactions
142.11 when a health care provider's identifier is required.

142.12 (e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility
142.13 information and conduct health care eligibility benefit inquiry and response transactions
142.14 according to the requirements of section 62J.536.

142.15 Sec. 7. Minnesota Statutes 2020, section 62J.498, is amended to read:

142.16 **62J.498 HEALTH INFORMATION EXCHANGE.**

142.17 Subdivision 1. **Definitions.** (a) The following definitions apply to sections 62J.498 to
142.18 62J.4982:

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

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

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

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

143.1 (f) "Health data intermediary" means an entity that provides the technical capabilities
143.2 or related products and services to enable health information exchange among health care
143.3 providers that are not related health care entities as defined in section 144.291, subdivision
143.4 2, paragraph (k). This includes but is not limited to health information service providers
143.5 (HISP), electronic health record vendors, and pharmaceutical electronic data intermediaries
143.6 as defined in section 62J.495.

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

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

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

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

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

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

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

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

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

144.1 ~~(m) "Meaningful use" means use of certified electronic health record technology to~~
 144.2 ~~improve quality, safety, and efficiency and reduce health disparities; engage patients and~~
 144.3 ~~families; improve care coordination and population and public health; and maintain privacy~~
 144.4 ~~and security of patient health information as established by the Centers for Medicare and~~
 144.5 ~~Medicaid Services and the Minnesota Department of Human Services pursuant to sections~~
 144.6 ~~4101, 4102, and 4201 of the HITECH Act.~~

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

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

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

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

144.19 (3) a group, professional corporation, or other organization that provides the services of
 144.20 individuals or entities identified in clause (2), including but not limited to a medical clinic,
 144.21 a medical group, a home health care agency, an urgent care center, and an emergent care
 144.22 center;

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

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

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

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

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

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

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

145.6 (2) require information to be provided as needed from health information exchange
145.7 service providers in order to meet requirements established under sections 62J.498 to
145.8 62J.4982;

145.9 ~~(2)~~ (3) provide ongoing monitoring to ensure compliance with criteria established under
145.10 sections 62J.498 to 62J.4982;

145.11 ~~(3)~~ (4) respond to public complaints related to health information exchange services;

145.12 ~~(4)~~ (5) take enforcement actions as necessary, including the imposition of fines,
145.13 suspension, or revocation of certificates of authority as outlined in section 62J.4982;

145.14 ~~(5)~~ (6) provide a biennial report on the status of health information exchange services
145.15 that includes but is not limited to:

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

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

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

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

145.25 ~~(6)~~ (7) other duties necessary to protect the public interest.

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

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

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

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

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

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

146.14 Sec. 8. Minnesota Statutes 2020, section 62J.4981, is amended to read:

146.15 **62J.4981 CERTIFICATE OF AUTHORITY TO PROVIDE HEALTH**
146.16 **INFORMATION EXCHANGE SERVICES.**

146.17 Subdivision 1. **Authority to require organizations to apply.** The commissioner shall
146.18 require ~~a health data intermediary~~ or a health information organization to apply for a
146.19 certificate of authority under this section. An applicant may continue to operate until the
146.20 commissioner acts on the application. If the application is denied, the applicant is considered
146.21 a health information exchange service provider whose certificate of authority has been
146.22 revoked under section 62J.4982, subdivision 2, paragraph (d).

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

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

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

147.4 ~~(1) hold reciprocal agreements with at least one state-certified health information~~
147.5 ~~organization to access patient data, and for the transmission and receipt of clinical~~
147.6 ~~transactions. Reciprocal agreements must meet the requirements established in subdivision~~
147.7 ~~5; and~~

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

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

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

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

147.23 (1) the entity is a legally established organization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

149.29 (4) a copy of each standard agreement or contract intended to bind the participating
149.30 entities and the health information ~~exchange service provider~~ organization. Contractual
149.31 provisions shall be consistent with the purposes of this section, in regard to the services to
149.32 be performed under the standard agreement or contract, the manner in which payment for

150.1 services is determined, the nature and extent of responsibilities to be retained by the health
150.2 information organization, and contractual termination provisions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

151.20 Sec. 9. Minnesota Statutes 2020, section 62J.4982, is amended to read:

151.21 **62J.4982 ENFORCEMENT AUTHORITY; COMPLIANCE.**

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

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

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

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

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

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

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

152.5 (7) whether the violation was intentional;

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

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

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

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

152.15 (12) the financial condition of the health information ~~exchange service provider~~
152.16 organization including, but not limited to, whether the health information ~~exchange service~~
152.17 ~~provider~~ organization had financial difficulties that affected its ability to comply or whether
152.18 the imposition of an administrative monetary penalty would jeopardize the ability of the
152.19 health information ~~exchange service provider~~ organization to continue to deliver health
152.20 information exchange services.

152.21 The commissioner shall give reasonable notice in writing to the health information
152.22 ~~exchange service provider~~ organization of the intent to levy the penalty and the reasons for
152.23 it. A health information ~~exchange service provider~~ organization may have 15 days within
152.24 which to contest whether the facts found constitute a violation of sections 62J.4981 and
152.25 62J.4982, according to the contested case and judicial review provisions of sections 14.57
152.26 to 14.69.

152.27 (b) If the commissioner has reason to believe that a violation of section 62J.4981 or
152.28 62J.4982 has occurred or is likely, the commissioner may confer with the persons involved
152.29 before commencing action under subdivision 2. The commissioner may notify the health
152.30 information ~~exchange service provider~~ organization and the representatives, or other persons
152.31 who appear to be involved in the suspected violation, to arrange a voluntary conference
152.32 with the alleged violators or their authorized representatives. The purpose of the conference
152.33 is to attempt to learn the facts about the suspected violation and, if it appears that a violation

153.1 has occurred or is threatened, to find a way to correct or prevent it. The conference is not
153.2 governed by any formal procedural requirements, and may be conducted as the commissioner
153.3 considers appropriate.

153.4 (c) The commissioner may issue an order directing a health information ~~exchange service~~
153.5 ~~provider~~ organization or a representative of a health information ~~exchange service provider~~
153.6 organization to cease and desist from engaging in any act or practice in violation of sections
153.7 62J.4981 and 62J.4982.

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

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

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

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

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

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

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

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

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

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

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

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

154.14 (d) If the certificate of authority of a health information ~~exchange service provider~~
154.15 organization is revoked, the organization shall proceed, immediately following the effective
154.16 date of the order of revocation, to wind up its affairs, and shall conduct no further business
154.17 except as necessary to the orderly conclusion of the affairs of the organization. The
154.18 organization shall engage in no further advertising or solicitation. The commissioner may,
154.19 by written order, permit further operation of the organization as the commissioner finds to
154.20 be in the best interest of participating entities, to the end that participating entities will be
154.21 given the greatest practical opportunity to access continuing health information exchange
154.22 services.

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

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

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

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

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

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

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

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

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

155.17 Subd. 4. **Coordination.** The commissioner shall, to the extent possible, seek the advice
155.18 of the Minnesota e-Health Advisory Committee, in the review and update of criteria for the
155.19 certification and recertification of health information ~~exchange service providers~~
155.20 organizations when implementing sections 62J.498 to 62J.4982.

155.21 Subd. 5. **Fees and monetary penalties.** (a) The commissioner shall assess fees on every
155.22 health information ~~exchange service provider~~ organization subject to sections 62J.4981 and
155.23 62J.4982 as follows:

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

155.26 (2) ~~filing an application for certificate of authority to operate as a health data intermediary,~~
155.27 ~~\$7,000;~~

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

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

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

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

156.4 Sec. 10. Minnesota Statutes 2020, section 62J.63, subdivision 1, is amended to read:

156.5 Subdivision 1. **Establishment; administration** Support for state health care
156.6 purchasing and performance measurement. The commissioner of health shall establish
156.7 and administer the Center for Health Care Purchasing Improvement as an administrative
156.8 unit within the Department of Health. The Center for Health Care Purchasing Improvement
156.9 shall support the state in its efforts to be a more prudent and efficient purchaser of quality
156.10 health care services. The center shall, aid the state in developing and using more common
156.11 strategies and approaches for health care performance measurement and health care
156.12 purchasing. The common strategies and approaches shall, promote greater transparency of
156.13 health care costs and quality; and greater accountability for health care results and
156.14 improvement. The center shall also, and identify barriers to more efficient, effective, quality
156.15 health care and options for overcoming the barriers.

156.16 Sec. 11. Minnesota Statutes 2020, section 62J.63, subdivision 2, is amended to read:

156.17 Subd. 2. **Staffing; Duties; scope.** (a) The commissioner of health may appoint a director,
156.18 and up to three additional senior-level staff or codirectors, and other staff as needed who
156.19 are under the direction of the commissioner. The staff of the center are in the unclassified
156.20 service.:

156.21 (b) ~~With the authorization of the commissioner of health, and in consultation or~~
156.22 ~~interagency agreement with the appropriate commissioners of state agencies, the director,~~
156.23 ~~or codirectors, may:~~

156.24 (1) ~~initiate projects to develop plan designs for state health care purchasing;~~

156.25 (2) (1) require reports or surveys to evaluate the performance of current health care
156.26 purchasing or administrative simplification strategies;

156.27 (3) (2) calculate fiscal impacts, including net savings and return on investment, of health
156.28 care purchasing strategies and initiatives;

156.29 (4) ~~conduct policy audits of state programs to measure conformity to state statute or~~
156.30 ~~other purchasing initiatives or objectives;~~

157.1 ~~(5)~~ (3) support the Administrative Uniformity Committee under ~~section~~ sections 62J.50
157.2 and 62J.536 and other relevant groups or activities to advance agreement on health care
157.3 administrative process streamlining;

157.4 ~~(6) consult with the Health Economics Unit of the Department of Health regarding~~
157.5 ~~reports and assessments of the health care marketplace;~~

157.6 ~~(7) consult with the Department of Commerce regarding health care regulatory issues~~
157.7 ~~and legislative initiatives;~~

157.8 ~~(8) work with appropriate Department of Human Services staff and the Centers for~~
157.9 ~~Medicare and Medicaid Services to address federal requirements and conformity issues for~~
157.10 ~~health care purchasing;~~

157.11 ~~(9) assist the Minnesota Comprehensive Health Association in health care purchasing~~
157.12 ~~strategies;~~

157.13 ~~(10) convene medical directors of agencies engaged in health care purchasing for advice,~~
157.14 ~~collaboration, and exploring possible synergies;~~

157.15 ~~(11)~~ (4) contact and participate with other relevant health care task forces, study activities,
157.16 and similar efforts with regard to health care performance measurement and
157.17 performance-based purchasing; and

157.18 ~~(12)~~ (5) assist in seeking external funding through appropriate grants or other funding
157.19 opportunities and may administer grants and externally funded projects.

157.20 Sec. 12. Minnesota Statutes 2020, section 62U.04, subdivision 4, is amended to read:

157.21 Subd. 4. **Encounter data.** ~~(a) Beginning July 1, 2009, and every six months thereafter,~~
157.22 All health plan companies and third-party administrators shall submit encounter data on a
157.23 monthly basis to a private entity designated by the commissioner of health. The data shall
157.24 be submitted in a form and manner specified by the commissioner subject to the following
157.25 requirements:

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

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

158.1 (3) except for the identifier described in clause (2), the data must not include information
158.2 that is not included in a health care claim or equivalent encounter information transaction
158.3 that is required under section 62J.536.

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

158.10 (c) Data on providers collected under this subdivision are private data on individuals or
158.11 nonpublic data, as defined in section 13.02. Notwithstanding the data classifications in this
158.12 paragraph, data on providers collected under this subdivision may be released or published
158.13 as authorized in subdivision 11. Notwithstanding the definition of summary data in section
158.14 13.02, subdivision 19, summary data prepared under this subdivision may be derived from
158.15 nonpublic data. The commissioner or the commissioner's designee shall establish procedures
158.16 and safeguards to protect the integrity and confidentiality of any data that it maintains.

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

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

158.25 Sec. 13. Minnesota Statutes 2020, section 62U.04, subdivision 5, is amended to read:

158.26 Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter,
158.27 all health plan companies and third-party administrators shall submit data on their contracted
158.28 prices with health care providers to a private entity designated by the commissioner of health
158.29 for the purposes of performing the analyses required under this subdivision. The data shall
158.30 be submitted in the form and manner specified by the commissioner of health.

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

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

159.4 (c) Data collected under this subdivision are nonpublic data as defined in section 13.02.
159.5 Notwithstanding the data classification in this paragraph, data collected under this subdivision
159.6 may be released or published as authorized in subdivision 11. Notwithstanding the definition
159.7 of summary data in section 13.02, subdivision 19, summary data prepared under this section
159.8 may be derived from nonpublic data. The commissioner shall establish procedures and
159.9 safeguards to protect the integrity and confidentiality of any data that it maintains.

159.10 Sec. 14. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

159.11 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
159.12 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
159.13 designee shall only use the data submitted under subdivisions 4 and 5 for the following
159.14 purposes:

159.15 (1) to evaluate the performance of the health care home program as authorized under
159.16 section 62U.03, subdivision 7;

159.17 (2) to study, in collaboration with the reducing avoidable readmissions effectively
159.18 (RARE) campaign, hospital readmission trends and rates;

159.19 (3) to analyze variations in health care costs, quality, utilization, and illness burden based
159.20 on geographical areas or populations;

159.21 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments
159.22 of Health and Human Services, including the analysis of health care cost, quality, and
159.23 utilization baseline and trend information for targeted populations and communities; and

159.24 (5) to compile one or more public use files of summary data or tables that must:

159.25 (i) be available to the public for no or minimal cost by March 1, 2016, and available by
159.26 web-based electronic data download by June 30, 2019;

159.27 (ii) not identify individual patients, ~~or payers, or providers~~ but that may identify the
159.28 rendering or billing hospital, clinic, or medical practice;

159.29 (iii) be updated by the commissioner, at least annually, with the most current data
159.30 available;

160.1 (iv) contain clear and conspicuous explanations of the characteristics of the data, such
160.2 as the dates of the data contained in the files, the absence of costs of care for uninsured
160.3 patients or nonresidents, and other disclaimers that provide appropriate context; and

160.4 (v) not lead to the collection of additional data elements beyond what is authorized under
160.5 this section as of June 30, 2015.

160.6 (b) The commissioner may publish the results of the authorized uses identified in
160.7 paragraph (a) ~~so long as the data released publicly do not contain information or descriptions~~
160.8 ~~in which the identity of individual hospitals, clinics, or other providers may be discerned.~~
160.9 The data published under this paragraph may identify hospitals, clinics, and medical practices
160.10 so long as no individual health professionals are identified and the commissioner finds the
160.11 data to be accurate, valid, and suitable for publication for such use.

160.12 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from
160.13 using the data collected under subdivision 4 to complete the state-based risk adjustment
160.14 system assessment due to the legislature on October 1, 2015.

160.15 (d) The commissioner or the commissioner's designee may use the data submitted under
160.16 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
160.17 2023.

160.18 (e) The commissioner shall consult with the all-payer claims database work group
160.19 established under subdivision 12 regarding the technical considerations necessary to create
160.20 the public use files of summary data described in paragraph (a), clause (5).

160.21 Sec. 15. Minnesota Statutes 2020, section 103H.201, subdivision 1, is amended to read:

160.22 Subdivision 1. **Procedure.** (a) If groundwater quality monitoring results show that there
160.23 is a degradation of groundwater, the commissioner of health may promulgate health risk
160.24 limits under subdivision 2 for substances degrading the groundwater.

160.25 (b) Health risk limits shall be determined by two methods depending on their toxicological
160.26 end point.

160.27 (c) For systemic toxicants that are not carcinogens, the adopted health risk limits shall
160.28 be derived using United States Environmental Protection Agency risk assessment methods
160.29 using a reference dose, a drinking water equivalent, and a relative source contribution factor.

160.30 (d) For toxicants that are known or probable carcinogens, the adopted health risk limits
160.31 shall be derived from a quantitative estimate of the chemical's carcinogenic potency published

161.1 by the United States Environmental Protection Agency ~~and~~ or determined by the
161.2 commissioner to have undergone thorough scientific review.

161.3 **Sec. 16. [144.066] DISTRIBUTION OF COVID-19 VACCINES.**

161.4 **Subdivision 1. Definitions.** (a) The terms defined in this subdivision apply to this section
161.5 and sections 144.0661 to 144.0663.

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

161.7 (c) "COVID-19 vaccine" means a vaccine against severe acute respiratory syndrome
161.8 coronavirus 2 (SARS-CoV-2).

161.9 (d) "Department" means the Department of Health.

161.10 (e) "Disproportionately impacted community" means a community or population that
161.11 has been disproportionately and negatively impacted by the COVID-19 pandemic.

161.12 (f) "Local health department" has the meaning given in section 145A.02, subdivision
161.13 8b.

161.14 (g) "Mobile vaccination vehicle" means a vehicle-mounted unit that is either motorized
161.15 or trailered, that is readily movable without disassembling, and at which vaccines are
161.16 provided in more than one geographic location.

161.17 **Subd. 2. Distribution.** The commissioner shall establish and maintain partnerships or
161.18 agreements with local health departments; local health care providers, including community
161.19 health centers and primary care providers; and local pharmacies to administer COVID-19
161.20 vaccines throughout the state. COVID-19 vaccines may also be administered via mobile
161.21 vaccination vehicles authorized under section 144.0662.

161.22 **Subd. 3. Second dose or booster.** For all COVID-19 vaccines for which a second dose
161.23 or booster is required, during the first vaccine appointment the registered vaccine provider
161.24 should be directed by the department during the vaccine provider registration process to
161.25 assist vaccine recipients with scheduling an appointment for the second dose or booster.
161.26 This assistance may be provided during the observation period following vaccine
161.27 administration.

161.28 **Subd. 4. Nondiscrimination.** Nothing in sections 144.066 to 144.0663 shall be construed
161.29 to allow or require the denial of any benefit or opportunity on the basis of race, color, creed,
161.30 marital status, status with regard to public assistance, disability, genetic information, sexual
161.31 orientation, age, religion, national origin, sex, or membership in a local human rights
161.32 commission.

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

162.2 Sec. 17. **[144.0661] EQUITABLE COVID-19 VACCINE DISTRIBUTION.**

162.3 Subdivision 1. **COVID-19 vaccination equity and outreach.** The commissioner shall
162.4 establish positions to continue the department's COVID-19 vaccination equity and outreach
162.5 activities and to plan and implement actions and programs to overcome disparities in
162.6 COVID-19 vaccination rates that are rooted in historic and current racism; biases based on
162.7 ethnicity, income, primary language, immigration status, or disability; geography; or
162.8 transportation access, language access, or Internet access. This work shall be managed by
162.9 a director who shall serve in a leadership role in the department's COVID-19 response.

162.10 Subd. 2. **Vaccine education and outreach campaign; direct delivery of**
162.11 **information.** (a) The commissioner shall administer a COVID-19 vaccine education and
162.12 outreach campaign that engages in direct delivery of information to members of
162.13 disproportionately impacted communities. In this campaign, the commissioner shall contract
162.14 with community-based organizations including community faith-based organizations, tribal
162.15 governments, local health departments, and local health care providers, including community
162.16 health centers and primary care providers, to deliver the following information in a culturally
162.17 relevant and linguistically appropriate manner:

162.18 (1) medically and scientifically accurate information on the safety, efficacy, science,
162.19 and benefits of vaccines generally and COVID-19 vaccines in particular;

162.20 (2) information on how members of disproportionately impacted communities may
162.21 obtain a COVID-19 vaccine including, if applicable, obtaining a vaccine from a mobile
162.22 vaccination vehicle; and

162.23 (3) measures to prevent transmission of COVID-19, including adequate indoor ventilation,
162.24 wearing face coverings, and physical distancing from individuals outside the household.

162.25 (b) This information must be delivered directly by methods that include phone calls,
162.26 text messages, physically distanced door-to-door and street canvassing, and digital
162.27 event-based communication involving live and interactive messengers. For purposes of this
162.28 subdivision, direct delivery shall not include delivery by television, radio, newspaper, or
162.29 other forms of mass media.

162.30 Subd. 3. **Vaccine education and outreach campaign; mass media.** The commissioner
162.31 shall administer a mass media campaign to provide COVID-19 vaccine education and
162.32 outreach to members of disproportionately impacted communities. In this campaign, the
162.33 commissioner shall contract with media vendors to provide the following information to

163.1 members of disproportionately impacted communities in a manner that is culturally relevant
163.2 and linguistically appropriate:

163.3 (1) medically and scientifically accurate information on the safety, efficacy, science,
163.4 and benefits of COVID-19 vaccines; and

163.5 (2) information on how members of disproportionately impacted communities may
163.6 obtain a COVID-19 vaccine.

163.7 Subd. 4. **Community assistance.** The commissioner shall administer a program to help
163.8 members of disproportionately impacted communities arrange for and prepare to obtain a
163.9 COVID-19 vaccine and to support transportation-limited members of these communities
163.10 with transportation to vaccination appointments or otherwise arrange for vaccine providers
163.11 to reach members of these communities.

163.12 Subd. 5. **Equitable distribution of COVID-19 vaccines.** The commissioner shall
163.13 establish a set of metrics to measure the equitable distribution of COVID-19 vaccines in
163.14 the state, and shall set and periodically update goals for COVID-19 vaccine distribution in
163.15 the state that are focused on equity.

163.16 Subd. 6. **Expiration of programs.** The vaccine education and outreach programs in
163.17 subdivisions 2 and 3 and the community assistance program in subdivision 4 shall operate
163.18 until a sufficient percentage of individuals in each county or census tract have received the
163.19 full series of COVID-19 vaccines to protect individuals in each county or census tract from
163.20 COVID-19.

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

163.22 Sec. 18. **[144.0662] MOBILE VACCINATION PROGRAM.**

163.23 Subdivision 1. **Administration.** The commissioner, in partnership with local health
163.24 departments and the regional health care coalitions, shall administer a mobile vaccination
163.25 program in which mobile vaccination vehicles are deployed to communities around the state
163.26 to provide COVID-19 vaccines to individuals. The commissioner shall deploy mobile
163.27 vaccination vehicles to communities to improve access to vaccines based on factors that
163.28 include but are not limited to vulnerability, likelihood of exposure, limits to transportation
163.29 access, rate of vaccine uptake, and limited access to vaccines or barriers to obtaining vaccines.

163.30 Subd. 2. **Eligibility.** Notwithstanding the phases and priorities of the state's COVID-19
163.31 allocation and prioritization plan or guidance, all individuals in a community to which a
163.32 mobile vaccination vehicle is deployed shall be eligible to receive COVID-19 vaccines from
163.33 the vehicle.

164.1 Subd. 3. **Staffing.** Each mobile vaccination vehicle must be staffed in accordance with
164.2 Centers for Disease Control and Prevention guidelines and may be staffed with additional
164.3 support staff based on needs determined by local request. Additional support staff may
164.4 include but are not limited to community partners and translators.

164.5 Subd. 4. **Second doses.** For vaccine recipients who receive a first dose of a COVID-19
164.6 vaccine from a mobile vaccination vehicle, vehicle staff shall provide assistance in scheduling
164.7 an appointment with a mobile vaccination vehicle or with another vaccine provider for any
164.8 needed second dose or booster. The commissioner shall, to the extent possible, deploy
164.9 mobile vaccination vehicles in a manner that allows vaccine recipients to receive second
164.10 doses or boosters from a mobile vaccination vehicle.

164.11 Subd. 5. **Expiration.** The commissioner shall administer the mobile vaccination vehicle
164.12 program until a sufficient percentage of individuals in each county or census tract have
164.13 received the full series of COVID-19 vaccines to protect individuals in each county or
164.14 census tract from the spread of COVID-19.

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

164.16 Sec. 19. **[144.0663] COVID-19 VACCINATION PLAN AND DATA; REPORTS.**

164.17 Subdivision 1. **COVID-19 vaccination plan; implementation protocols.** The
164.18 commissioner shall:

164.19 (1) publish the set of metrics and goals for equitable COVID-19 vaccine distribution
164.20 established by the commissioner under section 144.0661, subdivision 5; and

164.21 (2) publish implementation protocols to address the disparities in COVID-19 vaccination
164.22 rates in certain communities and ensure that members of disproportionately impacted
164.23 communities are given adequate access to COVID-19 vaccines.

164.24 Subd. 2. **Data on COVID-19 vaccines.** On at least a weekly basis, the commissioner
164.25 shall publish on the department website:

164.26 (1) data measuring compliance with the set of metrics and goals for equitable COVID-19
164.27 vaccine distribution established by the commissioner under section 144.0661, subdivision
164.28 5; and

164.29 (2) summary data on individuals who have received one or two doses of a COVID-19
164.30 vaccine, broken out by race, gender, ethnicity, age within an age range, and zip code.

165.1 Subd. 3. Quarterly reports. On a quarterly basis while funds are available, the
165.2 commissioner shall report to the chairs and ranking minority members of the legislative
165.3 committees with jurisdiction over finance, ways and means, and health care:

165.4 (1) funds distributed to local health departments for COVID-19 activities and the sources
165.5 of the funds; and

165.6 (2) funds expended to implement sections 144.066 to 144.0663.

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

165.8 Sec. 20. Minnesota Statutes 2020, section 144.0724, subdivision 1, is amended to read:

165.9 Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner
165.10 of health shall establish resident reimbursement case mix classifications based upon the
165.11 assessments of residents of nursing homes and boarding care homes conducted under this
165.12 section and according to section 256R.17.

165.13 Sec. 21. Minnesota Statutes 2020, section 144.0724, subdivision 2, is amended to read:

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

165.16 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
165.17 periods in the MDS assessment process. This look-back period is also called the observation
165.18 or assessment period.

165.19 (b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

165.20 (c) "Index maximization" means classifying a resident who could be assigned to more
165.21 than one category, to the category with the highest case mix index.

165.22 (d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment,
165.23 and functional status elements, that include common definitions and coding categories
165.24 specified by the Centers for Medicare and Medicaid Services and designated by the
165.25 ~~Minnesota~~ Department of Health.

165.26 (e) "Representative" means a person who is the resident's guardian or conservator, the
165.27 person authorized to pay the nursing home expenses of the resident, a representative of the
165.28 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
165.29 other individual designated by the resident.

166.1 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
166.2 facility's residents according to their clinical and functional status identified in data supplied
166.3 by the facility's Minimum Data Set.

166.4 (g) "Activities of daily living" ~~means grooming,~~ includes personal hygiene, dressing,
166.5 bathing, transferring, bed mobility, ~~positioning,~~ locomotion, eating, and toileting.

166.6 (h) "Nursing facility level of care determination" means the assessment process that
166.7 results in a determination of a resident's or prospective resident's need for nursing facility
166.8 level of care as established in subdivision 11 for purposes of medical assistance payment
166.9 of long-term care services for:

166.10 (1) nursing facility services under section 256B.434 or chapter 256R;

166.11 (2) elderly waiver services under chapter 256S;

166.12 (3) CADI and BI waiver services under section 256B.49; and

166.13 (4) state payment of alternative care services under section 256B.0913.

166.14 Sec. 22. Minnesota Statutes 2020, section 144.0724, subdivision 3a, is amended to read:

166.15 Subd. 3a. **Resident reimbursement case mix classifications beginning January 1,**
166.16 **2012.** (a) Beginning January 1, 2012, resident reimbursement case mix classifications shall
166.17 be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor
166.18 version mandated by the Centers for Medicare and Medicaid Services that nursing facilities
166.19 are required to complete for all residents. The commissioner of health shall establish resident
166.20 classifications according to the RUG-IV, 48 group, resource utilization groups. Resident
166.21 classification must be established based on the individual items on the Minimum Data Set,
166.22 which must be completed according to the Long Term Care Facility Resident Assessment
166.23 Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare
166.24 and Medicaid Services.

166.25 (b) Each resident must be classified based on the information from the Minimum Data
166.26 Set according to general categories as ~~defined in the Case Mix Classification Manual for~~
166.27 ~~Nursing Facilities~~ issued by the Minnesota Department of Health.

166.28 Sec. 23. Minnesota Statutes 2020, section 144.0724, subdivision 5, is amended to read:

166.29 Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an
166.30 admission assessment for all residents who stay in the facility 14 days or less-, unless the
166.31 resident is admitted and discharged from the facility on the same day, in which case the

167.1 admission assessment is not required. When an admission assessment is not submitted, the
167.2 case mix classification shall be the rate with a case mix index of 1.0.

167.3 (b) Notwithstanding the admission assessment requirements of paragraph (a), a facility
167.4 may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents
167.5 who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make
167.6 this election annually.

167.7 (c) Nursing facilities must elect one of the options described in paragraphs (a) and (b)
167.8 by reporting to the commissioner of health, as prescribed by the commissioner. The election
167.9 is effective on July 1 each year.

167.10 Sec. 24. Minnesota Statutes 2020, section 144.0724, subdivision 7, is amended to read:

167.11 Subd. 7. **Notice of resident reimbursement case mix classification.** (a) The
167.12 commissioner of health shall provide to a nursing facility a notice for each resident of the
167.13 ~~reimbursement~~ classification established under subdivision 1. The notice must inform the
167.14 resident of the case mix classification ~~that was~~ assigned, the opportunity to review the
167.15 documentation supporting the classification, the opportunity to obtain clarification from the
167.16 commissioner, and the opportunity to request a reconsideration of the classification and the
167.17 address and telephone number of the Office of Ombudsman for Long-Term Care. The
167.18 commissioner must transmit the notice of resident classification by electronic means to the
167.19 nursing facility. ~~A~~ The nursing facility is responsible for the distribution of the notice to
167.20 each resident, ~~to the person responsible for the payment of the resident's nursing home~~
167.21 ~~expenses, or to another person designated by the resident or the resident's representative.~~
167.22 This notice must be distributed within three working business days after the facility's receipt
167.23 ~~of the electronic file of notice of case mix classifications from the commissioner of health.~~

167.24 (b) If a facility submits a ~~modification to the most recent assessment used to establish~~
167.25 ~~a case mix classification conducted under subdivision 3 that results~~ modifying assessment
167.26 resulting in a change in the case mix classification, the facility ~~shall give~~ must provide a
167.27 written notice to the resident or the resident's representative ~~about~~ regarding the item or
167.28 items that was were modified and the reason for the ~~modification~~ modifications. The notice
167.29 ~~of modified assessment may~~ must be provided ~~at the same time that the resident or resident's~~
167.30 ~~representative is provided the resident's modified notice of classification~~ within three business
167.31 days after distribution of the resident case mix classification notice.

168.1 Sec. 25. Minnesota Statutes 2020, section 144.0724, subdivision 8, is amended to read:

168.2 Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or
168.3 resident's representative, or the nursing facility or boarding care home may request that the
168.4 commissioner of health reconsider the assigned reimbursement case mix classification and
168.5 any item or items changed during the audit process. The request for reconsideration must
168.6 be submitted in writing to the commissioner ~~within 30 days of the day the resident or the~~
168.7 ~~resident's representative receives the resident classification notice~~ of health.

168.8 (b) For reconsideration requests initiated by the resident or the resident's representative:

168.9 (1) The resident or the resident's representative must submit in writing a reconsideration
168.10 request to the facility administrator within 30 days of receipt of the resident classification
168.11 notice. The written request for reconsideration must include the ~~name of the resident, the~~
168.12 ~~name and address of the facility in which the resident resides, the reasons for the~~
168.13 ~~reconsideration, and documentation supporting the request. The documentation accompanying~~
168.14 ~~the reconsideration request is limited to a copy of the MDS that determined the classification~~
168.15 ~~and other documents that would support or change the MDS findings.~~

168.16 (2) Within three business days of receiving the reconsideration request, the nursing
168.17 facility must submit to the commissioner of health a completed reconsideration request
168.18 form, a copy of the resident's or resident's representative's written request, and all supporting
168.19 documentation used to complete the assessment being considered. If the facility fails to
168.20 provide the required information, the reconsideration will be completed with the information
168.21 submitted and the facility cannot make further reconsideration requests on this classification.

168.22 ~~(b)~~ (3) Upon written request and within three business days, the nursing facility must
168.23 give the resident or the resident's representative a copy of the assessment form being
168.24 reconsidered and the other all supporting documentation that was given to the commissioner
168.25 of health used to support complete the assessment findings. ~~The nursing facility shall also~~
168.26 ~~provide access to and a copy of other information from the resident's record that has been~~
168.27 ~~requested by or on behalf of the resident to support a resident's reconsideration request. A~~
168.28 ~~copy of any requested material must be provided within three working days of receipt of a~~
168.29 ~~written request for the information.~~ Notwithstanding any law to the contrary, the facility
168.30 may not charge a fee for providing copies of the requested documentation. If a facility fails
168.31 to provide the ~~material~~ required documents within this time, it is subject to the issuance of
168.32 a correction order and penalty assessment under sections 144.653 and 144A.10.

168.33 Notwithstanding those sections, any correction order issued under this subdivision must
168.34 require that the nursing facility immediately comply with the request for information, and

169.1 ~~that~~ as of the date of the issuance of the correction order, the facility shall forfeit to the state
169.2 a \$100 fine for the first day of noncompliance, and an increase in the \$100 fine by \$50
169.3 increments for each day the noncompliance continues.

169.4 ~~(c) in addition to the information required under paragraphs (a) and (b), a reconsideration~~
169.5 ~~request from a nursing facility must contain the following information: (i) the date the~~
169.6 ~~reimbursement classification notices were received by the facility; (ii) the date the~~
169.7 ~~classification notices were distributed to the resident or the resident's representative; and~~
169.8 ~~(iii) For reconsideration requests initiated by the facility:~~

169.9 (1) The facility is required to inform the resident or the resident's representative in writing
169.10 that a reconsideration of the resident's case mix classification is being requested. The notice
169.11 must inform the resident or the resident's representative:

169.12 (i) of the date and reason for the reconsideration request;

169.13 (ii) of the potential for a classification and subsequent rate change;

169.14 (iii) of the extent of the potential rate change;

169.15 (iv) that copies of the request and supporting documentation are available for review;

169.16 and

169.17 (v) that the resident or the resident's representative has the right to request a
169.18 reconsideration.

169.19 (2) Within 30 days of receipt of the audit exit report or resident classification notice, the
169.20 facility must submit to the commissioner of health a completed reconsideration request
169.21 form, all supporting documentation used to complete the assessment being reconsidered,
169.22 and a copy of a the notice sent to informing the resident or to the resident's representative.
169.23 ~~This notice must inform the resident or the resident's representative that a reconsideration~~
169.24 ~~of the resident's classification is being requested, the reason for the request, that the resident's~~
169.25 ~~rate will change if the request is approved by the commissioner, the extent of the change,~~
169.26 ~~that copies of the facility's request and supporting documentation are available for review,~~
169.27 ~~and that the resident also has the right to request a reconsideration.~~

169.28 (3) If the facility fails to provide the required information listed in item (iii) with the
169.29 reconsideration request, the commissioner may request that the facility provide the
169.30 information within 14 calendar days, the reconsideration request ~~must~~ may be denied if the
169.31 information is then not provided, and the facility may not make further reconsideration
169.32 requests on that specific reimbursement this classification.

170.1 (d) Reconsideration by the commissioner must be made by individuals not involved in
170.2 reviewing the assessment, audit, or reconsideration that established the disputed classification.
170.3 The reconsideration must be based upon the assessment that determined the classification
170.4 and upon the information provided to the commissioner of health under paragraphs (a) ~~and~~
170.5 ~~(b)~~ to (c). If necessary for evaluating the reconsideration request, the commissioner may
170.6 conduct on-site reviews. Within 15 ~~working~~ business days of receiving the request for
170.7 reconsideration, the commissioner shall affirm or modify the original resident classification.
170.8 The original classification must be modified if the commissioner determines that the
170.9 assessment resulting in the classification did not accurately reflect characteristics of the
170.10 resident at the time of the assessment. ~~The resident and the nursing facility or boarding care~~
170.11 ~~home shall be notified within five working days after the decision is made.~~ The commissioner
170.12 must transmit the reconsideration classification notice by electronic means to the nursing
170.13 facility. The nursing facility is responsible for the distribution of the notice to the resident
170.14 or the resident's representative. The notice must be distributed by the nursing facility within
170.15 three business days after receipt. A decision by the commissioner under this subdivision is
170.16 the final administrative decision of the agency for the party requesting reconsideration.

170.17 (e) The ~~resident~~ case mix classification established by the commissioner shall be the
170.18 classification ~~that~~ which applies to the resident while the request for reconsideration is
170.19 pending. If a request for reconsideration applies to an assessment used to determine nursing
170.20 facility level of care under subdivision 4, paragraph (c), the resident shall continue to be
170.21 eligible for nursing facility level of care while the request for reconsideration is pending.

170.22 (f) The commissioner may request additional documentation regarding a reconsideration
170.23 necessary to make an accurate reconsideration determination.

170.24 Sec. 26. Minnesota Statutes 2020, section 144.0724, subdivision 9, is amended to read:

170.25 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
170.26 assessments performed under section 256R.17 through any of the following: desk audits;
170.27 on-site review of residents and their records; and interviews with staff, residents, or residents'
170.28 families. The commissioner shall reclassify a resident if the commissioner determines that
170.29 the resident was incorrectly classified.

170.30 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

170.31 (c) A facility must grant the commissioner access to examine the medical records relating
170.32 to the resident assessments selected for audit under this subdivision. The commissioner may
170.33 also observe and speak to facility staff and residents.

171.1 (d) The commissioner shall consider documentation under the time frames for coding
171.2 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
171.3 Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

171.4 (e) The commissioner shall develop an audit selection procedure that includes the
171.5 following factors:

171.6 (1) Each facility shall be audited annually. If a facility has two successive audits in which
171.7 the percentage of change is five percent or less and the facility has not been the subject of
171.8 a special audit in the past 36 months, the facility may be audited biannually. A stratified
171.9 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
171.10 shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed
171.11 as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a
171.12 minimum of ten assessments. If the total change between the first and second samples is
171.13 35 percent or greater, the commissioner may expand the audit to all of the remaining
171.14 assessments.

171.15 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
171.16 again within six months. If a facility has two expanded audits within a 24-month period,
171.17 that facility will be audited at least every six months for the next 18 months.

171.18 (3) The commissioner may conduct special audits if the commissioner determines that
171.19 circumstances exist that could alter or affect the validity of case mix classifications of
171.20 residents. These circumstances include, but are not limited to, the following:

171.21 (i) frequent changes in the administration or management of the facility;

171.22 (ii) an unusually high percentage of residents in a specific case mix classification;

171.23 (iii) a high frequency in the number of reconsideration requests received from a facility;

171.24 (iv) frequent adjustments of case mix classifications as the result of reconsiderations or
171.25 audits;

171.26 (v) a criminal indictment alleging provider fraud;

171.27 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

171.28 (vii) an atypical pattern of scoring minimum data set items;

171.29 (viii) nonsubmission of assessments;

171.30 (ix) late submission of assessments; or

171.31 (x) a previous history of audit changes of 35 percent or greater.

172.1 (f) ~~Within 15 working days of completing the audit process, the commissioner shall~~
172.2 ~~make available electronically the results of the audit to the facility. If the results of the audit~~
172.3 ~~reflect a change in the resident's case mix classification, a case mix classification notice~~
172.4 ~~will be made available electronically to the facility, using the procedure in subdivision 7,~~
172.5 ~~paragraph (a). The notice must contain the resident's classification and a statement informing~~
172.6 ~~the resident, the resident's authorized representative, and the facility of their right to review~~
172.7 ~~the commissioner's documents supporting the classification and to request a reconsideration~~
172.8 ~~of the classification. This notice must also include the address and telephone number of the~~
172.9 ~~Office of Ombudsman for Long-Term Care. If the audit results in a case mix classification~~
172.10 ~~change, the commissioner must transmit the audit classification notice by electronic means~~
172.11 ~~to the nursing facility within 15 business days of completing an audit. The nursing facility~~
172.12 ~~is responsible for distribution of the notice to each resident or the resident's representative.~~
172.13 ~~This notice must be distributed by the nursing facility within three business days after~~
172.14 ~~receipt. The notice must inform the resident of the case mix classification assigned, the~~
172.15 ~~opportunity to review the documentation supporting the classification, the opportunity to~~
172.16 ~~obtain clarification from the commissioner, the opportunity to request a reconsideration of~~
172.17 ~~the classification, and the address and telephone number of the Office of Ombudsman for~~
172.18 ~~Long-Term Care.~~

172.19 Sec. 27. Minnesota Statutes 2020, section 144.0724, subdivision 12, is amended to read:

172.20 Subd. 12. **Appeal of nursing facility level of care determination.** (a) A resident or
172.21 prospective resident whose level of care determination results in a denial of long-term care
172.22 services can appeal the determination as outlined in section 256B.0911, subdivision 3a,
172.23 paragraph (h), clause (9).

172.24 (b) The commissioner of human services shall ensure that notice of changes in eligibility
172.25 due to a nursing facility level of care determination is provided to each affected recipient
172.26 or the recipient's guardian at least 30 days before the effective date of the change. The notice
172.27 shall include the following information:

172.28 (1) how to obtain further information on the changes;

172.29 (2) how to receive assistance in obtaining other services;

172.30 (3) a list of community resources; and

172.31 (4) appeal rights.

172.32 ~~A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses~~
172.33 ~~(1) and (2), may request continued services pending appeal within the time period allowed~~

173.1 ~~to request an appeal under section 256.045, subdivision 3, paragraph (i). This paragraph is~~
 173.2 ~~in effect for appeals filed between January 1, 2015, and December 31, 2016.~~

173.3 Sec. 28. Minnesota Statutes 2020, section 144.1205, subdivision 2, is amended to read:

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

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

173.8	TYPE	<u>ANNUAL</u>
173.9		<u>LICENSE FEE</u>
173.10		\$19,920
173.11	Academic broad scope - type A, B, or C	<u>\$25,896</u>
173.12	Academic broad scope - type B	19,920
173.13	Academic broad scope - type C	19,920
173.14	<u>Academic broad scope - type A, B, or C (4-8 locations)</u>	<u>\$31,075</u>
173.15	<u>Academic broad scope - type A, B, or C (9 or more locations)</u>	<u>\$36,254</u>
173.16		19,920
173.17	Medical broad scope - type A	<u>\$25,896</u>
173.18	<u>Medical broad scope- type A (4-8 locations)</u>	<u>\$31,075</u>
173.19	<u>Medical broad scope- type A (9 or more locations)</u>	<u>\$36,254</u>
173.20	Medical institution - diagnostic and therapeutic	3,680
173.21	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
173.22	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
173.23	<u>medical therapy emerging technologies</u>	<u>\$4,784</u>
173.24	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
173.25	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
173.26	<u>medical therapy emerging technologies (4-8 locations)</u>	<u>\$5,740</u>
173.27	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
173.28	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
173.29	<u>medical therapy emerging technologies (9 or more locations)</u>	<u>\$6,697</u>
173.30	Medical institution - diagnostic (no written directives)	3,680
173.31	Medical private practice - diagnostic and therapeutic	3,680
173.32	Medical private practice - diagnostic (no written directives)	3,680
173.33	Eye applicators	3,680
173.34	Nuclear medical vans	3,680
173.35	High dose rate afterloader	3,680
173.36	Mobile high dose rate afterloader	3,680
173.37	Medical therapy - other emerging technology	3,680
173.38		8,960
173.39	Teletherapy	<u>\$11,648</u>

174.1		8,960
174.2	Gamma knife	<u>\$11,648</u>
174.3	Veterinary medicine	2,000 <u>\$2,600</u>
174.4	In vitro testing lab	2,000 <u>\$2,600</u>
174.5		8,800
174.6	Nuclear pharmacy	<u>\$11,440</u>
174.7	<u>Nuclear pharmacy (5 or more locations)</u>	<u>\$13,728</u>
174.8	Radiopharmaceutical distribution (10 CFR 32.72)	3,840 <u>\$4,992</u>
174.9	Radiopharmaceutical processing and distribution (10 CFR	8,800
174.10	32.72)	<u>\$11,440</u>
174.11	<u>Radiopharmaceutical processing and distribution (10 CFR</u>	<u>\$13,728</u>
174.12	<u>32.72) (5 or more locations)</u>	
174.13	Medical sealed sources - distribution (10 CFR 32.74)	3,840 <u>\$4,992</u>
174.14	Medical sealed sources - processing and distribution (10 CFR	8,800
174.15	32.74)	<u>\$11,440</u>
174.16	<u>Medical sealed sources - processing and distribution (10 CFR</u>	<u>\$13,728</u>
174.17	<u>32.74) (5 or more locations)</u>	
174.18	Well logging - sealed sources	3,760 <u>\$4,888</u>
174.19	Measuring systems - (fixed gauge, portable gauge, gas	
174.20	<u>chromatograph, other)</u>	2,000 <u>\$2,600</u>
174.21	Measuring systems - portable gauge	2,000
174.22	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
174.23	<u>chromatograph, other) (4-8 locations)</u>	<u>\$3,120</u>
174.24	<u>Measuring systems - (fixed gauge, portable gauge, gas</u>	
174.25	<u>chromatograph, other) (9 or more locations)</u>	<u>\$3,640</u>
174.26	X-ray fluorescent analyzer	1,520 <u>\$1,976</u>
174.27	Measuring systems - gas chromatograph	2,000
174.28	Measuring systems - other	2,000
174.29	Broad scope Manufacturing and distribution - type A <u>broad</u>	19,920
174.30	<u>scope</u>	<u>\$25,896</u>
174.31	<u>Manufacturing and distribution - type A broad scope (4-8</u>	
174.32	<u>locations)</u>	<u>\$31,075</u>
174.33	<u>Manufacturing and distribution - type A broad scope (9 or more</u>	
174.34	<u>locations)</u>	<u>\$36,254</u>
174.35	Broad scope Manufacturing and distribution - type B <u>or C broad</u>	17,600
174.36	<u>scope</u>	<u>\$22,880</u>
174.37	Broad scope Manufacturing and distribution - type C	17,600
174.38	<u>Manufacturing and distribution - type B or C broad scope (4-8</u>	
174.39	<u>locations)</u>	<u>\$27,456</u>
174.40	<u>Manufacturing and distribution - type B or C broad scope (9</u>	
174.41	<u>or more locations)</u>	<u>\$32,032</u>
174.42	Manufacturing and distribution - other	5,280 <u>\$6,864</u>
174.43	<u>Manufacturing and distribution - other (4-8 locations)</u>	<u>\$8,236</u>

175.1	<u>Manufacturing and distribution - other (9 or more locations)</u>		<u>\$9,609</u>
175.2			18,640
175.3	Nuclear laundry		<u>\$24,232</u>
175.4	Decontamination services	4,960	<u>\$6,448</u>
175.5	Leak test services only	2,000	<u>\$2,600</u>
175.6	Instrument calibration service only, less than 100 curies	2,000	<u>\$2,600</u>
175.7	Instrument calibration service only, 100 curies or more		2,000
175.8	Service, maintenance, installation, source changes, etc.	4,960	<u>\$6,448</u>
175.9	Waste disposal service, prepackaged only	6,000	<u>\$7,800</u>
175.10			8,320
175.11	Waste disposal		<u>\$10,816</u>
175.12	Distribution - general licensed devices (sealed sources)	1,760	<u>\$2,288</u>
175.13	Distribution - general licensed material (unsealed sources)	1,120	<u>\$1,456</u>
175.14			9,840
175.15	Industrial radiography - fixed <u>or temporary</u> location		<u>\$12,792</u>
175.16	Industrial radiography - temporary job sites		9,840
175.17	<u>Industrial radiography - fixed or temporary location (5 or more</u>		
175.18	<u>locations)</u>		<u>\$16,629</u>
175.19	Irradiators, self-shielding, less than 10,000 curies	2,880	<u>\$3,744</u>
175.20	Irradiators, other, less than 10,000 curies	5,360	<u>\$6,968</u>
175.21	Irradiators, self-shielding, 10,000 curies or more		2,880
175.22			9,520
175.23	Research and development - type A, B, or C broad scope		<u>\$12,376</u>
175.24	Research and development - type B broad scope		9,520
175.25	Research and development - type C broad scope		9,520
175.26	<u>Research and development - type A, B, or C broad scope (4-8</u>		
175.27	<u>locations)</u>		<u>\$14,851</u>
175.28	<u>Research and development - type A, B, or C broad scope (9 or</u>		
175.29	<u>more locations)</u>		<u>\$17,326</u>
175.30	Research and development - other	4,480	<u>\$5,824</u>
175.31	Storage - no operations	2,000	<u>\$2,600</u>
175.32	Source material - shielding	584	<u>\$759</u>
175.33	Special nuclear material plutonium - neutron source in device	3,680	<u>\$4,784</u>
175.34	Pacemaker by-product and/or special nuclear material - medical	3,680	<u>\$4,784</u>
175.35	(institution)		
175.36	Pacemaker by-product and/or special nuclear material -	5,280	<u>\$6,864</u>
175.37	manufacturing and distribution		
175.38	Accelerator-produced radioactive material	3,840	<u>\$4,992</u>
175.39	Nonprofit educational institutions	300	<u>\$500</u>
175.40	General license registration		150

176.1 Sec. 29. Minnesota Statutes 2020, section 144.1205, subdivision 4, is amended to read:

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

176.4	TYPE	APPLICATION FEE
176.5		\$5,920
176.6	Academic broad scope - type A, B, or C	<u>\$6,808</u>
176.7	Academic broad scope - type B	5,920
176.8	Academic broad scope - type C	5,920
176.9	Medical broad scope - type A	3,920 <u>\$4,508</u>
176.10	<u>Medical - diagnostic, diagnostic and therapeutic, mobile nuclear</u>	
176.11	<u>medicine, eye applicators, high dose rate afterloaders, and</u>	
176.12	<u>medical therapy emerging technologies</u>	<u>\$1,748</u>
176.13	Medical institution - diagnostic and therapeutic	1,520
176.14	Medical institution - diagnostic (no written directives)	1,520
176.15	Medical private practice - diagnostic and therapeutic	1,520
176.16	Medical private practice - diagnostic (no written directives)	1,520
176.17	Eye applicators	1,520
176.18	Nuclear medical vans	1,520
176.19	High dose rate afterloader	1,520
176.20	Mobile high dose rate afterloader	1,520
176.21	Medical therapy - other emerging technology	1,520
176.22	Teletherapy	5,520 <u>\$6,348</u>
176.23	Gamma knife	5,520 <u>\$6,348</u>
176.24	Veterinary medicine	960 <u>\$1,104</u>
176.25	In vitro testing lab	960 <u>\$1,104</u>
176.26	Nuclear pharmacy	4,880 <u>\$5,612</u>
176.27	Radiopharmaceutical distribution (10 CFR 32.72)	2,160 <u>\$2,484</u>
176.28	Radiopharmaceutical processing and distribution (10 CFR	
176.29	32.72)	4,880 <u>\$5,612</u>
176.30	Medical sealed sources - distribution (10 CFR 32.74)	2,160 <u>\$2,484</u>
176.31	Medical sealed sources - processing and distribution (10 CFR	
176.32	32.74)	4,880 <u>\$5,612</u>
176.33	Well logging - sealed sources	1,600 <u>\$1,840</u>
176.34	Measuring systems - (<u>fixed gauge, portable gauge, gas</u>	
176.35	<u>chromatograph, other</u>)	960 <u>\$1,104</u>
176.36	Measuring systems - portable gauge	960
176.37	X-ray fluorescent analyzer	584 <u>\$671</u>
176.38	Measuring systems - gas chromatograph	960
176.39	Measuring systems - other	960

177.1	Broad scope Manufacturing and distribution - type A, B, and		
177.2	<u>C broad scope</u>	5,920	<u>\$6,854</u>
177.3	Broad scope manufacturing and distribution - type B		5,920
177.4	Broad scope manufacturing and distribution - type C		5,920
177.5	Manufacturing and distribution - other	2,320	<u>\$2,668</u>
177.6			10,080
177.7	Nuclear laundry		<u>\$11,592</u>
177.8	Decontamination services	2,640	<u>\$3,036</u>
177.9	Leak test services only	960	<u>\$1,104</u>
177.10	Instrument calibration service only, less than 100 curies	960	<u>\$1,104</u>
177.11	Instrument calibration service only, 100 curies or more		960
177.12	Service, maintenance, installation, source changes, etc.	2,640	<u>\$3,036</u>
177.13	Waste disposal service, prepackaged only	2,240	<u>\$2,576</u>
177.14	Waste disposal	1,520	<u>\$1,748</u>
177.15	Distribution - general licensed devices (sealed sources)	880	<u>\$1,012</u>
177.16	Distribution - general licensed material (unsealed sources)	520	<u>\$598</u>
177.17	Industrial radiography - fixed <u>or temporary</u> location	2,640	<u>\$3,036</u>
177.18	Industrial radiography - temporary job sites		2,640
177.19	Irradiators, self-shielding, less than 10,000 curies	1,440	<u>\$1,656</u>
177.20	Irradiators, other, less than 10,000 curies	2,960	<u>\$3,404</u>
177.21	Irradiators, self-shielding, 10,000 curies or more		1,440
177.22	Research and development - type A, B, or C broad scope	4,960	<u>\$5,704</u>
177.23	Research and development - type B broad scope		4,960
177.24	Research and development - type C broad scope		4,960
177.25	Research and development - other	2,400	<u>\$2,760</u>
177.26	Storage - no operations	960	<u>\$1,104</u>
177.27	Source material - shielding	136	<u>\$156</u>
177.28	Special nuclear material plutonium - neutron source in device	1,200	<u>\$1,380</u>
177.29	Pacemaker by-product and/or special nuclear material - medical	1,200	<u>\$1,380</u>
177.30	(institution)		
177.31	Pacemaker by-product and/or special nuclear material -	2,320	<u>\$2,668</u>
177.32	manufacturing and distribution		
177.33	Accelerator-produced radioactive material	4,100	<u>\$4,715</u>
177.34	Nonprofit educational institutions	300	<u>\$345</u>
177.35	General license registration		0
177.36	Industrial radiographer certification		150

178.1 Sec. 30. Minnesota Statutes 2020, section 144.1205, subdivision 8, is amended to read:

178.2 Subd. 8. **Reciprocity fee.** A licensee submitting an application for reciprocal recognition
178.3 of a materials license issued by another agreement state or the United States Nuclear
178.4 Regulatory Commission for a period of 180 days or less during a calendar year must pay
178.5 ~~\$1,200~~ \$2,400. For a period of 181 days or more, the licensee must obtain a license under
178.6 subdivision 4.

178.7 Sec. 31. Minnesota Statutes 2020, section 144.1205, subdivision 9, is amended to read:

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

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

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

178.14 Sec. 32. Minnesota Statutes 2020, section 144.1205, is amended by adding a subdivision
178.15 to read:

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

178.19 Sec. 33. Minnesota Statutes 2020, section 144.125, subdivision 1, is amended to read:

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

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

178.30 (c) The fee to support the newborn screening program, including tests administered
178.31 under this section and section 144.966, shall be ~~\$135~~ \$177 per specimen. This fee amount

179.1 shall be deposited in the state treasury and credited to the state government special revenue
179.2 fund.

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

179.6 Sec. 34. [144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.

179.7 Subdivision 1. Citation. This section may be cited as the "Dignity in Pregnancy and
179.8 Childbirth Act."

179.9 Subd. 2. Continuing education requirement. (a) Hospitals with obstetric care and birth
179.10 centers must provide continuing education on anti-racism training and implicit bias. The
179.11 continuing education must be evidence-based and must include at a minimum the following
179.12 criteria:

179.13 (1) education aimed at identifying personal, interpersonal, institutional, structural, and
179.14 cultural barriers to inclusion;

179.15 (2) identifying and implementing corrective measures to promote anti-racism practices
179.16 and decrease implicit bias at the interpersonal and institutional levels, including the
179.17 institution's ongoing policies and practices;

179.18 (3) providing information on the ongoing effects of historical and contemporary exclusion
179.19 and oppression of Black and Indigenous communities with the greatest health disparities
179.20 related to maternal and infant mortality and morbidity;

179.21 (4) providing information and discussion of health disparities in the perinatal health care
179.22 field including how systemic racism and implicit bias have different impacts on health
179.23 outcomes for different racial and ethnic communities; and

179.24 (5) soliciting perspectives of diverse, local constituency groups and experts on racial,
179.25 identity, cultural, and provider-community relationship issues.

179.26 (b) In addition to the initial continuing educational requirement in paragraph (a), hospitals
179.27 with obstetric care and birth centers must provide an annual refresher course that reflects
179.28 current trends on race, culture, identity, and anti-racism principles and institutional implicit
179.29 bias.

179.30 (c) Hospitals with obstetric care and birth centers must develop continuing education
179.31 materials on anti-racism and implicit bias that must be provided and updated annually for

180.1 direct care employees and contractors who routinely care for patients who are pregnant or
180.2 postpartum.

180.3 (d) Hospitals with obstetric care and birth centers shall coordinate with health-related
180.4 licensing boards to obtain continuing education credits for the trainings and materials
180.5 required in this section. The commissioner of health shall monitor compliance with this
180.6 section. Initial training for the continuing education requirements in this subdivision must
180.7 be completed by December 31, 2022. The commissioner may inspect the training records
180.8 or require reports on the continuing education materials in this section from hospitals with
180.9 obstetric care and birth centers.

180.10 (e) A facility described in paragraph (d) must provide a certificate of training completion
180.11 to another facility or a training attendee upon request. A facility may accept the training
180.12 certificate from another facility for a health care provider that works in more than one
180.13 facility.

180.14 Sec. 35. Minnesota Statutes 2020, section 144.1481, subdivision 1, is amended to read:

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

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

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

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

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

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

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

180.29 (7) a dentist licensed under chapter 150A;

180.30 (8) a midlevel practitioner;

180.31 ~~(8)~~ (9) a registered nurse or licensed practical nurse;

181.1 ~~(9)~~ (10) a licensed health care professional from an occupation not otherwise represented
181.2 on the committee;

181.3 ~~(10)~~ (11) a representative of an institution of higher education located outside the
181.4 seven-county metropolitan area that provides training for rural health care providers; and

181.5 ~~(11)~~ (12) three consumers, at least one of whom must be an advocate for persons who
181.6 are mentally ill or developmentally disabled.

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

181.13 Sec. 36. Minnesota Statutes 2020, section 144.1911, subdivision 6, is amended to read:

181.14 Subd. 6. **International medical graduate primary care residency grant program**
181.15 **and revolving account.** (a) The commissioner shall award grants to support primary care
181.16 residency positions designated for Minnesota immigrant physicians who are willing to serve
181.17 in rural or underserved areas of the state. No grant shall exceed \$150,000 per residency
181.18 position per year. Eligible primary care residency grant recipients include accredited family
181.19 medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and
181.20 pediatric residency programs. Eligible primary care residency programs shall apply to the
181.21 commissioner. Applications must include the number of anticipated residents to be funded
181.22 using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to
181.23 grantees in a grant agreement do not lapse until the grant agreement expires. Before any
181.24 funds are distributed, a grant recipient shall provide the commissioner with the following:

181.25 (1) a copy of the signed contract between the primary care residency program and the
181.26 participating international medical graduate;

181.27 (2) certification that the participating international medical graduate has lived in
181.28 Minnesota for at least two years and is certified by the Educational Commission on Foreign
181.29 Medical Graduates. Residency programs may also require that participating international
181.30 medical graduates hold a Minnesota certificate of clinical readiness for residency, once the
181.31 certificates become available; and

181.32 (3) verification that the participating international medical graduate has executed a
181.33 participant agreement pursuant to paragraph (b).

182.1 (b) Upon acceptance by a participating residency program, international medical graduates
182.2 shall enter into an agreement with the commissioner to provide primary care for at least
182.3 five years in a rural or underserved area of Minnesota after graduating from the residency
182.4 program and make payments to the revolving international medical graduate residency
182.5 account for five years beginning in their second year of postresidency employment.
182.6 Participants shall pay \$15,000 or ten percent of their annual compensation each year,
182.7 whichever is less.

182.8 (c) A revolving international medical graduate residency account is established as an
182.9 account in the special revenue fund in the state treasury. The commissioner of management
182.10 and budget shall credit to the account appropriations, payments, and transfers to the account.
182.11 Earnings, such as interest, dividends, and any other earnings arising from fund assets, must
182.12 be credited to the account. Funds in the account are appropriated annually to the
182.13 commissioner to award grants and administer the grant program established in paragraph
182.14 (a). Notwithstanding any law to the contrary, any funds deposited in the account do not
182.15 expire. The commissioner may accept contributions to the account from private sector
182.16 entities subject to the following provisions:

182.17 (1) the contributing entity may not specify the recipient or recipients of any grant issued
182.18 under this subdivision;

182.19 (2) the commissioner shall make public the identity of any private contributor to the
182.20 account, as well as the amount of the contribution provided; and

182.21 (3) a contributing entity may not specify that the recipient or recipients of any funds use
182.22 specific products or services, nor may the contributing entity imply that a contribution is
182.23 an endorsement of any specific product or service.

182.24 Sec. 37. Minnesota Statutes 2020, section 144.212, is amended by adding a subdivision
182.25 to read:

182.26 Subd. 12. Homeless youth. "Homeless youth" has the meaning given in section 256K.45,
182.27 subdivision 1a.

182.28 Sec. 38. Minnesota Statutes 2020, section 144.225, subdivision 2, is amended to read:

182.29 Subd. 2. **Data about births.** (a) Except as otherwise provided in this subdivision, data
182.30 pertaining to the birth of a child to a woman who was not married to the child's father when
182.31 the child was conceived nor when the child was born, including the original record of birth
182.32 and the certified vital record, are confidential data. At the time of the birth of a child to a

183.1 woman who was not married to the child's father when the child was conceived nor when
183.2 the child was born, the mother may designate demographic data pertaining to the birth as
183.3 public. Notwithstanding the designation of the data as confidential, it may be disclosed:

183.4 (1) to a parent or guardian of the child;

183.5 (2) to the child when the child is 16 years of age or older, except as provided in clause
183.6 (3);

183.7 (3) to the child if the child is a homeless youth;

183.8 ~~(3)~~ (4) under paragraph (b), (e), or (f); or

183.9 ~~(4)~~ (5) pursuant to a court order. For purposes of this section, a subpoena does not
183.10 constitute a court order.

183.11 (b) Unless the child is adopted, data pertaining to the birth of a child that are not accessible
183.12 to the public become public data if 100 years have elapsed since the birth of the child who
183.13 is the subject of the data, or as provided under section 13.10, whichever occurs first.

183.14 (c) If a child is adopted, data pertaining to the child's birth are governed by the provisions
183.15 relating to adoption records, including sections 13.10, subdivision 5; 144.218, subdivision
183.16 1; 144.2252; and 259.89.

183.17 (d) The name and address of a mother under paragraph (a) and the child's date of birth
183.18 may be disclosed to the county social services, tribal health department, or public health
183.19 member of a family services collaborative for purposes of providing services under section
183.20 124D.23.

183.21 (e) The commissioner of human services shall have access to birth records for:

183.22 (1) the purposes of administering medical assistance and the MinnesotaCare program;

183.23 (2) child support enforcement purposes; and

183.24 (3) other public health purposes as determined by the commissioner of health.

183.25 (f) Tribal child support programs shall have access to birth records for child support
183.26 enforcement purposes.

183.27 Sec. 39. Minnesota Statutes 2020, section 144.225, subdivision 7, is amended to read:

183.28 Subd. 7. **Certified birth or death record.** (a) The state registrar or local issuance office
183.29 shall issue a certified birth or death record or a statement of no vital record found to an
183.30 individual upon the individual's proper completion of an attestation provided by the
183.31 commissioner and, except as provided in section 144.2255, payment of the required fee:

- 184.1 (1) to a person who ~~has a tangible interest in the requested vital record. A person who~~
184.2 ~~has a tangible interest~~ is:
- 184.3 (i) the subject of the vital record;
- 184.4 (ii) a child of the subject;
- 184.5 (iii) the spouse of the subject;
- 184.6 (iv) a parent of the subject;
- 184.7 (v) the grandparent or grandchild of the subject;
- 184.8 (vi) if the requested record is a death record, a sibling of the subject;
- 184.9 ~~(vii) the party responsible for filing the vital record;~~
- 184.10 ~~(viii)~~ (vii) the legal custodian, guardian or conservator, or health care agent of the subject;
- 184.11 ~~(ix)~~ (viii) a personal representative, by sworn affidavit of the fact that the certified copy
184.12 is required for administration of the estate;
- 184.13 ~~(x)~~ (ix) a successor of the subject, as defined in section 524.1-201, if the subject is
184.14 deceased, by sworn affidavit of the fact that the certified copy is required for administration
184.15 of the estate;
- 184.16 ~~(xi)~~ (x) if the requested record is a death record, a trustee of a trust by sworn affidavit
184.17 of the fact that the certified copy is needed for the proper administration of the trust;
- 184.18 ~~(xii)~~ (xi) a person or entity who demonstrates that a certified vital record is necessary
184.19 for the determination or protection of a personal or property right, pursuant to rules adopted
184.20 by the commissioner; or
- 184.21 ~~(xiii)~~ (xii) an adoption agency in order to complete confidential postadoption searches
184.22 as required by section 259.83;
- 184.23 (2) to any local, state, tribal, or federal governmental agency upon request if the certified
184.24 vital record is necessary for the governmental agency to perform its authorized duties;
- 184.25 (3) to an attorney representing the subject of the vital record or another person listed in
184.26 clause (1), upon evidence of the attorney's license;
- 184.27 (4) pursuant to a court order issued by a court of competent jurisdiction. For purposes
184.28 of this section, a subpoena does not constitute a court order; or
- 184.29 (5) to a representative authorized by a person under clauses (1) to (4).

185.1 (b) The state registrar or local issuance office shall also issue a certified death record to
185.2 an individual described in paragraph (a), clause (1), items (ii) to ~~(viii)~~ (xi), if, on behalf of
185.3 the individual, a licensed mortician furnishes the registrar with a properly completed
185.4 attestation in the form provided by the commissioner within 180 days of the time of death
185.5 of the subject of the death record. This paragraph is not subject to the requirements specified
185.6 in Minnesota Rules, part 4601.2600, subpart 5, item B.

185.7 Sec. 40. [144.2255] CERTIFIED BIRTH RECORD FOR HOMELESS YOUTH.

185.8 Subdivision 1. Application; certified birth record. A subject of a birth record who is
185.9 a homeless youth in Minnesota or another state may apply to the state registrar or a local
185.10 issuance office for a certified birth record according to this section. The state registrar or
185.11 local issuance office shall issue a certified birth record or statement of no vital record found
185.12 to a subject of a birth record who submits:

185.13 (1) a completed application signed by the subject of the birth record;

185.14 (2) a statement that the subject of the birth record is a homeless youth, signed by the
185.15 subject of the birth record; and

185.16 (3) one of the following:

185.17 (i) a document of identity listed in Minnesota Rules, part 4601.2600, subpart 8, or, at
185.18 the discretion of the state registrar or local issuance office, Minnesota Rules, part 4601.2600,
185.19 subpart 9;

185.20 (ii) a statement that complies with Minnesota Rules, part 4601.2600, subparts 6 and 7;
185.21 or

185.22 (iii) a statement verifying that the subject of the birth record is a homeless youth that
185.23 complies with the requirements in subdivision 2 and is from an employee of a human services
185.24 agency that receives public funding to provide services to homeless youth, runaway youth,
185.25 youth with mental illness, or youth with substance use disorders; a school staff person who
185.26 provides services to homeless youth; or a school social worker.

185.27 Subd. 2. Statement verifying subject is a homeless youth. A statement verifying that
185.28 a subject of a birth record is a homeless youth must include:

185.29 (1) the following information regarding the individual providing the statement: first
185.30 name, middle name, if any, and last name; home or business address; telephone number, if
185.31 any; and e-mail address, if any;

186.1 (2) the first name, middle name, if any, and last name of the subject of the birth record;
186.2 and

186.3 (3) a statement specifying the relationship of the individual providing the statement to
186.4 the subject of the birth record and verifying that the subject of the birth record is a homeless
186.5 youth.

186.6 The individual providing the statement must also provide a copy of the individual's
186.7 employment identification.

186.8 Subd. 3. **Expiration; reissuance.** If a subject of a birth record obtains a certified birth
186.9 record under this section using the statement specified in subdivision 1, clause (3), item
186.10 (iii), the certified birth record issued shall expire six months after the date of issuance. Upon
186.11 expiration of the certified birth record, the subject of the birth record may surrender the
186.12 expired birth record to the state registrar or a local issuance office and obtain another birth
186.13 record. Each certified birth record obtained under this subdivision shall expire six months
186.14 after the date of issuance. If the subject of the birth record does not surrender the expired
186.15 birth record, the subject may apply for a certified birth record using the process in subdivision
186.16 1.

186.17 Subd. 4. **Fees waived.** The state registrar or local issuance office shall not charge any
186.18 fee for issuance of a certified birth record or statement of no vital record found under this
186.19 section.

186.20 Subd. 5. **Data practices.** Data listed under subdivision 1, clauses (2) and (3), item (iii),
186.21 are private data on individuals.

186.22 **EFFECTIVE DATE.** This section is effective the day following final enactment for
186.23 applications for and the issuance of certified birth records on or after January 1, 2022.

186.24 Sec. 41. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
186.25 to read:

186.26 Subd. 7. **Transaction fees.** The state registrar may charge and permit agents to charge
186.27 a convenience fee and a transaction fee for electronic transactions and transactions by
186.28 telephone or Internet, as well as the fees established under subdivisions 1 to 4. The
186.29 convenience fee may not exceed three percent of the cost of the charges for payment. The
186.30 state registrar may permit agents to charge and retain a transaction fee as payment agreed
186.31 upon under contract. When an electronic convenience fee or transaction fee is charged, the
186.32 agent charging the fee is required to post information on their web page informing individuals
186.33 of the fee. The information must be near the point of payment, clearly visible, include the

187.1 amount of the fee, and state: "This contracted agent is allowed by state law to charge a
187.2 convenience fee and transaction fee for this electronic transaction."

187.3 Sec. 42. Minnesota Statutes 2020, section 144.226, is amended by adding a subdivision
187.4 to read:

187.5 Subd. 8. **Birth record fees waived for homeless youth.** A subject of a birth record who
187.6 is a homeless youth shall not be charged any of the fees specified in subdivisions 1 and 3
187.7 to 6 for a certified birth record or statement of no vital record found under section 144.2255.

187.8 **EFFECTIVE DATE.** This section is effective the day following final enactment for
187.9 applications for and the issuance of certified birth records on or after January 1, 2022.

187.10 Sec. 43. Minnesota Statutes 2020, section 144.55, subdivision 4, is amended to read:

187.11 **Subd. 4. Routine inspections; presumption.** Any hospital surveyed and accredited
187.12 under the standards of the hospital accreditation program of an approved accrediting
187.13 organization that submits to the commissioner within a reasonable time copies of (a) its
187.14 currently valid accreditation certificate and accreditation letter, together with accompanying
187.15 recommendations and comments and (b) any further recommendations, progress reports
187.16 and correspondence directly related to the accreditation is presumed to comply with
187.17 application requirements of subdivision 1 and the standards requirements of subdivision 3
187.18 and no further routine inspections or accreditation information shall be required by the
187.19 commissioner to determine compliance. Notwithstanding the provisions of sections 144.54
187.20 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this
187.21 section. The provisions of section 144.653 relating to the assessment and collection of fines
187.22 shall not apply to any hospital. The commissioner of health shall annually conduct, with
187.23 notice, validation inspections of a selected sample of the number of hospitals accredited by
187.24 an approved accrediting organization, not to exceed ten percent of accredited hospitals, for
187.25 the purpose of determining compliance with the provisions of subdivision 3. If a validation
187.26 survey discloses a failure to comply with subdivision 3, the provisions of section 144.653
187.27 relating to correction orders, reinspections, and notices of noncompliance shall apply. The
187.28 commissioner shall also conduct any inspection necessary to determine whether hospital
187.29 construction, addition, or remodeling projects comply with standards for construction
187.30 promulgated in rules pursuant to subdivision 3. The commissioner shall also conduct any
187.31 inspections necessary to determine whether a hospital or hospital corporate system continues
187.32 to satisfy the conditions on which a hospital construction moratorium exception was granted
187.33 under section 144.551. Pursuant to section 144.653, the commissioner shall inspect any

188.1 hospital that does not have a currently valid hospital accreditation certificate from an
188.2 approved accrediting organization. Nothing in this subdivision shall be construed to limit
188.3 the investigative powers of the Office of Health Facility Complaints as established in sections
188.4 144A.51 to 144A.54.

188.5 Sec. 44. Minnesota Statutes 2020, section 144.55, subdivision 6, is amended to read:

188.6 Subd. 6. **Suspension, revocation, and refusal to renew.** (a) The commissioner may
188.7 refuse to grant or renew, or may suspend or revoke, a license on any of the following grounds:

188.8 (1) violation of any of the provisions of sections 144.50 to 144.56 or the rules or standards
188.9 issued pursuant thereto, or Minnesota Rules, chapters 4650 and 4675;

188.10 (2) permitting, aiding, or abetting the commission of any illegal act in the institution;

188.11 (3) conduct or practices detrimental to the welfare of the patient; or

188.12 (4) obtaining or attempting to obtain a license by fraud or misrepresentation; or

188.13 (5) with respect to hospitals and outpatient surgical centers, if the commissioner
188.14 determines that there is a pattern of conduct that one or more physicians or advanced practice
188.15 registered nurses who have a "financial or economic interest," as defined in section 144.6521,
188.16 subdivision 3, in the hospital or outpatient surgical center, have not provided the notice and
188.17 disclosure of the financial or economic interest required by section 144.6521.

188.18 (b) The commissioner shall not renew a license for a boarding care bed in a resident
188.19 room with more than four beds.

188.20 (c) The commissioner shall not renew licenses for hospital beds issued to a hospital or
188.21 hospital corporate system pursuant to a hospital construction moratorium exception under
188.22 section 144.551 if the commissioner determines the hospital or hospital corporate system
188.23 is not satisfying the conditions on which the exception was granted.

188.24 **EFFECTIVE DATE.** This section is effective for license renewals occurring on or after
188.25 July 1, 2021.

188.26 Sec. 45. Minnesota Statutes 2020, section 144.551, subdivision 1, is amended to read:

188.27 Subdivision 1. **Restricted construction or modification.** (a) The following construction
188.28 or modification may not be commenced:

188.29 (1) any erection, building, alteration, reconstruction, modernization, improvement,
188.30 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
188.31 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site

189.1 to another, or otherwise results in an increase or redistribution of hospital beds within the
189.2 state; and

189.3 (2) the establishment of a new hospital.

189.4 (b) This section does not apply to:

189.5 (1) construction or relocation within a county by a hospital, clinic, or other health care
189.6 facility that is a national referral center engaged in substantial programs of patient care,
189.7 medical research, and medical education meeting state and national needs that receives more
189.8 than 40 percent of its patients from outside the state of Minnesota;

189.9 (2) a project for construction or modification for which a health care facility held an
189.10 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
189.11 certificate;

189.12 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
189.13 appeal results in an order reversing the denial;

189.14 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
189.15 section 2;

189.16 (5) a project involving consolidation of pediatric specialty hospital services within the
189.17 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
189.18 of pediatric specialty hospital beds among the hospitals being consolidated;

189.19 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
189.20 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
189.21 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
189.22 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
189.23 hospitals must be reinstated at the capacity that existed on each site before the relocation;

189.24 (7) the relocation or redistribution of hospital beds within a hospital building or
189.25 identifiable complex of buildings provided the relocation or redistribution does not result
189.26 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
189.27 one physical site or complex to another; or (iii) redistribution of hospital beds within the
189.28 state or a region of the state;

189.29 (8) relocation or redistribution of hospital beds within a hospital corporate system that
189.30 involves the transfer of beds from a closed facility site or complex to an existing site or
189.31 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
189.32 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
189.33 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal

190.1 health systems agency boundary in place on July 1, 1983; ~~and~~ (iv) the relocation or
190.2 redistribution does not involve the construction of a new hospital building; and (v) the
190.3 transferred beds are used first to replace within the hospital corporate system the total number
190.4 of beds previously used in the closed facility site or complex for mental health services and
190.5 substance use disorder services. Only after the hospital corporate system has fulfilled the
190.6 requirements of this item may the remainder of the available capacity of the closed facility
190.7 site or complex be transferred for any other purpose;

190.8 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
190.9 County that primarily serves adolescents and that receives more than 70 percent of its
190.10 patients from outside the state of Minnesota;

190.11 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
190.12 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
190.13 and (ii) the total licensed capacity of the replacement hospital, either at the time of
190.14 construction of the initial building or as the result of future expansion, will not exceed 70
190.15 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

190.16 (11) the relocation of licensed hospital beds from an existing state facility operated by
190.17 the commissioner of human services to a new or existing facility, building, or complex
190.18 operated by the commissioner of human services; from one regional treatment center site
190.19 to another; or from one building or site to a new or existing building or site on the same
190.20 campus;

190.21 (12) the construction or relocation of hospital beds operated by a hospital having a
190.22 statutory obligation to provide hospital and medical services for the indigent that does not
190.23 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27
190.24 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
190.25 Medical Center to Regions Hospital under this clause;

190.26 (13) a construction project involving the addition of up to 31 new beds in an existing
190.27 nonfederal hospital in Beltrami County;

190.28 (14) a construction project involving the addition of up to eight new beds in an existing
190.29 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

190.30 (15) a construction project involving the addition of 20 new hospital beds in an existing
190.31 hospital in Carver County serving the southwest suburban metropolitan area;

191.1 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
191.2 of up to two psychiatric facilities or units for children provided that the operation of the
191.3 facilities or units have received the approval of the commissioner of human services;

191.4 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
191.5 services in an existing hospital in Itasca County;

191.6 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
191.7 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
191.8 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
191.9 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

191.10 (19) a critical access hospital established under section 144.1483, clause (9), and section
191.11 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
191.12 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
191.13 to the extent that the critical access hospital does not seek to exceed the maximum number
191.14 of beds permitted such hospital under federal law;

191.15 (20) notwithstanding section 144.552, a project for the construction of a new hospital
191.16 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

191.17 (i) the project, including each hospital or health system that will own or control the entity
191.18 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
191.19 Council as of March 1, 2006;

191.20 (ii) the entity that will hold the new hospital license will be owned or controlled by one
191.21 or more not-for-profit hospitals or health systems that have previously submitted a plan or
191.22 plans for a project in Maple Grove as required under section 144.552, and the plan or plans
191.23 have been found to be in the public interest by the commissioner of health as of April 1,
191.24 2005;

191.25 (iii) the new hospital's initial inpatient services must include, but are not limited to,
191.26 medical and surgical services, obstetrical and gynecological services, intensive care services,
191.27 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
191.28 services, and emergency room services;

191.29 (iv) the new hospital:

191.30 (A) will have the ability to provide and staff sufficient new beds to meet the growing
191.31 needs of the Maple Grove service area and the surrounding communities currently being
191.32 served by the hospital or health system that will own or control the entity that will hold the
191.33 new hospital license;

- 192.1 (B) will provide uncompensated care;
- 192.2 (C) will provide mental health services, including inpatient beds;
- 192.3 (D) will be a site for workforce development for a broad spectrum of health-care-related
192.4 occupations and have a commitment to providing clinical training programs for physicians
192.5 and other health care providers;
- 192.6 (E) will demonstrate a commitment to quality care and patient safety;
- 192.7 (F) will have an electronic medical records system, including physician order entry;
- 192.8 (G) will provide a broad range of senior services;
- 192.9 (H) will provide emergency medical services that will coordinate care with regional
192.10 providers of trauma services and licensed emergency ambulance services in order to enhance
192.11 the continuity of care for emergency medical patients; and
- 192.12 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
192.13 the control of the entity holding the new hospital license; and
- 192.14 (v) as of 30 days following submission of a written plan, the commissioner of health
192.15 has not determined that the hospitals or health systems that will own or control the entity
192.16 that will hold the new hospital license are unable to meet the criteria of this clause;
- 192.17 (21) a project approved under section 144.553;
- 192.18 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
192.19 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
192.20 is approved by the Cass County Board;
- 192.21 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
192.22 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
192.23 a separately licensed 13-bed skilled nursing facility;
- 192.24 (24) notwithstanding section 144.552, a project for the construction and expansion of a
192.25 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
192.26 who are under 21 years of age on the date of admission. The commissioner conducted a
192.27 public interest review of the mental health needs of Minnesota and the Twin Cities
192.28 metropolitan area in 2008. No further public interest review shall be conducted for the
192.29 construction or expansion project under this clause;
- 192.30 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
192.31 commissioner finds the project is in the public interest after the public interest review
192.32 conducted under section 144.552 is complete;

193.1 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
193.2 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
193.3 admission, if the commissioner finds the project is in the public interest after the public
193.4 interest review conducted under section 144.552 is complete;

193.5 (ii) this project shall serve patients in the continuing care benefit program under section
193.6 256.9693. The project may also serve patients not in the continuing care benefit program;
193.7 and

193.8 (iii) if the project ceases to participate in the continuing care benefit program, the
193.9 commissioner must complete a subsequent public interest review under section 144.552. If
193.10 the project is found not to be in the public interest, the license must be terminated six months
193.11 from the date of that finding. If the commissioner of human services terminates the contract
193.12 without cause or reduces per diem payment rates for patients under the continuing care
193.13 benefit program below the rates in effect for services provided on December 31, 2015, the
193.14 project may cease to participate in the continuing care benefit program and continue to
193.15 operate without a subsequent public interest review;

193.16 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
193.17 in Hennepin County that is exclusively for patients who are under 21 years of age on the
193.18 date of admission; ~~or~~

193.19 (28) a project to add 55 licensed beds in an existing safety net, level I trauma center
193.20 hospital in Ramsey County as designated under section 383A.91, subdivision 5, of which
193.21 15 beds are to be used for inpatient mental health and 40 are to be used for other services.
193.22 In addition, five unlicensed observation mental health beds shall be added;

193.23 (29) notwithstanding section 144.552, a project to add 45 licensed beds in an existing
193.24 safety net, level I trauma center hospital in Ramsey County as designated under section
193.25 383A.91, subdivision 5. The commissioner conducted a public interest review of the
193.26 construction and expansion of this hospital in 2018. No further public interest review shall
193.27 be conducted for the project under this clause; or

193.28 (30) the addition of licensed beds in a hospital or hospital corporate system to primarily
193.29 provide mental health services or substance use disorder services. In order to add beds under
193.30 this clause, a hospital must have an emergency department and must not be a hospital that
193.31 solely provides treatment to adults for mental illnesses or substance use disorders. Beds
193.32 added under this clause must be available to serve medical assistance and MinnesotaCare
193.33 enrollees. Notwithstanding section 144.552, public interest review shall not be required for
193.34 an addition of beds under this clause.

194.1 **EFFECTIVE DATE.** (a) Paragraph (b), clause (29), is effective the day following final
194.2 enactment, contingent upon:

194.3 (1) the addition of the 15 inpatient mental health beds specified in paragraph (b), clause
194.4 (28), to the Ramsey County level I trauma center's bed capacity;

194.5 (2) five of the 45 additional beds authorized in paragraph (b), clause (29), being
194.6 designated for use for inpatient mental health and added to the hospital's bed capacity before
194.7 the remaining 40 beds authorized under that clause are added; and

194.8 (3) the Ramsey County level I trauma center's agreement to not participate in the Revenue
194.9 Recapture Act under Minnesota Statutes, chapter 270, and Minnesota Statutes, section
194.10 270C.41.

194.11 (b) The amendment to paragraph (b), clause (8), and paragraph (b), clause (30), are
194.12 effective the day following final enactment.

194.13 Sec. 46. Minnesota Statutes 2020, section 144.551, is amended by adding a subdivision
194.14 to read:

194.15 Subd. 5. **Monitoring.** The commissioner shall monitor the implementation of exceptions
194.16 under this section. Each hospital or hospital corporate system granted an exception under
194.17 this section shall submit to the commissioner each year a report on how the hospital or
194.18 hospital corporate system continues to satisfy the conditions on which the exception was
194.19 granted.

194.20 Sec. 47. Minnesota Statutes 2020, section 144.555, is amended to read:

194.21 **144.555 HOSPITAL FACILITY OR CAMPUS CLOSINGS, RELOCATING**
194.22 **SERVICES, OR CEASING TO OFFER CERTAIN SERVICES; PATIENT**
194.23 **RELOCATIONS.**

194.24 Subdivision 1. **Notice of closing or curtailing service operations; facilities other than**
194.25 **hospitals.** If a facility licensed under sections 144.50 to 144.56, other than a hospital,
194.26 voluntarily plans to cease operations or to curtail operations to the extent that patients or
194.27 residents must be relocated, the controlling persons of the facility must notify the
194.28 commissioner of health at least 90 days before the scheduled cessation or curtailment. The
194.29 commissioner shall cooperate with the controlling persons and advise them about relocating
194.30 the patients or residents.

194.31 **Subd. 1a. Notice of closing, curtailing operations, relocating services, or ceasing to**
194.32 **offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under

195.1 sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health at
195.2 least nine months before a scheduled action if the hospital or hospital campus voluntarily
195.3 plans to:

195.4 (1) cease operations;

195.5 (2) curtail operations to the extent that patients must be relocated;

195.6 (3) relocate the provision of health services to another hospital or another hospital
195.7 campus; or

195.8 (4) cease offering maternity care and newborn care services, intensive care unit services,
195.9 inpatient mental health services, or inpatient substance use disorder treatment services.

195.10 (b) The commissioner shall cooperate with the controlling persons and advise them
195.11 about relocating the patients. The controlling persons of the hospital or hospital campus
195.12 must comply with section 144.556.

195.13 Subd. 1b. **Public hearing.** Upon receiving notice under subdivision 1a, the commissioner
195.14 shall conduct a public hearing on the scheduled cessation of operations, curtailment of
195.15 operations, relocation of health services, or cessation in offering health services. The
195.16 commissioner must provide adequate public notice of the hearing in a time and manner
195.17 determined by the commissioner. The public hearing must be held in the community where
195.18 the hospital or hospital campus is located at least six months before the scheduled cessation
195.19 or curtailment of operations, relocation of health services, or cessation in offering health
195.20 services. The controlling persons of the hospital or hospital campus must participate in the
195.21 public hearing. The public hearing must include:

195.22 (1) an explanation by the controlling persons of the reasons for ceasing or curtailing
195.23 operations, relocating health services, or ceasing to offer any of the listed health services;

195.24 (2) a description of the actions that controlling persons will take to ensure that residents
195.25 in the hospital's or campus's service area have continued access to the health services being
195.26 eliminated, curtailed, or relocated;

195.27 (3) an opportunity for public testimony on the scheduled cessation or curtailment of
195.28 operations, relocation of health services, or cessation in offering any of the listed health
195.29 services, and on the hospital's or campus's plan to ensure continued access to those health
195.30 services being eliminated, curtailed, or relocated; and

195.31 (4) an opportunity for the controlling persons to respond to questions from interested
195.32 persons.

196.1 Subd. 2. **Penalty.** Failure to notify the commissioner under subdivision 1 or 1a or failure
196.2 to participate in a public hearing under subdivision 1b may result in issuance of a correction
196.3 order under section 144.653, subdivision 5.

196.4 Sec. 48. [144.556] RIGHT OF FIRST REFUSAL FOR HOSPITAL OR HOSPITAL
196.5 CAMPUS.

196.6 Subdivision 1. **Prerequisite before sale, conveyance, or ceasing operations of hospital**
196.7 **or hospital campus.** The controlling persons of a hospital licensed under sections 144.50
196.8 to 144.56 shall not sell or convey the hospital or a campus of the hospital, offer to sell or
196.9 convey the hospital or hospital campus, or voluntarily cease operations of the hospital or
196.10 hospital campus unless the controlling persons have first made a good faith offer to sell or
196.11 convey the hospital or hospital campus to the home rule charter or statutory city, county,
196.12 town, or hospital district in which the hospital or hospital campus is located.

196.13 Subd. 2. **Offer.** The offer to sell or convey the hospital or hospital campus must be at a
196.14 price that does not exceed the current fair market value of the hospital or hospital campus.
196.15 A party to whom an offer is made under subdivision 1 must accept or decline the offer
196.16 within 60 days after receipt. If the party fails to respond within 60 days after receipt, the
196.17 offer is deemed declined.

196.18 Sec. 49. Minnesota Statutes 2020, section 144.9501, subdivision 17, is amended to read:

196.19 Subd. 17. **Lead hazard reduction.** "Lead hazard reduction" means abatement or interim
196.20 controls undertaken to make a residence, child care facility, school, ~~or~~ playground, or other
196.21 location where lead hazards are identified lead-safe by complying with the lead standards
196.22 and methods adopted under section 144.9508.

196.23 Sec. 50. Minnesota Statutes 2020, section 144.9502, subdivision 3, is amended to read:

196.24 Subd. 3. **Reports of blood lead analysis required.** (a) Every hospital, medical clinic,
196.25 medical laboratory, other facility, or individual performing blood lead analysis shall report
196.26 the results after the analysis of each specimen analyzed, for both capillary and venous
196.27 specimens, and epidemiologic information required in this section to the commissioner of
196.28 health, within the time frames set forth in clauses (1) and (2):

196.29 (1) within two working days by telephone, fax, or electronic transmission as prescribed
196.30 by the commissioner, with written or electronic confirmation within one month as prescribed
196.31 by the commissioner, for a venous blood lead level equal to or greater than 15 micrograms
196.32 of lead per deciliter of whole blood; or

197.1 (2) within one month in writing or by electronic transmission as prescribed by the
197.2 commissioner, for any capillary result or for a venous blood lead level less than 15
197.3 micrograms of lead per deciliter of whole blood.

197.4 (b) If a blood lead analysis is performed outside of Minnesota and the facility performing
197.5 the analysis does not report the blood lead analysis results and epidemiological information
197.6 required in this section to the commissioner, the provider who collected the blood specimen
197.7 must satisfy the reporting requirements of this section. For purposes of this section, "provider"
197.8 has the meaning given in section 62D.02, subdivision 9.

197.9 (c) The commissioner shall coordinate with hospitals, medical clinics, medical
197.10 laboratories, and other facilities performing blood lead analysis to develop a universal
197.11 reporting form and mechanism.

197.12 Sec. 51. Minnesota Statutes 2020, section 144.9504, subdivision 2, is amended to read:

197.13 Subd. 2. **Lead risk assessment.** (a) Notwithstanding section 144.9501, subdivision 6a,
197.14 for purposes of this subdivision, "child" means an individual under 18 years of age.

197.15 (b) An assessing agency shall conduct a lead risk assessment of a residence, residential
197.16 or commercial child care facility, playground, school, or other location where lead hazards
197.17 are suspected according to the venous blood lead level and time frame set forth in clauses
197.18 (1) to (4) for purposes of secondary prevention:

197.19 (1) within 48 hours of a child or pregnant female in the residence, residential or
197.20 commercial child care facility, playground, school, or other location where lead hazards are
197.21 suspected being identified to the agency as having a venous blood lead level equal to or
197.22 greater than 60 micrograms of lead per deciliter of whole blood;

197.23 (2) within five working days of a child or pregnant female in the residence, residential
197.24 or commercial child care facility, playground, school, or other location where lead hazards
197.25 are suspected being identified to the agency as having a venous blood lead level equal to
197.26 or greater than 45 micrograms of lead per deciliter of whole blood;

197.27 ~~(3) within ten working days of a child in the residence being identified to the agency as~~
197.28 ~~having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter~~
197.29 ~~of whole blood; or~~

197.30 ~~(4)~~(3) within ten working days of a child or pregnant female in the residence, residential
197.31 or commercial child care facility, playground, school, or other location where lead hazards
197.32 are suspected being identified to the agency as having a venous blood lead level equal to
197.33 or greater than ten micrograms of lead per deciliter of whole blood; or

198.1 (4) within 20 working days of a child or pregnant female in the residence, residential or
198.2 commercial child care facility, playground, school, or other location where lead hazards are
198.3 suspected being identified to the agency as having a venous blood lead level equal to or
198.4 greater than five micrograms per deciliter of whole blood.

198.5 An assessing agency may refer investigations at sites other than the child's or pregnant
198.6 female's residence to the commissioner.

198.7 ~~(b)~~ (c) Within the limits of available local, state, and federal appropriations, an assessing
198.8 agency may also conduct a lead risk assessment for children with any elevated blood lead
198.9 level.

198.10 ~~(e)~~ (d) In a building with two or more dwelling units, an assessing agency shall assess
198.11 the individual unit in which the conditions of this section are met and shall inspect all
198.12 common areas accessible to a child. If a child visits one or more other sites such as another
198.13 residence, or a residential or commercial child care facility, playground, or school, the
198.14 assessing agency shall also inspect the other sites. The assessing agency shall have one
198.15 additional day added to the time frame set forth in this subdivision to complete the lead risk
198.16 assessment for each additional site.

198.17 ~~(d)~~ (e) Within the limits of appropriations, the assessing agency shall identify the known
198.18 addresses for the previous 12 months of the child or pregnant female with venous blood
198.19 lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms
198.20 per deciliter for the pregnant female; notify the property owners, landlords, and tenants at
198.21 those addresses that an elevated blood lead level was found in a person who resided at the
198.22 property; and give them primary prevention information. Within the limits of appropriations,
198.23 the assessing agency may perform a risk assessment and issue corrective orders in the
198.24 properties, if it is likely that the previous address contributed to the child's or pregnant
198.25 female's blood lead level. The assessing agency shall provide the notice required by this
198.26 subdivision without identifying the child or pregnant female with the elevated blood lead
198.27 level. The assessing agency is not required to obtain the consent of the child's parent or
198.28 guardian or the consent of the pregnant female for purposes of this subdivision. This
198.29 information shall be classified as private data on individuals as defined under section 13.02,
198.30 subdivision 12.

198.31 ~~(e)~~ (f) The assessing agency shall conduct the lead risk assessment according to rules
198.32 adopted by the commissioner under section 144.9508. An assessing agency shall have lead
198.33 risk assessments performed by lead risk assessors licensed by the commissioner according
198.34 to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk

199.1 assessment, the assessing agency shall begin legal proceedings to gain entry to the property
199.2 and the time frame for conducting a lead risk assessment set forth in this subdivision no
199.3 longer applies. A lead risk assessor or assessing agency may observe the performance of
199.4 lead hazard reduction in progress and shall enforce the provisions of this section under
199.5 section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with
199.6 appropriate analytical equipment to determine the lead content, except that deteriorated
199.7 painted surfaces or bare soil need not be tested if the property owner agrees to engage in
199.8 lead hazard reduction on those surfaces. The lead content of drinking water must be measured
199.9 if another probable source of lead exposure is not identified. Within a standard metropolitan
199.10 statistical area, an assessing agency may order lead hazard reduction of bare soil without
199.11 measuring the lead content of the bare soil if the property is in a census tract in which soil
199.12 sampling has been performed according to rules established by the commissioner and at
199.13 least 25 percent of the soil samples contain lead concentrations above the standard in section
199.14 144.9508.

199.15 ~~(f)~~ (g) Each assessing agency shall establish an administrative appeal procedure which
199.16 allows a property owner to contest the nature and conditions of any lead order issued by
199.17 the assessing agency. Assessing agencies must consider appeals that propose lower cost
199.18 methods that make the residence lead safe. The commissioner shall use the authority and
199.19 appeal procedure granted under sections 144.989 to 144.993.

199.20 ~~(g)~~ (h) Sections 144.9501 to 144.9512 neither authorize nor prohibit an assessing agency
199.21 from charging a property owner for the cost of a lead risk assessment.

199.22 Sec. 52. Minnesota Statutes 2020, section 144.9504, subdivision 5, is amended to read:

199.23 Subd. 5. **Lead orders.** (a) An assessing agency, after conducting a lead risk assessment,
199.24 shall order a property owner to perform lead hazard reduction on all lead sources that exceed
199.25 a standard adopted according to section 144.9508. If lead risk assessments and lead orders
199.26 are conducted at times when weather or soil conditions do not permit the lead risk assessment
199.27 or lead hazard reduction, external surfaces and soil lead shall be assessed, and lead orders
199.28 complied with, if necessary, at the first opportunity that weather and soil conditions allow.

199.29 (b) If, after conducting a lead risk assessment, an assessing agency determines that the
199.30 property owner's lead hazard originated from another source location, the assessing agency
199.31 may order the responsible person of the source location to:

199.32 (1) perform lead hazard reduction at the site where the assessing agency conducted the
199.33 lead risk assessment; and

200.1 (2) remediate the conditions at the source location that allowed the lead hazard, pollutant,
200.2 or contaminant to migrate from the source location.

200.3 (c) For purposes of this subdivision, "pollutant or contaminant" has the meaning given
200.4 in section 115B.02, subdivision 13, and "responsible person" has the meaning given in
200.5 section 115B.03.

200.6 ~~(b)~~ (d) If the paint standard under section 144.9508 is violated, but the paint is intact,
200.7 the assessing agency shall not order the paint to be removed unless the intact paint is a
200.8 known source of actual lead exposure to a specific person. Before the assessing agency may
200.9 order the intact paint to be removed, a reasonable effort must be made to protect the child
200.10 and preserve the intact paint by the use of guards or other protective devices and methods.

200.11 ~~(e)~~ (e) Whenever windows and doors or other components covered with deteriorated
200.12 lead-based paint have sound substrate or are not rotting, those components should be repaired,
200.13 sent out for stripping or planed down to remove deteriorated lead-based paint, or covered
200.14 with protective guards instead of being replaced, provided that such an activity is the least
200.15 cost method. However, a property owner who has been ordered to perform lead hazard
200.16 reduction may choose any method to address deteriorated lead-based paint on windows,
200.17 doors, or other components, provided that the method is approved in rules adopted under
200.18 section 144.9508 and that it is appropriate to the specific property.

200.19 ~~(d)~~ (f) Lead orders must require that any source of damage, such as leaking roofs,
200.20 plumbing, and windows, be repaired or replaced, as needed, to prevent damage to
200.21 lead-containing interior surfaces.

200.22 ~~(e)~~ (g) The assessing agency is not required to pay for lead hazard reduction. The
200.23 assessing agency shall enforce the lead orders issued to a property owner under this section.

200.24 Sec. 53. Minnesota Statutes 2020, section 144G.08, subdivision 7, as amended by Laws
200.25 2020, Seventh Special Session chapter 1, article 6, section 5, is amended to read:

200.26 Subd. 7. **Assisted living facility.** "Assisted living facility" means ~~a facility that~~ an
200.27 establishment where an operating person or legal entity, either directly or through contract,
200.28 business relationship, or common ownership with another person or entity, provides sleeping
200.29 accommodations and assisted living services to one or more adults in the facility. Assisted
200.30 living facility includes assisted living facility with dementia care, and does not include:

200.31 (1) emergency shelter, transitional housing, or any other residential units serving
200.32 exclusively or primarily homeless individuals, as defined under section 116L.361;

200.33 (2) a nursing home licensed under chapter 144A;

- 201.1 (3) a hospital, certified boarding care, or supervised living facility licensed under sections
201.2 144.50 to 144.56;
- 201.3 (4) a lodging establishment licensed under chapter 157 and Minnesota Rules, parts
201.4 9520.0500 to 9520.0670, or under chapter 245D or 245G;
- 201.5 (5) services and residential settings licensed under chapter 245A, including adult foster
201.6 care and services and settings governed under the standards in chapter 245D;
- 201.7 (6) a private home in which the residents are related by kinship, law, or affinity with the
201.8 provider of services;
- 201.9 (7) a duly organized condominium, cooperative, and common interest community, or
201.10 owners' association of the condominium, cooperative, and common interest community
201.11 where at least 80 percent of the units that comprise the condominium, cooperative, or
201.12 common interest community are occupied by individuals who are the owners, members, or
201.13 shareholders of the units;
- 201.14 (8) a temporary family health care dwelling as defined in sections 394.307 and 462.3593;
- 201.15 (9) a setting offering services conducted by and for the adherents of any recognized
201.16 church or religious denomination for its members exclusively through spiritual means or
201.17 by prayer for healing;
- 201.18 (10) housing financed pursuant to sections 462A.37 and 462A.375, units financed with
201.19 low-income housing tax credits pursuant to United States Code, title 26, section 42, and
201.20 units financed by the Minnesota Housing Finance Agency that are intended to serve
201.21 individuals with disabilities or individuals who are homeless, except for those developments
201.22 that market or hold themselves out as assisted living facilities and provide assisted living
201.23 services;
- 201.24 (11) rental housing developed under United States Code, title 42, section 1437, or United
201.25 States Code, title 12, section 1701q;
- 201.26 (12) rental housing designated for occupancy by only elderly or elderly and disabled
201.27 residents under United States Code, title 42, section 1437e, or rental housing for qualifying
201.28 families under Code of Federal Regulations, title 24, section 983.56;
- 201.29 (13) rental housing funded under United States Code, title 42, chapter 89, or United
201.30 States Code, title 42, section 8011;
- 201.31 ~~(14) a covered setting as defined in section 325F.721, subdivision 1, paragraph (b); or~~

202.1 ~~(15)~~(14) any establishment that exclusively or primarily serves as a shelter or temporary
202.2 shelter for victims of domestic or any other form of violence.

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

202.4 Sec. 54. Minnesota Statutes 2020, section 144G.84, is amended to read:

202.5 **144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA.**

202.6 (a) In addition to the minimum services required in section 144G.41, an assisted living
202.7 facility with dementia care must also provide the following services:

202.8 (1) assistance with activities of daily living that address the needs of each resident with
202.9 dementia due to cognitive or physical limitations. These services must meet or be in addition
202.10 to the requirements in the licensing rules for the facility. Services must be provided in a
202.11 person-centered manner that promotes resident choice, dignity, and sustains the resident's
202.12 abilities;

202.13 (2) nonpharmacological practices that are person-centered and evidence-informed;

202.14 (3) services to prepare and educate persons living with dementia and their legal and
202.15 designated representatives about transitions in care and ensuring complete, timely
202.16 communication between, across, and within settings; and

202.17 (4) services that provide residents with choices for meaningful engagement with other
202.18 facility residents and the broader community.

202.19 (b) Each resident must be evaluated for activities according to the licensing rules of the
202.20 facility. In addition, the evaluation must address the following:

202.21 (1) past and current interests;

202.22 (2) current abilities and skills;

202.23 (3) emotional and social needs and patterns;

202.24 (4) physical abilities and limitations;

202.25 (5) adaptations necessary for the resident to participate; and

202.26 (6) identification of activities for behavioral interventions.

202.27 (c) An individualized activity plan must be developed for each resident based on their
202.28 activity evaluation. The plan must reflect the resident's activity preferences and needs.

203.1 (d) A selection of daily structured and non-structured activities must be provided and
 203.2 included on the resident's activity service or care plan as appropriate. Daily activity options
 203.3 based on resident evaluation may include but are not limited to:

203.4 (1) occupation or chore related tasks;

203.5 (2) scheduled and planned events such as entertainment or outings;

203.6 (3) spontaneous activities for enjoyment or those that may help defuse a behavior;

203.7 (4) one-to-one activities that encourage positive relationships between residents and
 203.8 staff such as telling a life story, reminiscing, or playing music;

203.9 (5) spiritual, creative, and intellectual activities;

203.10 (6) sensory stimulation activities;

203.11 (7) physical activities that enhance or maintain a resident's ability to ambulate or move;

203.12 and

203.13 (8) a resident's individualized activity plan for regular outdoor activities activity.

203.14 (e) Behavioral symptoms that negatively impact the resident and others in the assisted
 203.15 living facility with dementia care must be evaluated and included on the service or care
 203.16 plan. The staff must initiate and coordinate outside consultation or acute care when indicated.

203.17 (f) Support must be offered to family and other significant relationships on a regularly
 203.18 scheduled basis but not less than quarterly.

203.19 (g) ~~Access to secured outdoor space and walkways that allow residents to enter and~~
 203.20 ~~return without staff assistance must be provided.~~ Existing housing with services
 203.21 establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted
 203.22 living facility license must provide residents with regular access to outdoor space. A licensee
 203.23 with new construction on or after August 1, 2021, or a new licensee that was not previously
 203.24 registered under chapter 144D prior to August 1, 2021, must provide regular access to
 203.25 secured outdoor space on the premises of the facility. A resident's access to outdoor space
 203.26 must be in accordance with the resident's documented care plan.

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

203.28 Sec. 55. **[145.87] HOME VISITING FOR PREGNANT WOMEN AND FAMILIES**
 203.29 **WITH YOUNG CHILDREN.**

203.30 Subdivision 1. Definitions. (a) The terms defined in this subdivision apply to this section
 203.31 and have the meanings given them.

204.1 (b) "Evidence-based home visiting program" means a program that:

204.2 (1) is based on a clear, consistent program or model that is research-based and grounded
204.3 in relevant, empirically based knowledge;

204.4 (2) is linked to program-determined outcomes and is associated with a national
204.5 organization, institution of higher education, or national or state public health institute;

204.6 (3) has comprehensive home visitation standards that ensure high-quality service delivery
204.7 and continuous quality improvement;

204.8 (4) has demonstrated significant, sustained positive outcomes; and

204.9 (5) either:

204.10 (i) has been evaluated using rigorous randomized controlled research designs and the
204.11 evaluation results have been published in a peer-reviewed journal; or

204.12 (ii) is based on quasi-experimental research using two or more separate, comparable
204.13 client samples.

204.14 (c) "Evidence-informed home visiting program" means a program that:

204.15 (1) has data or evidence demonstrating effectiveness at achieving positive outcomes for
204.16 pregnant women and young children; and

204.17 (2) either:

204.18 (i) has an active evaluation of the program; or

204.19 (ii) has a plan and timeline for an active evaluation of the program to be conducted.

204.20 (d) "Health equity" means every individual has a fair opportunity to attain the individual's
204.21 full health potential and no individual is disadvantaged from achieving this potential.

204.22 (e) "Promising practice home visiting program" means a program that has shown
204.23 improvement toward achieving positive outcomes for pregnant women or young children.

204.24 Subd. 2. Grants for home visiting programs. (a) The commissioner of health shall
204.25 award grants to community health boards, nonprofit organizations, and tribal nations to start
204.26 up or expand voluntary home visiting programs serving pregnant women and families with
204.27 young children. Home visiting programs supported under this section shall provide voluntary
204.28 home visits by early childhood professionals or health professionals, including but not
204.29 limited to nurses, social workers, early childhood educators, and trained paraprofessionals.
204.30 Grant money shall be used to:

205.1 (1) establish or expand evidence-based, evidence-informed, or promising practice home
205.2 visiting programs that address health equity and utilize community-driven health strategies;

205.3 (2) serve families with young children or pregnant women who have high needs or are
205.4 high-risk, including but not limited to a family with low income, a parent or pregnant woman
205.5 with a mental illness or a substance use disorder, or a parent or pregnant woman experiencing
205.6 housing instability or domestic abuse; and

205.7 (3) improve program outcomes in two or more of the following areas:

205.8 (i) maternal and newborn health;

205.9 (ii) school readiness and achievement;

205.10 (iii) family economic self-sufficiency;

205.11 (iv) coordination and referral for other community resources and supports;

205.12 (v) reduction in child injuries, abuse, or neglect; or

205.13 (vi) reduction in crime or domestic violence.

205.14 (b) Grants awarded to evidence-informed and promising practice home visiting programs
205.15 must include money to evaluate program outcomes for up to four of the areas listed in
205.16 paragraph (a), clause (3).

205.17 Subd. 3. **Grant prioritization.** (a) In awarding grants, the commissioner shall give
205.18 priority to community health boards, nonprofit organizations, and tribal nations seeking to
205.19 expand home visiting services with community or regional partnerships.

205.20 (b) The commissioner shall allocate at least 75 percent of the grant money awarded each
205.21 grant cycle to evidence-based home visiting programs that address health equity and up to
205.22 25 percent of the grant money awarded each grant cycle to evidence-informed or promising
205.23 practice home visiting programs that address health equity and utilize community-driven
205.24 health strategies.

205.25 Subd. 4. **Administrative costs.** The commissioner may use up to seven percent of the
205.26 annual appropriation under this section to provide training and technical assistance and to
205.27 administer and evaluate the program. The commissioner may contract for training,
205.28 capacity-building support for grantees or potential grantees, technical assistance, and
205.29 evaluation support.

205.30 Subd. 5. **Use of state general fund appropriations.** Appropriations dedicated to
205.31 establishing or expanding evidence-based home visiting programs shall, for grants awarded
205.32 on or after July 1, 2021, be awarded according to this section. This section shall not govern

206.1 grant awards of federal funds for home visiting programs and shall not govern grant awards
206.2 using state general fund appropriations dedicated to establishing or expanding nurse-family
206.3 partnership home visiting programs.

206.4 Sec. 56. Minnesota Statutes 2020, section 145.893, subdivision 1, is amended to read:

206.5 Subdivision 1. ~~Vouchers~~ Food benefits. An eligible individual shall receive ~~vouchers~~
206.6 food benefits for the purchase of specified nutritional supplements in type and quantity
206.7 approved by the commissioner. Alternate forms of delivery may be developed by the
206.8 commissioner in appropriate cases.

206.9 Sec. 57. Minnesota Statutes 2020, section 145.894, is amended to read:

206.10 **145.894 STATE COMMISSIONER OF HEALTH; DUTIES, RESPONSIBILITIES.**

206.11 The commissioner of health shall:

206.12 (1) develop a comprehensive state plan for the delivery of nutritional supplements to
206.13 pregnant and lactating women, infants, and children;

206.14 (2) contract with existing local public or private nonprofit organizations for the
206.15 administration of the nutritional supplement program;

206.16 (3) develop and implement a public education program promoting the provisions of
206.17 sections 145.891 to 145.897, and provide for the delivery of individual and family nutrition
206.18 education and counseling at project sites. The education programs must include a campaign
206.19 to promote breast feeding;

206.20 (4) develop in cooperation with other agencies and vendors a uniform state ~~voucher~~ food
206.21 benefit system for the delivery of nutritional supplements;

206.22 (5) authorize local health agencies to issue ~~vouchers bimonthly~~ food benefits trimonthly
206.23 to some or all eligible individuals served by the agency, provided the agency demonstrates
206.24 that the federal minimum requirements for providing nutrition education will continue to
206.25 be met and that the quality of nutrition education and health services provided by the agency
206.26 will not be adversely impacted;

206.27 (6) investigate and implement a system to reduce the cost of nutritional supplements
206.28 and maintain ongoing negotiations with nonparticipating manufacturers and suppliers to
206.29 maximize cost savings;

206.30 (7) develop, analyze, and evaluate the health aspects of the nutritional supplement
206.31 program and establish nutritional guidelines for the program;

207.1 (8) apply for, administer, and annually expend at least 99 percent of available federal
207.2 or private funds;

207.3 (9) aggressively market services to eligible individuals by conducting ongoing outreach
207.4 activities and by coordinating with and providing marketing materials and technical assistance
207.5 to local human services and community service agencies and nonprofit service providers;

207.6 (10) determine, on July 1 of each year, the number of pregnant women participating in
207.7 each special supplemental food program for women, infants, and children (WIC) ~~and, in~~
207.8 ~~1986, 1987, and 1988, at the commissioner's discretion, designate a different food program~~
207.9 ~~deliverer if the current deliverer fails to increase the participation of pregnant women in the~~
207.10 ~~program by at least ten percent over the previous year's participation rate;~~

207.11 (11) promulgate all rules necessary to carry out the provisions of sections 145.891 to
207.12 145.897; and

207.13 (12) ensure that any state appropriation to supplement the federal program is spent
207.14 consistent with federal requirements.

207.15 Sec. 58. Minnesota Statutes 2020, section 145.897, is amended to read:

207.16 **145.897 ~~VOUCHERS~~ FOOD BENEFITS.**

207.17 ~~Vouchers~~ Food benefits issued pursuant to sections 145.891 to 145.897 shall be only
207.18 for the purchase of those foods determined by the ~~commissioner~~ United States Department
207.19 of Agriculture to be desirable nutritional supplements for pregnant and lactating women,
207.20 infants and children. ~~These foods shall include, but not be limited to, iron-fortified infant~~
207.21 ~~formula, vegetable or fruit juices, cereal, milk, cheese, and eggs.~~

207.22 Sec. 59. Minnesota Statutes 2020, section 145.899, is amended to read:

207.23 **145.899 WIC ~~VOUCHERS~~ FOOD BENEFITS FOR ORGANICS.**

207.24 ~~Vouchers~~ Food benefits for the special supplemental nutrition program for women,
207.25 infants, and children (WIC) may be used to purchase cost-neutral organic WIC allowable
207.26 food. The commissioner of health shall regularly evaluate the list of WIC allowable food
207.27 in accordance with federal requirements and shall add to the list any organic WIC allowable
207.28 foods determined to be cost-neutral.

207.29 Sec. 60. Minnesota Statutes 2020, section 145.901, subdivision 2, is amended to read:

207.30 Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as
207.31 defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined

208.1 in section 13.83, subdivision 1, and health records created, maintained, or stored by providers
208.2 ~~as defined in section 144.291, subdivision 2, paragraph (i)~~, without the consent of the subject
208.3 of the data, and without the consent of the parent, spouse, other guardian, or legal
208.4 representative of the subject of the data, when the subject of the data is a woman who died
208.5 during a pregnancy or within 12 months of a fetal death, a live birth, or other termination
208.6 of a pregnancy.

208.7 The commissioner has access only to medical data and health records related to deaths
208.8 that occur on or after July 1, 2000, including the names of the providers, clinics, or other
208.9 health services such as family home visiting programs; the women, infants, and children
208.10 (WIC) program; prescription monitoring programs; and behavioral health services, where
208.11 care was received before, during, or related to the pregnancy or death. The commissioner
208.12 has access to records maintained by a medical examiner, a coroner, or hospitals or to hospital
208.13 discharge data, for the purpose of providing the name and location of any pre-pregnancy,
208.14 prenatal, or other care received by the subject of the data up to one year after the end of the
208.15 pregnancy.

208.16 (b) The provider or responsible authority that creates, maintains, or stores the data shall
208.17 furnish the data upon the request of the commissioner. The provider or responsible authority
208.18 may charge a fee for providing the data, not to exceed the actual cost of retrieving and
208.19 duplicating the data.

208.20 (c) The commissioner shall make a good faith reasonable effort to notify the parent,
208.21 spouse, other guardian, or legal representative of the subject of the data before collecting
208.22 data on the subject. For purposes of this paragraph, "reasonable effort" means one notice
208.23 is sent by certified mail to the last known address of the parent, spouse, guardian, or legal
208.24 representative informing the recipient of the data collection and offering a public health
208.25 nurse support visit if desired.

208.26 (d) The commissioner does not have access to coroner or medical examiner data that
208.27 are part of an active investigation as described in section 13.83.

208.28 (e) The commissioner may request and receive from a coroner or medical examiner the
208.29 name of the health care provider that provided prenatal, postpartum, or other health services
208.30 to the subject of the data.

208.31 (f) The commissioner may access Department of Human Services data to identify sources
208.32 of care and services to assist with the evaluation of welfare systems, including housing, to
208.33 reduce preventable maternal deaths.

209.1 (g) The commissioner may request and receive law enforcement reports or incident
209.2 reports related to the subject of the data.

209.3 Sec. 61. Minnesota Statutes 2020, section 145.901, subdivision 4, is amended to read:

209.4 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source
209.5 records under subdivision 2, including identifying information on individual providers, data
209.6 subjects, or their children, and data derived by the commissioner under subdivision 3 for
209.7 the purpose of carrying out maternal death studies, are classified as confidential data on
209.8 individuals or confidential data on decedents, as defined in sections 13.02, subdivision 3,
209.9 and 13.10, subdivision 1, paragraph (a).

209.10 (b) Information classified under paragraph (a) shall not be subject to discovery or
209.11 introduction into evidence in any administrative, civil, or criminal proceeding. Such
209.12 information otherwise available from an original source shall not be immune from discovery
209.13 or barred from introduction into evidence merely because it was utilized by the commissioner
209.14 in carrying out maternal death studies.

209.15 (c) Summary data on maternal death studies created by the commissioner, which does
209.16 not identify individual data subjects or individual providers, shall be public in accordance
209.17 with section 13.05, subdivision 7.

209.18 (d) Data provided by the commissioner of human services to the commissioner of health
209.19 under this section retain the same classification the data held when retained by the
209.20 commissioner of human services, as required under section 13.03, subdivision 4, paragraph
209.21 (c).

209.22 Sec. 62. [145.9013] SEVERE MATERNAL MORBIDITY STUDIES.

209.23 Subdivision 1. Purpose. (a) The commissioner of health may conduct maternal morbidity
209.24 studies to assist the planning, implementation, and evaluation of medical, health, and welfare
209.25 service systems and to reduce the numbers of preventable adverse maternal outcomes in
209.26 Minnesota.

209.27 (b) For purposes of this section, "maternal morbidity" has the meaning given to severe
209.28 maternal morbidity by the Centers for Disease Control and Prevention and includes an
209.29 unexpected outcome of labor or delivery that results in significant short- or long-term
209.30 consequences to a woman's health.

209.31 Subd. 2. Access to data. (a) The commissioner has access to medical data as defined in
209.32 section 13.384, subdivision 1, paragraph (b), and health records created, maintained, or

210.1 stored by providers when the subject of the data experienced one or more maternal
210.2 morbidities during a pregnancy or within 12 months of the end of a pregnancy. The
210.3 commissioner has access only to medical data and health records related to maternal
210.4 morbidities that occur on or after January 1, 2015, including the names of providers and
210.5 clinics where care was received before, during, or related to the pregnancy. The commissioner
210.6 has access to records maintained by family home visiting programs; the women, infants,
210.7 and children (WIC) program; prescription monitoring programs; behavioral health services
210.8 programs; substance use disorder treatment facilities; and hospitals for the purpose of
210.9 providing the name and location of any pre-pregnancy, prenatal, or other care received by
210.10 the subject of the data up to one year following the end of the pregnancy.

210.11 (b) The provider or responsible authority that creates, maintains, or stores the data under
210.12 paragraph (a) shall provide the commissioner with access to information on each maternal
210.13 morbidity case in the manner and at times that the commissioner designates. The provider
210.14 or responsible authority may charge a fee for providing the data, not to exceed the actual
210.15 cost of retrieving and duplicating the data.

210.16 (c) Once the commissioner has determined that the subject of the data meets the criteria
210.17 in paragraph (a) for a maternal morbidity review, the commissioner must inform the subject
210.18 of the data about the collection of the subject's data under this section. At any time during
210.19 the maternal morbidity review process, the subject of the data may request in writing, using
210.20 a form prescribed by the commissioner, that the commissioner remove the subject of the
210.21 data's personal identifying information from data obtained by the commissioner under this
210.22 section. The commissioner must comply with such requests. For purposes of this paragraph,
210.23 "inform the subject of the data about the collection of the subject's data" means one notice
210.24 sent by certified mail to the last known address of the subject of the data.

210.25 (d) The subject of the data may voluntarily participate in an informant interview with
210.26 staff on behalf of the commissioner related to the maternal experience. If the subject of the
210.27 data agrees to the interview, the commissioner may compensate the subject of the data for
210.28 time and other expenses related to the interview.

210.29 (e) The commissioner may access Department of Human Services data to identify sources
210.30 of care and services to assist with the evaluation of welfare systems to reduce preventable
210.31 maternal morbidities.

210.32 Subd. 3. **Management of records.** After the commissioner has collected all data about
210.33 a subject of a maternal morbidity study needed to perform the study, the data from source
210.34 records obtained under subdivision 2, other than data identifying the subject, must be

211.1 transferred to separate records to be maintained by the commissioner. Notwithstanding
211.2 section 138.17, after the data has been transferred, all source records obtained under
211.3 subdivision 2 possessed by the commissioner must be destroyed.

211.4 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source
211.5 records under subdivision 2, including identifying information on individual providers, data
211.6 subjects, or their children, and data derived by the commissioner under subdivision 3 for
211.7 the purpose of carrying out maternal morbidity studies, are classified as confidential data
211.8 on individuals or confidential data on decedents, as defined in sections 13.02, subdivision
211.9 3, and 13.10, subdivision 1, paragraph (a).

211.10 (b) Information classified under paragraph (a) shall not be subject to discovery or
211.11 introduction into evidence in any administrative, civil, or criminal proceeding. Such
211.12 information otherwise available from an original source shall not be immune from discovery
211.13 or barred from introduction into evidence merely because the information was utilized by
211.14 the commissioner in carrying out maternal morbidity studies.

211.15 (c) Summary data on maternal morbidity studies created by the commissioner, which
211.16 does not identify individual data subjects or individual providers, shall be public in
211.17 accordance with section 13.05, subdivision 7.

211.18 (d) Data provided by the commissioner of human services to the commissioner of health
211.19 under this section retains the same classification the data held when retained by the
211.20 commissioner of human services, as required under section 13.03, subdivision 4, paragraph
211.21 (c).

211.22 Sec. 63. Minnesota Statutes 2020, section 152.01, subdivision 23, is amended to read:

211.23 Subd. 23. **Analog.** (a) Except as provided in paragraph (b), "analog" means a substance,
211.24 the chemical structure of which is substantially similar to the chemical structure of a
211.25 controlled substance in Schedule I or II:

211.26 (1) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system
211.27 that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic
211.28 effect on the central nervous system of a controlled substance in Schedule I or II; or

211.29 (2) with respect to a particular person, if the person represents or intends that the substance
211.30 have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is
211.31 substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect
211.32 on the central nervous system of a controlled substance in Schedule I or II.

211.33 (b) "Analog" does not include:

- 212.1 (1) a controlled substance;
- 212.2 (2) any substance for which there is an approved new drug application under the Federal
212.3 Food, Drug, and Cosmetic Act; ~~or~~
- 212.4 (3) with respect to a particular person, any substance, if an exemption is in effect for
212.5 investigational use, for that person, as provided by United States Code, title 21, section 355,
212.6 and the person is registered as a controlled substance researcher as required under section
212.7 152.12, subdivision 3, to the extent conduct with respect to the substance is pursuant to the
212.8 exemption and registration; or
- 212.9 (4) marijuana or tetrahydrocannabinols naturally contained in a plant of the genus
212.10 cannabis or in the resinous extractives of the plant.
- 212.11 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
212.12 committed on or after that date.
- 212.13 Sec. 64. Minnesota Statutes 2020, section 152.02, subdivision 2, is amended to read:
- 212.14 Subd. 2. **Schedule I.** (a) Schedule I consists of the substances listed in this subdivision.
- 212.15 (b) Opiates. Unless specifically excepted or unless listed in another schedule, any of the
212.16 following substances, including their analogs, isomers, esters, ethers, salts, and salts of
212.17 isomers, esters, and ethers, whenever the existence of the analogs, isomers, esters, ethers,
212.18 and salts is possible:
- 212.19 (1) acetylmethadol;
- 212.20 (2) allylprodine;
- 212.21 (3) alphacetylmethadol (except levo-alphacetylmethadol, also known as levomethadyl
212.22 acetate);
- 212.23 (4) alphameprodine;
- 212.24 (5) alphamethadol;
- 212.25 (6) alpha-methylfentanyl benzethidine;
- 212.26 (7) betacetylmethadol;
- 212.27 (8) betameprodine;
- 212.28 (9) betamethadol;
- 212.29 (10) betaprodine;
- 212.30 (11) clonitazene;

- 213.1 (12) dextromoramide;
- 213.2 (13) diampromide;
- 213.3 (14) diethylambutene;
- 213.4 (15) difenoxin;
- 213.5 (16) dimenoxadol;
- 213.6 (17) dimepheptanol;
- 213.7 (18) dimethylambutene;
- 213.8 (19) dioxaphetyl butyrate;
- 213.9 (20) dipipanone;
- 213.10 (21) ethylmethylthiambutene;
- 213.11 (22) etonitazene;
- 213.12 (23) etoxeridine;
- 213.13 (24) furethidine;
- 213.14 (25) hydroxypethidine;
- 213.15 (26) ketobemidone;
- 213.16 (27) levomoramide;
- 213.17 (28) levophenacilmorphan;
- 213.18 (29) 3-methylfentanyl;
- 213.19 (30) acetyl-alpha-methylfentanyl;
- 213.20 (31) alpha-methylthiofentanyl;
- 213.21 (32) benzylfentanyl beta-hydroxyfentanyl;
- 213.22 (33) beta-hydroxy-3-methylfentanyl;
- 213.23 (34) 3-methylthiofentanyl;
- 213.24 (35) thenylfentanyl;
- 213.25 (36) thiofentanyl;
- 213.26 (37) para-fluorofentanyl;
- 213.27 (38) morpheridine;

- 214.1 (39) 1-methyl-4-phenyl-4-propionoxypiperidine;
- 214.2 (40) noracymethadol;
- 214.3 (41) norlevorphanol;
- 214.4 (42) normethadone;
- 214.5 (43) norpipanone;
- 214.6 (44) 1-(2-phenylethyl)-4-phenyl-4-acetoxypiperidine (PEPAP);
- 214.7 (45) phenadoxone;
- 214.8 (46) phenampromide;
- 214.9 (47) phenomorphan;
- 214.10 (48) phenoperidine;
- 214.11 (49) piritramide;
- 214.12 (50) proheptazine;
- 214.13 (51) properidine;
- 214.14 (52) propiram;
- 214.15 (53) racemoramide;
- 214.16 (54) tilidine;
- 214.17 (55) trimeperidine;
- 214.18 (56) N-(1-Phenethylpiperidin-4-yl)-N-phenylacetamide (acetyl fentanyl);
- 214.19 (57) 3,4-dichloro-N-[(1R,2R)-2-(dimethylamino)cyclohexyl]-N-
- 214.20 methylbenzamide(U47700);
- 214.21 (58) N-phenyl-N-[1-(2-phenylethyl)piperidin-4-yl]furan-2-carboxamide(furanylfentanyl);
- 214.22 (59) 4-(4-bromophenyl)-4-dimethylamino-1-phenethylcyclohexanol (bromadol);
- 214.23 (60) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopropanecarboxamide (Cyclopropyl
- 214.24 fentanyl);
- 214.25 (61) N-(1-phenethylpiperidin-4-yl)-N-phenylbutanamide) (butyryl fentanyl);
- 214.26 (62) 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) (MT-45);
- 214.27 (63) N-(1-phenethylpiperidin-4-yl)-N-phenylcyclopentanecarboxamide (cyclopentyl
- 214.28 fentanyl);

- 215.1 (64) N-(1-phenethylpiperidin-4-yl)-N-phenylisobutyramide (isobutyryl fentanyl);
- 215.2 (65) N-(1-phenethylpiperidin-4-yl)-N-phenylpentanamide (valeryl fentanyl);
- 215.3 (66) N-(4-chlorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide
- 215.4 (para-chloroisobutyryl fentanyl);
- 215.5 (67) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)butyramide (para-fluorobutyryl
- 215.6 fentanyl);
- 215.7 (68) N-(4-methoxyphenyl)-N-(1-phenethylpiperidin-4-yl)butyramide
- 215.8 (para-methoxybutyryl fentanyl);
- 215.9 (69) N-(2-fluorophenyl)-2-methoxy-N-(1-phenethylpiperidin-4-yl)acetamide (ocfentanil);
- 215.10 (70) N-(4-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)isobutyramide (4-fluoroisobutyryl
- 215.11 fentanyl or para-fluoroisobutyryl fentanyl);
- 215.12 (71) N-(1-phenethylpiperidin-4-yl)-N-phenylacrylamide (acryl fentanyl or
- 215.13 acryloylfentanyl);
- 215.14 (72) 2-methoxy-N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide (methoxyacetyl
- 215.15 fentanyl);
- 215.16 (73) N-(2-fluorophenyl)-N-(1-phenethylpiperidin-4-yl)propionamide (ortho-fluorofentanyl
- 215.17 or 2-fluorofentanyl);
- 215.18 (74) N-(1-phenethylpiperidin-4-yl)-N-phenyltetrahydrofuran-2-carboxamide
- 215.19 (tetrahydrofuranyl fentanyl); and
- 215.20 (75) Fentanyl-related substances, their isomers, esters, ethers, salts and salts of isomers,
- 215.21 esters and ethers, meaning any substance not otherwise listed under another federal
- 215.22 Administration Controlled Substance Code Number or not otherwise listed in this section,
- 215.23 and for which no exemption or approval is in effect under section 505 of the Federal Food,
- 215.24 Drug, and Cosmetic Act, United States Code , title 21, section 355, that is structurally related
- 215.25 to fentanyl by one or more of the following modifications:
- 215.26 (i) replacement of the phenyl portion of the phenethyl group by any monocycle, whether
- 215.27 or not further substituted in or on the monocycle;
- 215.28 (ii) substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxyl, halo,
- 215.29 haloalkyl, amino, or nitro groups;
- 215.30 (iii) substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether,
- 215.31 hydroxyl, halo, haloalkyl, amino, or nitro groups;

- 216.1 (iv) replacement of the aniline ring with any aromatic monocycle whether or not further
216.2 substituted in or on the aromatic monocycle; or
- 216.3 (v) replacement of the N-propionyl group by another acyl group.
- 216.4 (c) Opium derivatives. Any of the following substances, their analogs, salts, isomers,
216.5 and salts of isomers, unless specifically excepted or unless listed in another schedule,
216.6 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:
- 216.7 (1) acetorphine;
- 216.8 (2) acetyldihydrocodeine;
- 216.9 (3) benzylmorphine;
- 216.10 (4) codeine methylbromide;
- 216.11 (5) codeine-n-oxide;
- 216.12 (6) cyprenorphine;
- 216.13 (7) desomorphine;
- 216.14 (8) dihydromorphine;
- 216.15 (9) drotebanol;
- 216.16 (10) etorphine;
- 216.17 (11) heroin;
- 216.18 (12) hydromorphenol;
- 216.19 (13) methyl-desorphine;
- 216.20 (14) methyldihydromorphine;
- 216.21 (15) morphine methylbromide;
- 216.22 (16) morphine methylsulfonate;
- 216.23 (17) morphine-n-oxide;
- 216.24 (18) myrophine;
- 216.25 (19) nicocodeine;
- 216.26 (20) nicomorphine;
- 216.27 (21) normorphine;
- 216.28 (22) pholcodine; and

217.1 (23) thebacon.

217.2 (d) Hallucinogens. Any material, compound, mixture or preparation which contains any
217.3 quantity of the following substances, their analogs, salts, isomers (whether optical, positional,
217.4 or geometric), and salts of isomers, unless specifically excepted or unless listed in another
217.5 schedule, whenever the existence of the analogs, salts, isomers, and salts of isomers is
217.6 possible:

217.7 (1) methylenedioxy amphetamine;

217.8 (2) methylenedioxymethamphetamine;

217.9 (3) methylenedioxy-N-ethylamphetamine (MDEA);

217.10 (4) n-hydroxy-methylenedioxyamphetamine;

217.11 (5) 4-bromo-2,5-dimethoxyamphetamine (DOB);

217.12 (6) 2,5-dimethoxyamphetamine (2,5-DMA);

217.13 (7) 4-methoxyamphetamine;

217.14 (8) 5-methoxy-3, 4-methylenedioxyamphetamine;

217.15 (9) alpha-ethyltryptamine;

217.16 (10) bufotenine;

217.17 (11) diethyltryptamine;

217.18 (12) dimethyltryptamine;

217.19 (13) 3,4,5-trimethoxyamphetamine;

217.20 (14) 4-methyl-2, 5-dimethoxyamphetamine (DOM);

217.21 (15) ibogaine;

217.22 (16) lysergic acid diethylamide (LSD);

217.23 (17) mescaline;

217.24 (18) parahexyl;

217.25 (19) N-ethyl-3-piperidyl benzilate;

217.26 (20) N-methyl-3-piperidyl benzilate;

217.27 (21) psilocybin;

217.28 (22) psilocyn;

- 218.1 (23) tenocyclidine (TPCP or TCP);
- 218.2 (24) N-ethyl-1-phenyl-cyclohexylamine (PCE);
- 218.3 (25) 1-(1-phenylcyclohexyl) pyrrolidine (PCPy);
- 218.4 (26) 1-[1-(2-thienyl)cyclohexyl]-pyrrolidine (TCPy);
- 218.5 (27) 4-chloro-2,5-dimethoxyamphetamine (DOC);
- 218.6 (28) 4-ethyl-2,5-dimethoxyamphetamine (DOET);
- 218.7 (29) 4-iodo-2,5-dimethoxyamphetamine (DOI);
- 218.8 (30) 4-bromo-2,5-dimethoxyphenethylamine (2C-B);
- 218.9 (31) 4-chloro-2,5-dimethoxyphenethylamine (2C-C);
- 218.10 (32) 4-methyl-2,5-dimethoxyphenethylamine (2C-D);
- 218.11 (33) 4-ethyl-2,5-dimethoxyphenethylamine (2C-E);
- 218.12 (34) 4-iodo-2,5-dimethoxyphenethylamine (2C-I);
- 218.13 (35) 4-propyl-2,5-dimethoxyphenethylamine (2C-P);
- 218.14 (36) 4-isopropylthio-2,5-dimethoxyphenethylamine (2C-T-4);
- 218.15 (37) 4-propylthio-2,5-dimethoxyphenethylamine (2C-T-7);
- 218.16 (38) 2-(8-bromo-2,3,6,7-tetrahydrofuro [2,3-f][1]benzofuran-4-yl)ethanamine
- 218.17 (2-CB-FLY);
- 218.18 (39) bromo-benzodifuranyl-isopropylamine (Bromo-DragonFLY);
- 218.19 (40) alpha-methyltryptamine (AMT);
- 218.20 (41) N,N-diisopropyltryptamine (DiPT);
- 218.21 (42) 4-acetoxy-N,N-dimethyltryptamine (4-AcO-DMT);
- 218.22 (43) 4-acetoxy-N,N-diethyltryptamine (4-AcO-DET);
- 218.23 (44) 4-hydroxy-N-methyl-N-propyltryptamine (4-HO-MPT);
- 218.24 (45) 4-hydroxy-N,N-dipropyltryptamine (4-HO-DPT);
- 218.25 (46) 4-hydroxy-N,N-diallyltryptamine (4-HO-DALT);
- 218.26 (47) 4-hydroxy-N,N-diisopropyltryptamine (4-HO-DiPT);
- 218.27 (48) 5-methoxy-N,N-diisopropyltryptamine (5-MeO-DiPT);

- 219.1 (49) 5-methoxy- α -methyltryptamine (5-MeO-AMT);
- 219.2 (50) 5-methoxy-N,N-dimethyltryptamine (5-MeO-DMT);
- 219.3 (51) 5-methylthio-N,N-dimethyltryptamine (5-MeS-DMT);
- 219.4 (52) 5-methoxy-N-methyl-N-isopropyltryptamine (5-MeO-MiPT);
- 219.5 (53) 5-methoxy- α -ethyltryptamine (5-MeO-AET);
- 219.6 (54) 5-methoxy-N,N-dipropyltryptamine (5-MeO-DPT);
- 219.7 (55) 5-methoxy-N,N-diethyltryptamine (5-MeO-DET);
- 219.8 (56) 5-methoxy-N,N-diallyltryptamine (5-MeO-DALT);
- 219.9 (57) methoxetamine (MXE);
- 219.10 (58) 5-iodo-2-aminoindane (5-IAI);
- 219.11 (59) 5,6-methylenedioxy-2-aminoindane (MDAI);
- 219.12 (60) 2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe);
- 219.13 (61) 2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe);
- 219.14 (62) 2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe);
- 219.15 (63) 2-(2,5-Dimethoxyphenyl)ethanamine (2C-H);
- 219.16 (64) 2-(4-Ethylthio-2,5-dimethoxyphenyl)ethanamine (2C-T-2);
- 219.17 (65) N,N-Dipropyltryptamine (DPT);
- 219.18 (66) 3-[1-(Piperidin-1-yl)cyclohexyl]phenol (3-HO-PCP);
- 219.19 (67) N-ethyl-1-(3-methoxyphenyl)cyclohexanamine (3-MeO-PCE);
- 219.20 (68) 4-[1-(3-methoxyphenyl)cyclohexyl]morpholine (3-MeO-PCMo);
- 219.21 (69) 1-[1-(4-methoxyphenyl)cyclohexyl]-piperidine (methoxydine, 4-MeO-PCP);
- 219.22 (70) 2-(2-Chlorophenyl)-2-(ethylamino)cyclohexan-1-one (N-Ethyl-norketamine,
219.23 ethketamine, NENK);
- 219.24 (71) methylenedioxy-N,N-dimethylamphetamine (MDDMA);
- 219.25 (72) 3-(2-Ethyl(methyl)aminoethyl)-1H-indol-4-yl (4-AcO-MET); and
- 219.26 (73) 2-Phenyl-2-(methylamino)cyclohexanone (deschloroketamine).
- 219.27 (e) Peyote. All parts of the plant presently classified botanically as *Lophophora williamsii*
- 219.28 Lemaire, whether growing or not, the seeds thereof, any extract from any part of the plant,

220.1 and every compound, manufacture, salts, derivative, mixture, or preparation of the plant,
220.2 its seeds or extracts. The listing of peyote as a controlled substance in Schedule I does not
220.3 apply to the nondrug use of peyote in bona fide religious ceremonies of the American Indian
220.4 Church, and members of the American Indian Church are exempt from registration. Any
220.5 person who manufactures peyote for or distributes peyote to the American Indian Church,
220.6 however, is required to obtain federal registration annually and to comply with all other
220.7 requirements of law.

220.8 (f) Central nervous system depressants. Unless specifically excepted or unless listed in
220.9 another schedule, any material compound, mixture, or preparation which contains any
220.10 quantity of the following substances, their analogs, salts, isomers, and salts of isomers
220.11 whenever the existence of the analogs, salts, isomers, and salts of isomers is possible:

220.12 (1) mecloqualone;

220.13 (2) methaqualone;

220.14 (3) gamma-hydroxybutyric acid (GHB), including its esters and ethers;

220.15 (4) flunitrazepam;

220.16 (5) 2-(2-Methoxyphenyl)-2-(methylamino)cyclohexanone (2-MeO-2-deschloroketamine,
220.17 methoxyketamine);

220.18 (6) tianeptine;

220.19 (7) clonazepam;

220.20 (8) etizolam;

220.21 (9) flubromazolam; and

220.22 (10) flubromazepam.

220.23 (g) Stimulants. Unless specifically excepted or unless listed in another schedule, any
220.24 material compound, mixture, or preparation which contains any quantity of the following
220.25 substances, their analogs, salts, isomers, and salts of isomers whenever the existence of the
220.26 analogs, salts, isomers, and salts of isomers is possible:

220.27 (1) aminorex;

220.28 (2) cathinone;

220.29 (3) fenethylamine;

220.30 (4) methcathinone;

- 221.1 (5) methylaminorex;
- 221.2 (6) N,N-dimethylamphetamine;
- 221.3 (7) N-benzylpiperazine (BZP);
- 221.4 (8) methylmethcathinone (mephedrone);
- 221.5 (9) 3,4-methylenedioxy-N-methylcathinone (methydone);
- 221.6 (10) methoxymethcathinone (methedrone);
- 221.7 (11) methylenedioxypropylone (MDPV);
- 221.8 (12) 3-fluoro-N-methylcathinone (3-FMC);
- 221.9 (13) methylethcathinone (MEC);
- 221.10 (14) 1-benzofuran-6-ylpropan-2-amine (6-APB);
- 221.11 (15) dimethylmethcathinone (DMMC);
- 221.12 (16) fluoroamphetamine;
- 221.13 (17) fluoromethamphetamine;
- 221.14 (18) α -methylaminobutyrophenone (MABP or buphedrone);
- 221.15 (19) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one (butylone);
- 221.16 (20) 2-(methylamino)-1-(4-methylphenyl)butan-1-one (4-MEMABP or BZ-6378);
- 221.17 (21) 1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl) pentan-1-one (naphthylpyrovalerone or
- 221.18 naphyrone);
- 221.19 (22) (alpha-pyrrolidinopentiophenone (alpha-PVP);
- 221.20 (23) (RS)-1-(4-methylphenyl)-2-(1-pyrrolidinyl)-1-hexanone (4-Me-PHP or MPHP);
- 221.21 (24) 2-(1-pyrrolidinyl)-hexanophenone (Alpha-PHP);
- 221.22 (25) 4-methyl-N-ethylcathinone (4-MEC);
- 221.23 (26) 4-methyl-alpha-pyrrolidinopropiophenone (4-MePPP);
- 221.24 (27) 2-(methylamino)-1-phenylpentan-1-one (pentedrone);
- 221.25 (28) 1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one (pentylone);
- 221.26 (29) 4-fluoro-N-methylcathinone (4-FMC);
- 221.27 (30) 3,4-methylenedioxy-N-ethylcathinone (ethylone);

- 222.1 (31) alpha-pyrrolidinobutiophenone (α -PBP);
- 222.2 (32) 5-(2-Aminopropyl)-2,3-dihydrobenzofuran (5-APDB);
- 222.3 (33) 1-phenyl-2-(1-pyrrolidinyl)-1-heptanone (PV8);
- 222.4 (34) 6-(2-Aminopropyl)-2,3-dihydrobenzofuran (6-APDB);
- 222.5 (35) 4-methyl-alpha-ethylaminopentiophenone (4-MEAPP);
- 222.6 (36) 4'-chloro-alpha-pyrrolidinopropiophenone (4'-chloro-PPP);
- 222.7 (37) 1-(1,3-Benzodioxol-5-yl)-2-(dimethylamino)butan-1-one (dibutylone, bk-DMBDB);
- 222.8 (38) 1-(3-chlorophenyl) piperazine (meta-chlorophenylpiperazine or mCPP);
- 222.9 (39) 1-(1,3-benzodioxol-5-yl)-2-(ethylamino)-pentan-1-one (N-ethylpentylone, ephylone);
- 222.10 and
- 222.11 (40) any other substance, except bupropion or compounds listed under a different
- 222.12 schedule, that is structurally derived from 2-aminopropan-1-one by substitution at the
- 222.13 1-position with either phenyl, naphthyl, or thiophene ring systems, whether or not the
- 222.14 compound is further modified in any of the following ways:
- 222.15 (i) by substitution in the ring system to any extent with alkyl, alkylenedioxy, alkoxy,
- 222.16 haloalkyl, hydroxyl, or halide substituents, whether or not further substituted in the ring
- 222.17 system by one or more other univalent substituents;
- 222.18 (ii) by substitution at the 3-position with an acyclic alkyl substituent;
- 222.19 (iii) by substitution at the 2-amino nitrogen atom with alkyl, dialkyl, benzyl, or
- 222.20 methoxybenzyl groups; or
- 222.21 (iv) by inclusion of the 2-amino nitrogen atom in a cyclic structure.
- 222.22 (h) ~~Marijuana~~, Synthetic tetrahydrocannabinols, and synthetic cannabinoids. Unless
- 222.23 specifically excepted or unless listed in another schedule, any ~~natural~~ or synthetic material,
- 222.24 compound, mixture, or preparation that contains any quantity of the following substances,
- 222.25 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
- 222.26 the existence of the isomers, esters, ethers, or salts is possible:
- 222.27 ~~(1) marijuana;~~
- 222.28 ~~(2) (1) synthetic~~ tetrahydrocannabinols ~~naturally contained in a plant of the genus~~
- 222.29 ~~Cannabis~~, that are the synthetic equivalents of the substances contained in the cannabis
- 222.30 plant or in the resinous extractives of the plant, or synthetic substances with similar chemical
- 222.31 structure and pharmacological activity to those substances contained in the plant or resinous

223.1 extract, including, but not limited to, 1 cis or trans tetrahydrocannabinol, 6 cis or trans
223.2 tetrahydrocannabinol, and 3,4 cis or trans tetrahydrocannabinol;

223.3 ~~(3)~~ (2) synthetic cannabinoids, including the following substances:

223.4 (i) Naphthoylindoles, which are any compounds containing a 3-(1-naphthoyl)indole
223.5 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
223.6 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
223.7 2-(4-morpholinyl)ethyl group, whether or not further substituted in the indole ring to any
223.8 extent and whether or not substituted in the naphthyl ring to any extent. Examples of
223.9 naphthoylindoles include, but are not limited to:

223.10 (A) 1-Pentyl-3-(1-naphthoyl)indole (JWH-018 and AM-678);

223.11 (B) 1-Butyl-3-(1-naphthoyl)indole (JWH-073);

223.12 (C) 1-Pentyl-3-(4-methoxy-1-naphthoyl)indole (JWH-081);

223.13 (D) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl)indole (JWH-200);

223.14 (E) 1-Propyl-2-methyl-3-(1-naphthoyl)indole (JWH-015);

223.15 (F) 1-Hexyl-3-(1-naphthoyl)indole (JWH-019);

223.16 (G) 1-Pentyl-3-(4-methyl-1-naphthoyl)indole (JWH-122);

223.17 (H) 1-Pentyl-3-(4-ethyl-1-naphthoyl)indole (JWH-210);

223.18 (I) 1-Pentyl-3-(4-chloro-1-naphthoyl)indole (JWH-398);

223.19 (J) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM-2201).

223.20 (ii) Naphthylmethylindoles, which are any compounds containing a
223.21 1H-indol-3-yl-(1-naphthyl)methane structure with substitution at the nitrogen atom of the
223.22 indole ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
223.23 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group, whether or not further
223.24 substituted in the indole ring to any extent and whether or not substituted in the naphthyl
223.25 ring to any extent. Examples of naphthylmethylindoles include, but are not limited to:

223.26 (A) 1-Pentyl-1H-indol-3-yl-(1-naphthyl)methane (JWH-175);

223.27 (B) 1-Pentyl-1H-indol-3-yl-(4-methyl-1-naphthyl)methane (JWH-184).

223.28 (iii) Naphthoylpyrroles, which are any compounds containing a 3-(1-naphthoyl)pyrrole
223.29 structure with substitution at the nitrogen atom of the pyrrole ring by an alkyl, haloalkyl,
223.30 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
223.31 2-(4-morpholinyl)ethyl group whether or not further substituted in the pyrrole ring to any

224.1 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
224.2 naphthoylpyrroles include, but are not limited to,
224.3 (5-(2-fluorophenyl)-1-pentylpyrrol-3-yl)-naphthalen-1-ylmethanone (JWH-307).

224.4 (iv) Naphthylmethylenes, which are any compounds containing a naphthylideneindene
224.5 structure with substitution at the 3-position of the indene ring by an alkyl, haloalkyl, alkenyl,
224.6 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
224.7 2-(4-morpholinyl)ethyl group whether or not further substituted in the indene ring to any
224.8 extent, whether or not substituted in the naphthyl ring to any extent. Examples of
224.9 naphthylmethylenes include, but are not limited to,
224.10 E-1-[1-(1-naphthalenylmethylene)-1H-inden-3-yl]pentane (JWH-176).

224.11 (v) Phenylacetylindoles, which are any compounds containing a 3-phenylacetylindole
224.12 structure with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl,
224.13 alkenyl, cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
224.14 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
224.15 extent, whether or not substituted in the phenyl ring to any extent. Examples of
224.16 phenylacetylindoles include, but are not limited to:

224.17 (A) 1-(2-cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole (RCS-8);

224.18 (B) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH-250);

224.19 (C) 1-pentyl-3-(2-methylphenylacetyl)indole (JWH-251);

224.20 (D) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH-203).

224.21 (vi) Cyclohexylphenols, which are compounds containing a
224.22 2-(3-hydroxycyclohexyl)phenol structure with substitution at the 5-position of the phenolic
224.23 ring by an alkyl, haloalkyl, alkenyl, cycloalkylmethyl, cycloalkylethyl,
224.24 1-(N-methyl-2-piperidinyl)methyl or 2-(4-morpholinyl)ethyl group whether or not substituted
224.25 in the cyclohexyl ring to any extent. Examples of cyclohexylphenols include, but are not
224.26 limited to:

224.27 (A) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP 47,497);

224.28 (B) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol
224.29 (Cannabicyclohexanol or CP 47,497 C8 homologue);

224.30 (C) 5-(1,1-dimethylheptyl)-2-[(1R,2R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]
224.31 -phenol (CP 55,940).

- 225.1 (vii) Benzoylindoles, which are any compounds containing a 3-(benzoyl)indole structure
225.2 with substitution at the nitrogen atom of the indole ring by an alkyl, haloalkyl, alkenyl,
225.3 cycloalkylmethyl, cycloalkylethyl, 1-(N-methyl-2-piperidinyl)methyl or
225.4 2-(4-morpholinyl)ethyl group whether or not further substituted in the indole ring to any
225.5 extent and whether or not substituted in the phenyl ring to any extent. Examples of
225.6 benzoylindoles include, but are not limited to:
- 225.7 (A) 1-Pentyl-3-(4-methoxybenzoyl)indole (RCS-4);
- 225.8 (B) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM-694);
- 225.9 (C) (4-methoxyphenyl-[2-methyl-1-(2-(4-morpholinyl)ethyl)indol-3-yl]methanone (WIN
225.10 48,098 or Pravadoline).
- 225.11 (viii) Others specifically named:
- 225.12 (A) (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
225.13 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (HU-210);
- 225.14 (B) (6aS,10aS)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)
225.15 -6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol (Dexanabinol or HU-211);
- 225.16 (C) 2,3-dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]
225.17 -1,4-benzoxazin-6-yl-1-naphthalenylmethanone (WIN 55,212-2);
- 225.18 (D) (1-pentylindol-3-yl)-(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144);
- 225.19 (E) (1-(5-fluoropentyl)-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone
225.20 (XLR-11);
- 225.21 (F) 1-pentyl-N-tricyclo[3.3.1.1^{3,7}]dec-1-yl-1H-indazole-3-carboxamide
225.22 (AKB-48(APINACA));
- 225.23 (G) N-((3s,5s,7s)-adamantan-1-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide
225.24 (5-Fluoro-AKB-48);
- 225.25 (H) 1-pentyl-8-quinolinyl ester-1H-indole-3-carboxylic acid (PB-22);
- 225.26 (I) 8-quinolinyl ester-1-(5-fluoropentyl)-1H-indole-3-carboxylic acid (5-Fluoro PB-22);
- 225.27 (J) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-pentyl-1H-indazole-3-carboxamide
225.28 (AB-PINACA);
- 225.29 (K) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-[(4-fluorophenyl)methyl]-
225.30 1H-indazole-3-carboxamide (AB-FUBINACA);

- 226.1 (L) N-[(1S)-1-(aminocarbonyl)-2-methylpropyl]-1-(cyclohexylmethyl)-1H-
226.2 indazole-3-carboxamide(AB-CHMINACA);
- 226.3 (M) (S)-methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3- methylbutanoate
226.4 (5-fluoro-AMB);
- 226.5 (N) [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl) methanone (THJ-2201);
- 226.6 (O) (1-(5-fluoropentyl)-1H-benzo[d]imidazol-2-yl)(naphthalen-1-yl)methanone
226.7 (FUBIMINA);
- 226.8 (P) (7-methoxy-1-(2-morpholinoethyl)-N-((1S,2S,4R)-1,3,3-trimethylbicyclo
226.9 [2.2.1]heptan-2-yl)-1H-indole-3-carboxamide (MN-25 or UR-12);
- 226.10 (Q) (S)-N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)
226.11 -1H-indole-3-carboxamide (5-fluoro-ABICA);
- 226.12 (R) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
226.13 -1H-indole-3-carboxamide;
- 226.14 (S) N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)
226.15 -1H-indazole-3-carboxamide;
- 226.16 (T) methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido) -3,3-dimethylbutanoate;
- 226.17 (U) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1(cyclohexylmethyl)-1
226.18 H-indazole-3-carboxamide (MAB-CHMINACA);
- 226.19 (V) N-(1-Amino-3,3-dimethyl-1-oxo-2-butanyl)-1-pentyl-1H-indazole-3-carboxamide
226.20 (ADB-PINACA);
- 226.21 (W) methyl (1-(4-fluorobenzyl)-1H-indazole-3-carbonyl)-L-valinate (FUB-AMB);
- 226.22 (X) N-[(1S)-2-amino-2-oxo-1-(phenylmethyl)ethyl]-1-(cyclohexylmethyl)-1H-Indazole-
226.23 3-carboxamide. (APP-CHMINACA);
- 226.24 (Y) quinolin-8-yl 1-(4-fluorobenzyl)-1H-indole-3-carboxylate (FUB-PB-22); and
- 226.25 (Z) methyl N-[1-(cyclohexylmethyl)-1H-indole-3-carbonyl]valinate (MMB-CHMICA).
- 226.26 (ix) Additional substances specifically named:
- 226.27 (A) 1-(5-fluoropentyl)-N-(2-phenylpropan-2-yl)-1
226.28 H-pyrrolo[2,3-B]pyridine-3-carboxamide (5F-CUMYL-P7AICA);
- 226.29 (B) 1-(4-cyanobutyl)-N-(2- phenylpropan-2-yl)-1 H-indazole-3-carboxamide
226.30 (4-CN-Cumyl-Butinaca);

- 227.1 (C) naphthalen-1-yl-1-(5-fluoropentyl)-1-H-indole-3-carboxylate (NM2201; CBL2201);
- 227.2 (D) N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(5-fluoropentyl)-1-
- 227.3 H-indazole-3-carboxamide (5F-ABPINACA);
- 227.4 (E) methyl-2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate
- 227.5 (MDMB CHMICA);
- 227.6 (F) methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3,3-dimethylbutanoate
- 227.7 (5F-ADB; 5F-MDMB-PINACA); and
- 227.8 (G) N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)
- 227.9 1H-indazole-3-carboxamide (ADB-FUBINACA).
- 227.10 (i) A controlled substance analog, to the extent that it is implicitly or explicitly intended
- 227.11 for human consumption.
- 227.12 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
- 227.13 committed on or after that date.
- 227.14 Sec. 65. Minnesota Statutes 2020, section 152.02, subdivision 3, is amended to read:
- 227.15 Subd. 3. **Schedule II.** (a) Schedule II consists of the substances listed in this subdivision.
- 227.16 (b) Unless specifically excepted or unless listed in another schedule, any of the following
- 227.17 substances whether produced directly or indirectly by extraction from substances of vegetable
- 227.18 origin or independently by means of chemical synthesis, or by a combination of extraction
- 227.19 and chemical synthesis:
- 227.20 (1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or
- 227.21 opiate.
- 227.22 (i) Excluding:
- 227.23 (A) apomorphine;
- 227.24 (B) thebaine-derived butorphanol;
- 227.25 (C) dextrophan;
- 227.26 (D) nalbuphine;
- 227.27 (E) nalmefene;
- 227.28 (F) naloxegol;
- 227.29 (G) naloxone;

- 228.1 (H) naltrexone; and
- 228.2 (I) their respective salts;
- 228.3 (ii) but including the following:
- 228.4 (A) opium, in all forms and extracts;
- 228.5 (B) codeine;
- 228.6 (C) dihydroetorphine;
- 228.7 (D) ethylmorphine;
- 228.8 (E) etorphine hydrochloride;
- 228.9 (F) hydrocodone;
- 228.10 (G) hydromorphone;
- 228.11 (H) metopon;
- 228.12 (I) morphine;
- 228.13 (J) oxycodone;
- 228.14 (K) oxymorphone;
- 228.15 (L) thebaine;
- 228.16 (M) oripavine;
- 228.17 (2) any salt, compound, derivative, or preparation thereof which is chemically equivalent
- 228.18 or identical with any of the substances referred to in clause (1), except that these substances
- 228.19 shall not include the isoquinoline alkaloids of opium;
- 228.20 (3) opium poppy and poppy straw;
- 228.21 (4) coca leaves and any salt, cocaine compound, derivative, or preparation of coca leaves
- 228.22 (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers
- 228.23 and derivatives), and any salt, compound, derivative, or preparation thereof which is
- 228.24 chemically equivalent or identical with any of these substances, except that the substances
- 228.25 shall not include decocainized coca leaves or extraction of coca leaves, which extractions
- 228.26 do not contain cocaine or ecgonine;
- 228.27 (5) concentrate of poppy straw (the crude extract of poppy straw in either liquid, solid,
- 228.28 or powder form which contains the phenanthrene alkaloids of the opium poppy).

- 229.1 (c) Any of the following opiates, including their isomers, esters, ethers, salts, and salts
229.2 of isomers, esters and ethers, unless specifically excepted, or unless listed in another schedule,
229.3 whenever the existence of such isomers, esters, ethers and salts is possible within the specific
229.4 chemical designation:
- 229.5 (1) alfentanil;
- 229.6 (2) alphaprodine;
- 229.7 (3) anileridine;
- 229.8 (4) bezitramide;
- 229.9 (5) bulk dextropropoxyphene (nondosage forms);
- 229.10 (6) carfentanil;
- 229.11 (7) dihydrocodeine;
- 229.12 (8) dihydromorphinone;
- 229.13 (9) diphenoxylate;
- 229.14 (10) fentanyl;
- 229.15 (11) isomethadone;
- 229.16 (12) levo-alpha-acetylmethadol (LAAM);
- 229.17 (13) levomethorphan;
- 229.18 (14) levorphanol;
- 229.19 (15) metazocine;
- 229.20 (16) methadone;
- 229.21 (17) methadone - intermediate, 4-cyano-2-dimethylamino-4, 4-diphenylbutane;
- 229.22 (18) moramide - intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylic
229.23 acid;
- 229.24 (19) pethidine;
- 229.25 (20) pethidine - intermediate - a, 4-cyano-1-methyl-4-phenylpiperidine;
- 229.26 (21) pethidine - intermediate - b, ethyl-4-phenylpiperidine-4-carboxylate;
- 229.27 (22) pethidine - intermediate - c, 1-methyl-4-phenylpiperidine-4-carboxylic acid;
- 229.28 (23) phenazocine;

- 230.1 (24) piminodine;
- 230.2 (25) racemethorphan;
- 230.3 (26) racemorphan;
- 230.4 (27) remifentanil;
- 230.5 (28) sufentanil;
- 230.6 (29) tapentadol;
- 230.7 (30) 4-Anilino-N-phenethylpiperidine.
- 230.8 (d) Unless specifically excepted or unless listed in another schedule, any material,
230.9 compound, mixture, or preparation which contains any quantity of the following substances
230.10 having a stimulant effect on the central nervous system:
- 230.11 (1) amphetamine, its salts, optical isomers, and salts of its optical isomers;
- 230.12 (2) methamphetamine, its salts, isomers, and salts of its isomers;
- 230.13 (3) phenmetrazine and its salts;
- 230.14 (4) methylphenidate;
- 230.15 (5) lisdexamfetamine.
- 230.16 (e) Unless specifically excepted or unless listed in another schedule, any material,
230.17 compound, mixture, or preparation which contains any quantity of the following substances
230.18 having a depressant effect on the central nervous system, including its salts, isomers, and
230.19 salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible
230.20 within the specific chemical designation:
- 230.21 (1) amobarbital;
- 230.22 (2) glutethimide;
- 230.23 (3) secobarbital;
- 230.24 (4) pentobarbital;
- 230.25 (5) phencyclidine;
- 230.26 (6) phencyclidine immediate precursors:
- 230.27 (i) 1-phenylcyclohexylamine;
- 230.28 (ii) 1-piperidinocyclohexanecarbonitrile;
- 230.29 (7) phenylacetone.

231.1 (f) Cannabis and cannabinoids:

231.2 (1) nabilone;

231.3 (2) unless specifically excepted or unless listed in another schedule, any natural material,
231.4 compound, mixture, or preparation that contains any quantity of the following substances,
231.5 their analogs, isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever
231.6 the existence of the isomers, esters, ethers, or salts is possible:

231.7 (i) marijuana; and

231.8 (ii) tetrahydrocannabinols naturally contained in a plant of the genus cannabis or in the
231.9 resinous extractives of the plant; and

231.10 ~~(2)~~ (3) dronabinol [(-)-delta-9-trans-tetrahydrocannabinol (delta-9-THC)] in an oral
231.11 solution in a drug product approved for marketing by the United States Food and Drug
231.12 Administration.

231.13 **EFFECTIVE DATE.** This section is effective August 1, 2021, and applies to crimes
231.14 committed on or after that date.

231.15 Sec. 66. Minnesota Statutes 2020, section 152.11, subdivision 1a, is amended to read:

231.16 Subd. 1a. **Prescription requirements for Schedule II controlled substances.** Except
231.17 as allowed under section 152.29, no person may dispense a controlled substance included
231.18 in Schedule II of section 152.02 without a prescription issued by a doctor of medicine, a
231.19 doctor of osteopathic medicine licensed to practice medicine, a doctor of dental surgery, a
231.20 doctor of dental medicine, a doctor of podiatry, or a doctor of veterinary medicine, lawfully
231.21 licensed to prescribe in this state or by a practitioner licensed to prescribe controlled
231.22 substances by the state in which the prescription is issued, and having a current federal Drug
231.23 Enforcement Administration registration number. The prescription must either be printed
231.24 or written in ink and contain the handwritten signature of the prescriber or be transmitted
231.25 electronically or by facsimile as permitted under subdivision 1. Provided that in emergency
231.26 situations, as authorized by federal law, such drug may be dispensed upon oral prescription
231.27 reduced promptly to writing and filed by the pharmacist. Such prescriptions shall be retained
231.28 in conformity with section 152.101. No prescription for a Schedule II substance may be
231.29 refilled.

232.1 Sec. 67. Minnesota Statutes 2020, section 152.11, is amended by adding a subdivision to
232.2 read:

232.3 Subd. 5. **Exception.** References in this section to Schedule II controlled substances do
232.4 not extend to marijuana or tetrahydrocannabinols.

232.5 Sec. 68. Minnesota Statutes 2020, section 152.12, is amended by adding a subdivision to
232.6 read:

232.7 Subd. 6. **Exception.** References in this section to Schedule II controlled substances do
232.8 not extend to marijuana or tetrahydrocannabinols.

232.9 Sec. 69. Minnesota Statutes 2020, section 152.125, subdivision 3, is amended to read:

232.10 Subd. 3. **Limits on applicability.** This section does not apply to:

232.11 (1) a physician's treatment of an individual for chemical dependency resulting from the
232.12 use of controlled substances in Schedules II to V of section 152.02;

232.13 (2) the prescription or administration of controlled substances in Schedules II to V of
232.14 section 152.02 to an individual whom the physician knows to be using the controlled
232.15 substances for nontherapeutic purposes;

232.16 (3) the prescription or administration of controlled substances in Schedules II to V of
232.17 section 152.02 for the purpose of terminating the life of an individual having intractable
232.18 pain; ~~or~~

232.19 (4) the prescription or administration of a controlled substance in Schedules II to V of
232.20 section 152.02 that is not a controlled substance approved by the United States Food and
232.21 Drug Administration for pain relief; or

232.22 (5) the administration of medical cannabis under sections 152.22 to 152.37.

232.23 Sec. 70. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
232.24 read:

232.25 Subd. 5c. **Hemp processor.** "Hemp processor" means a person or business licensed by
232.26 the commissioner of agriculture under chapter 18K to convert raw hemp into a product.

233.1 Sec. 71. Minnesota Statutes 2020, section 152.22, subdivision 6, is amended to read:

233.2 Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus
233.3 cannabis plant, or any mixture or preparation of them, including whole plant extracts and
233.4 resins, and is delivered in the form of:

233.5 (1) liquid, including, but not limited to, oil;

233.6 (2) pill;

233.7 (3) vaporized delivery method with use of liquid or oil ~~but which does not require the~~
233.8 ~~use of dried leaves or plant form; or;~~

233.9 (4) combustion with use of dried raw cannabis; or

233.10 ~~(4)~~ (5) any other method, ~~excluding smoking,~~ approved by the commissioner.

233.11 (b) This definition includes any part of the genus cannabis plant prior to being processed
233.12 into a form allowed under paragraph (a), that is possessed by a person while that person is
233.13 engaged in employment duties necessary to carry out a requirement under sections 152.22
233.14 to 152.37 for a registered manufacturer or a laboratory under contract with a registered
233.15 manufacturer. This definition also includes any hemp acquired by a manufacturer by a hemp
233.16 grower as permitted under section 152.29, subdivision 1, paragraph (b).

233.17 **EFFECTIVE DATE.** This section is effective the earlier of (1) March 1, 2022, or (2)
233.18 a date, as determined by the commissioner of health, by which (i) the rules adopted or
233.19 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
233.20 independent laboratories under contract with the manufacturers have the necessary procedures
233.21 and equipment in place to perform the required testing of dried raw cannabis. If this section
233.22 is effective before March 1, 2022, the commissioner shall provide notice of that effective
233.23 date to the public.

233.24 Sec. 72. Minnesota Statutes 2020, section 152.22, subdivision 11, is amended to read:

233.25 Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means
233.26 a person who:

233.27 (1) is at least 18 years old;

233.28 (2) does not have a conviction for a disqualifying felony offense;

233.29 (3) has been approved by the commissioner to assist a patient who ~~has been identified~~
233.30 ~~by a health care practitioner as developmentally or physically disabled and therefore~~ requires

234.1 assistance in administering medical cannabis or obtaining medical cannabis from a
234.2 distribution facility ~~due to the disability~~; and

234.3 (4) is authorized by the commissioner to assist the patient with the use of medical
234.4 cannabis.

234.5 Sec. 73. Minnesota Statutes 2020, section 152.22, is amended by adding a subdivision to
234.6 read:

234.7 Subd. 13a. Tribal medical cannabis program. "Tribal medical cannabis program"
234.8 means a medical cannabis program operated by a federally recognized Indian Tribe located
234.9 within the state that has been recognized by the commissioner of health in accordance with
234.10 section 152.25, subdivision 5.

234.11 Sec. 74. Minnesota Statutes 2020, section 152.23, is amended to read:

234.12 **152.23 LIMITATIONS.**

234.13 (a) Nothing in sections 152.22 to 152.37 permits any person to engage in and does not
234.14 prevent the imposition of any civil, criminal, or other penalties for:

234.15 (1) undertaking any task under the influence of medical cannabis that would constitute
234.16 negligence or professional malpractice;

234.17 (2) possessing or engaging in the use of medical cannabis:

234.18 (i) on a school bus or van;

234.19 (ii) on the grounds of any preschool or primary or secondary school;

234.20 (iii) in any correctional facility; or

234.21 (iv) on the grounds of any child care facility or home day care;

234.22 (3) vaporizing or combusting medical cannabis pursuant to section 152.22, subdivision
234.23 6:

234.24 (i) on any form of public transportation;

234.25 (ii) where the vapor would be inhaled by a nonpatient minor child or where the smoke
234.26 would be inhaled by a minor child; or

234.27 (iii) in any public place, including any indoor or outdoor area used by or open to the
234.28 general public or a place of employment as defined under section 144.413, subdivision 1b;
234.29 and

235.1 (4) operating, navigating, or being in actual physical control of any motor vehicle,
235.2 aircraft, train, or motorboat, or working on transportation property, equipment, or facilities
235.3 while under the influence of medical cannabis.

235.4 (b) Nothing in sections 152.22 to 152.37 require the medical assistance and
235.5 MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with
235.6 the medical use of cannabis. Medical assistance and MinnesotaCare shall continue to provide
235.7 coverage for all services related to treatment of an enrollee's qualifying medical condition
235.8 if the service is covered under chapter 256B or 256L.

235.9 Sec. 75. Minnesota Statutes 2020, section 152.25, is amended by adding a subdivision to
235.10 read:

235.11 Subd. 5. Tribal medical cannabis programs. Upon the request of an Indian Tribe
235.12 operating a Tribal medical cannabis program, the commissioner shall determine if the
235.13 standards for the Tribal medical cannabis program meet or exceed the standards required
235.14 under sections 152.22 to 152.37 in terms of qualifying for the medical cannabis program,
235.15 allowable forms of medical cannabis, production and distribution requirements, product
235.16 safety and testing, and security measures. If the commissioner determines that the Tribal
235.17 medical cannabis program meets or exceeds the standards in sections 152.22 to 152.37, the
235.18 commissioner shall recognize the Tribal medical cannabis program and shall post the Tribal
235.19 medical cannabis programs that have been recognized by the commissioner on the
235.20 Department of Health's website.

235.21 Sec. 76. Minnesota Statutes 2020, section 152.26, is amended to read:

235.22 **152.26 RULEMAKING.**

235.23 (a) The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules
235.24 for which notice is published in the State Register before January 1, 2015, may be adopted
235.25 using the process in section 14.389.

235.26 (b) The commissioner may adopt or amend rules, using the procedure in section 14.386,
235.27 paragraph (a), to implement the addition of dried raw cannabis as an allowable form of
235.28 medical cannabis under section 152.22, subdivision 6, paragraph (a), clause (4). Section
235.29 14.386, paragraph (b), does not apply to these rules.

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

236.1 Sec. 77. Minnesota Statutes 2020, section 152.27, subdivision 3, is amended to read:

236.2 Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application
236.3 for enrollment into the registry program. The application shall be available to the patient
236.4 and given to health care practitioners in the state who are eligible to serve as health care
236.5 practitioners. The application must include:

236.6 (1) the name, mailing address, and date of birth of the patient;

236.7 (2) the name, mailing address, and telephone number of the patient's health care
236.8 practitioner;

236.9 (3) the name, mailing address, and date of birth of the patient's designated caregiver, if
236.10 any, or the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse
236.11 will be acting as a caregiver;

236.12 (4) a copy of the certification from the patient's health care practitioner that is dated
236.13 within 90 days prior to submitting the application which certifies that the patient has been
236.14 diagnosed with a qualifying medical condition ~~and, if applicable, that, in the health care~~
236.15 ~~practitioner's medical opinion, the patient is developmentally or physically disabled and,~~
236.16 ~~as a result of that disability, the patient requires assistance in administering medical cannabis~~
236.17 ~~or obtaining medical cannabis from a distribution facility; and~~

236.18 (5) all other signed affidavits and enrollment forms required by the commissioner under
236.19 sections 152.22 to 152.37, including, but not limited to, the disclosure form required under
236.20 paragraph (c).

236.21 (b) The commissioner shall require a patient to resubmit a copy of the certification from
236.22 the patient's health care practitioner on a yearly basis and shall require that the recertification
236.23 be dated within 90 days of submission.

236.24 (c) The commissioner shall develop a disclosure form and require, as a condition of
236.25 enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

236.26 (1) a statement that, notwithstanding any law to the contrary, the commissioner, or an
236.27 employee of any state agency, may not be held civilly or criminally liable for any injury,
236.28 loss of property, personal injury, or death caused by any act or omission while acting within
236.29 the scope of office or employment under sections 152.22 to 152.37; and

236.30 (2) the patient's acknowledgment that enrollment in the patient registry program is
236.31 conditional on the patient's agreement to meet all of the requirements of sections 152.22 to
236.32 152.37.

237.1 Sec. 78. Minnesota Statutes 2020, section 152.27, subdivision 4, is amended to read:

237.2 Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a
237.3 designated caregiver for a patient if ~~the patient's health care practitioner has certified that~~
237.4 ~~the patient, in the health care practitioner's medical opinion, is developmentally or physically~~
237.5 ~~disabled and, as a result of that disability,~~ the patient requires assistance in administering
237.6 medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver
237.7 has agreed, in writing, to be the patient's designated caregiver. As a condition of registration
237.8 as a designated caregiver, the commissioner shall require the person to:

237.9 (1) be at least 18 years of age;

237.10 (2) agree to only possess the patient's medical cannabis for purposes of assisting the
237.11 patient; and

237.12 (3) agree that if the application is approved, the person will not be a registered designated
237.13 caregiver for more than ~~one patient, unless the~~ six registered patients at one time. Patients
237.14 who reside in the same residence shall count as one patient.

237.15 (b) The commissioner shall conduct a criminal background check on the designated
237.16 caregiver prior to registration to ensure that the person does not have a conviction for a
237.17 disqualifying felony offense. Any cost of the background check shall be paid by the person
237.18 seeking registration as a designated caregiver. A designated caregiver must have the criminal
237.19 background check renewed every two years.

237.20 (c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered
237.21 as a designated caregiver from also being enrolled in the registry program as a patient and
237.22 possessing and using medical cannabis as a patient.

237.23 Sec. 79. Minnesota Statutes 2020, section 152.27, subdivision 6, is amended to read:

237.24 Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees,
237.25 and signed disclosure, the commissioner shall enroll the patient in the registry program and
237.26 issue the patient and patient's registered designated caregiver or parent, legal guardian, or
237.27 spouse, if applicable, a registry verification. The commissioner shall approve or deny a
237.28 patient's application for participation in the registry program within 30 days after the
237.29 commissioner receives the patient's application and application fee. ~~The commissioner may~~
237.30 ~~approve applications up to 60 days after the receipt of a patient's application and application~~
237.31 ~~fees until January 1, 2016.~~ A patient's enrollment in the registry program shall only be
237.32 denied if the patient:

238.1 (1) does not have certification from a health care practitioner that the patient has been
238.2 diagnosed with a qualifying medical condition;

238.3 (2) has not signed and returned the disclosure form required under subdivision 3,
238.4 paragraph (c), to the commissioner;

238.5 (3) does not provide the information required; or

238.6 ~~(4) has previously been removed from the registry program for violations of section~~
238.7 ~~152.30 or 152.33; or~~

238.8 ~~(5)~~ (4) provides false information.

238.9 (b) The commissioner shall give written notice to a patient of the reason for denying
238.10 enrollment in the registry program.

238.11 (c) Denial of enrollment into the registry program is considered a final decision of the
238.12 commissioner and is subject to judicial review under the Administrative Procedure Act
238.13 pursuant to chapter 14.

238.14 (d) A patient's enrollment in the registry program may only be revoked upon the death
238.15 of the patient or if a patient violates a requirement under section 152.30 or 152.33. If a
238.16 patient's enrollment in the registry program has been revoked due to a violation of section
238.17 152.30 or 152.33, the patient may reapply for enrollment 12 months from the date the
238.18 patient's enrollment was revoked. The commissioner shall process the application in
238.19 accordance with this section.

238.20 (e) The commissioner shall develop a registry verification to provide to the patient, the
238.21 health care practitioner identified in the patient's application, and to the manufacturer. The
238.22 registry verification shall include:

238.23 (1) the patient's name and date of birth;

238.24 (2) the patient registry number assigned to the patient; and

238.25 (3) the name and date of birth of the patient's registered designated caregiver, if any, or
238.26 the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or
238.27 spouse will be acting as a caregiver.

238.28 (f) The commissioner shall not deny a patient's application for participation in the registry
238.29 program or revoke a patient's enrollment in the registry program solely because the patient
238.30 is also enrolled in a Tribal medical cannabis program.

239.1 Sec. 80. Minnesota Statutes 2020, section 152.28, subdivision 1, is amended to read:

239.2 Subdivision 1. **Health care practitioner duties.** (a) Prior to a patient's enrollment in
239.3 the registry program, a health care practitioner shall:

239.4 (1) determine, in the health care practitioner's medical judgment, whether a patient suffers
239.5 from a qualifying medical condition, and, if so determined, provide the patient with a
239.6 certification of that diagnosis;

239.7 ~~(2) determine whether a patient is developmentally or physically disabled and, as a result~~
239.8 ~~of that disability, the patient requires assistance in administering medical cannabis or~~
239.9 ~~obtaining medical cannabis from a distribution facility, and, if so determined, include that~~
239.10 ~~determination on the patient's certification of diagnosis;~~

239.11 ~~(3)~~ advise patients, registered designated caregivers, and parents, legal guardians, or
239.12 spouses who are acting as caregivers of the existence of any nonprofit patient support groups
239.13 or organizations;

239.14 ~~(4)~~ (3) provide explanatory information from the commissioner to patients with qualifying
239.15 medical conditions, including disclosure to all patients about the experimental nature of
239.16 therapeutic use of medical cannabis; the possible risks, benefits, and side effects of the
239.17 proposed treatment; the application and other materials from the commissioner; and provide
239.18 patients with the Tennessee warning as required by section 13.04, subdivision 2; and

239.19 ~~(5)~~ (4) agree to continue treatment of the patient's qualifying medical condition and
239.20 report medical findings to the commissioner.

239.21 (b) Upon notification from the commissioner of the patient's enrollment in the registry
239.22 program, the health care practitioner shall:

239.23 (1) participate in the patient registry reporting system under the guidance and supervision
239.24 of the commissioner;

239.25 (2) report health records of the patient throughout the ongoing treatment of the patient
239.26 to the commissioner in a manner determined by the commissioner and in accordance with
239.27 subdivision 2;

239.28 (3) determine, on a yearly basis, if the patient continues to suffer from a qualifying
239.29 medical condition and, if so, issue the patient a new certification of that diagnosis; and

239.30 (4) otherwise comply with all requirements developed by the commissioner.

240.1 (c) A health care practitioner may conduct a patient assessment to issue a recertification
240.2 as required under paragraph (b), clause (3), via telemedicine as defined under section
240.3 62A.671, subdivision 9.

240.4 (d) Nothing in this section requires a health care practitioner to participate in the registry
240.5 program.

240.6 Sec. 81. Minnesota Statutes 2020, section 152.29, subdivision 1, is amended to read:

240.7 Subdivision 1. **Manufacturer; requirements.** (a) A manufacturer may operate eight
240.8 distribution facilities, which may include the manufacturer's single location for cultivation,
240.9 harvesting, manufacturing, packaging, and processing but is not required to include that
240.10 location. The commissioner shall designate the geographical service areas to be served by
240.11 each manufacturer based on geographical need throughout the state to improve patient
240.12 access. A manufacturer shall not have more than two distribution facilities in each
240.13 geographical service area assigned to the manufacturer by the commissioner. A manufacturer
240.14 shall operate only one location where all cultivation, harvesting, manufacturing, packaging,
240.15 and processing of medical cannabis shall be conducted. This location may be one of the
240.16 manufacturer's distribution facility sites. The additional distribution facilities may dispense
240.17 medical cannabis and medical cannabis products but may not contain any medical cannabis
240.18 in a form other than those forms allowed under section 152.22, subdivision 6, and the
240.19 manufacturer shall not conduct any cultivation, harvesting, manufacturing, packaging, or
240.20 processing at the other distribution facility sites. Any distribution facility operated by the
240.21 manufacturer is subject to all of the requirements applying to the manufacturer under sections
240.22 152.22 to 152.37, including, but not limited to, security and distribution requirements.

240.23 (b) A manufacturer may acquire hemp grown in this state from a hemp grower, and may
240.24 acquire hemp products produced by a hemp processor. A manufacturer may manufacture
240.25 or process hemp and hemp products into an allowable form of medical cannabis under
240.26 section 152.22, subdivision 6. Hemp and hemp products acquired by a manufacturer under
240.27 this paragraph ~~is~~ are subject to the same quality control program, security and testing
240.28 requirements, and other requirements that apply to medical cannabis under sections 152.22
240.29 to 152.37 and Minnesota Rules, chapter 4770.

240.30 (c) A medical cannabis manufacturer shall contract with a laboratory approved by the
240.31 commissioner, subject to any additional requirements set by the commissioner, for purposes
240.32 of testing medical cannabis manufactured or hemp or hemp products acquired by the medical
240.33 cannabis manufacturer as to content, contamination, and consistency to verify the medical

241.1 cannabis meets the requirements of section 152.22, subdivision 6. The cost of laboratory
241.2 testing shall be paid by the manufacturer.

241.3 (d) The operating documents of a manufacturer must include:

241.4 (1) procedures for the oversight of the manufacturer and procedures to ensure accurate
241.5 record keeping;

241.6 (2) procedures for the implementation of appropriate security measures to deter and
241.7 prevent the theft of medical cannabis and unauthorized entrance into areas containing medical
241.8 cannabis; and

241.9 (3) procedures for the delivery and transportation of hemp between hemp growers and
241.10 manufacturers and for the delivery and transportation of hemp products between hemp
241.11 processors and manufacturers.

241.12 (e) A manufacturer shall implement security requirements, including requirements for
241.13 the delivery and transportation of hemp and hemp products, protection of each location by
241.14 a fully operational security alarm system, facility access controls, perimeter intrusion
241.15 detection systems, and a personnel identification system.

241.16 (f) A manufacturer shall not share office space with, refer patients to a health care
241.17 practitioner, or have any financial relationship with a health care practitioner.

241.18 (g) A manufacturer shall not permit any person to consume medical cannabis on the
241.19 property of the manufacturer.

241.20 (h) A manufacturer is subject to reasonable inspection by the commissioner.

241.21 (i) For purposes of sections 152.22 to 152.37, a medical cannabis manufacturer is not
241.22 subject to the Board of Pharmacy licensure or regulatory requirements under chapter 151.

241.23 (j) A medical cannabis manufacturer may not employ any person who is under 21 years
241.24 of age or who has been convicted of a disqualifying felony offense. An employee of a
241.25 medical cannabis manufacturer must submit a completed criminal history records check
241.26 consent form, a full set of classifiable fingerprints, and the required fees for submission to
241.27 the Bureau of Criminal Apprehension before an employee may begin working with the
241.28 manufacturer. The bureau must conduct a Minnesota criminal history records check and
241.29 the superintendent is authorized to exchange the fingerprints with the Federal Bureau of
241.30 Investigation to obtain the applicant's national criminal history record information. The
241.31 bureau shall return the results of the Minnesota and federal criminal history records checks
241.32 to the commissioner.

242.1 (k) A manufacturer may not operate in any location, whether for distribution or
242.2 cultivation, harvesting, manufacturing, packaging, or processing, within 1,000 feet of a
242.3 public or private school existing before the date of the manufacturer's registration with the
242.4 commissioner.

242.5 (l) A manufacturer shall comply with reasonable restrictions set by the commissioner
242.6 relating to signage, marketing, display, and advertising of medical cannabis.

242.7 (m) Before a manufacturer acquires hemp from a hemp grower or hemp products from
242.8 a hemp processor, the manufacturer must verify that the hemp grower or hemp processor
242.9 has a valid license issued by the commissioner of agriculture under chapter 18K.

242.10 (n) Until a state-centralized, seed-to-sale system is implemented that can track a specific
242.11 medical cannabis plant from cultivation through testing and point of sale, the commissioner
242.12 shall conduct at least one unannounced inspection per year of each manufacturer that includes
242.13 inspection of:

242.14 (1) business operations;

242.15 (2) physical locations of the manufacturer's manufacturing facility and distribution
242.16 facilities;

242.17 (3) financial information and inventory documentation, including laboratory testing
242.18 results; and

242.19 (4) physical and electronic security alarm systems.

242.20 Sec. 82. Minnesota Statutes 2020, section 152.29, subdivision 3, is amended to read:

242.21 Subd. 3. **Manufacturer; distribution.** (a) A manufacturer shall require that employees
242.22 licensed as pharmacists pursuant to chapter 151 be the only employees to give final approval
242.23 for the distribution of medical cannabis to a patient. A manufacturer may transport medical
242.24 cannabis or medical cannabis products that have been cultivated, harvested, manufactured,
242.25 packaged, and processed by that manufacturer to another registered manufacturer for the
242.26 other manufacturer to distribute.

242.27 (b) A manufacturer may distribute medical cannabis products, whether or not the products
242.28 have been manufactured by that manufacturer.

242.29 (c) Prior to distribution of any medical cannabis, the manufacturer shall:

242.30 (1) verify that the manufacturer has received the registry verification from the
242.31 commissioner for that individual patient;

243.1 (2) verify that the person requesting the distribution of medical cannabis is the patient,
243.2 the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse
243.3 listed in the registry verification using the procedures described in section 152.11, subdivision
243.4 2d;

243.5 (3) assign a tracking number to any medical cannabis distributed from the manufacturer;

243.6 (4) ensure that any employee of the manufacturer licensed as a pharmacist pursuant to
243.7 chapter 151 has consulted with the patient to determine the proper dosage for the individual
243.8 patient after reviewing the ranges of chemical compositions of the medical cannabis and
243.9 the ranges of proper dosages reported by the commissioner. For purposes of this clause, a
243.10 consultation may be conducted remotely ~~using a~~ by secure videoconference, telephone, or
243.11 other remote means, so long as the employee providing the consultation is able to confirm
243.12 the identity of the patient, ~~the consultation occurs while the patient is at a distribution facility,~~
243.13 and the consultation adheres to patient privacy requirements that apply to health care services
243.14 delivered through telemedicine. A pharmacist consultation under this clause is not required
243.15 when a manufacturer is distributing medical cannabis to a patient according to a
243.16 patient-specific dosage plan established with that manufacturer and is not modifying the
243.17 dosage or product being distributed under that plan and the medical cannabis is distributed
243.18 by a pharmacy technician;

243.19 (5) properly package medical cannabis in compliance with the United States Poison
243.20 Prevention Packing Act regarding child-resistant packaging and exemptions for packaging
243.21 for elderly patients, and label distributed medical cannabis with a list of all active ingredients
243.22 and individually identifying information, including:

243.23 (i) the patient's name and date of birth;

243.24 (ii) the name and date of birth of the patient's registered designated caregiver or, if listed
243.25 on the registry verification, the name of the patient's parent or legal guardian, if applicable;

243.26 (iii) the patient's registry identification number;

243.27 (iv) the chemical composition of the medical cannabis; and

243.28 (v) the dosage; and

243.29 (6) ensure that the medical cannabis distributed contains a maximum of a 90-day supply
243.30 of the dosage determined for that patient.

243.31 (d) A manufacturer shall require any employee of the manufacturer who is transporting
243.32 medical cannabis or medical cannabis products to a distribution facility or to another

244.1 registered manufacturer to carry identification showing that the person is an employee of
244.2 the manufacturer.

244.3 (e) A manufacturer shall distribute medical cannabis in dried raw cannabis form only
244.4 to a patient age 21 or older, or to the registered designated caregiver, parent, legal guardian,
244.5 or spouse of a patient age 21 or older.

244.6 **EFFECTIVE DATE.** Paragraph (e) is effective the earlier of (1) March 1, 2022, or (2)
244.7 a date, as determined by the commissioner of health, by which (i) the rules adopted or
244.8 amended under Minnesota Statutes, section 152.26, paragraph (b), are in effect and (ii) the
244.9 independent laboratories under contract with the manufacturers have the necessary procedures
244.10 and equipment in place to perform the required testing of dried raw cannabis. If this section
244.11 is effective before March 1, 2022, the commissioner shall provide notice of that effective
244.12 date to the public.

244.13 Sec. 83. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
244.14 read:

244.15 Subd. 3b. **Distribution to recipient in a motor vehicle.** A manufacturer may distribute
244.16 medical cannabis to a patient, registered designated caregiver, or parent, legal guardian, or
244.17 spouse of a patient who is at the distribution facility but remains in a motor vehicle, provided:

244.18 (1) distribution facility staff receive payment and distribute medical cannabis in a
244.19 designated zone that is as close as feasible to the front door of the distribution facility;

244.20 (2) the manufacturer ensures that the receipt of payment and distribution of medical
244.21 cannabis are visually recorded by a closed-circuit television surveillance camera at the
244.22 distribution facility and provides any other necessary security safeguards;

244.23 (3) the manufacturer does not store medical cannabis outside a restricted access area at
244.24 the distribution facility, and distribution facility staff transport medical cannabis from a
244.25 restricted access area at the distribution facility to the designated zone for distribution only
244.26 after confirming that the patient, designated caregiver, or parent, guardian, or spouse has
244.27 arrived in the designated zone;

244.28 (4) the payment and distribution of medical cannabis take place only after a pharmacist
244.29 consultation takes place, if required under subdivision 3, paragraph (c), clause (4);

244.30 (5) immediately following distribution of medical cannabis, distribution facility staff
244.31 enter the transaction in the state medical cannabis registry information technology database;
244.32 and

245.1 (6) immediately following distribution of medical cannabis, distribution facility staff
245.2 take the payment received into the distribution facility.

245.3 Sec. 84. Minnesota Statutes 2020, section 152.29, is amended by adding a subdivision to
245.4 read:

245.5 Subd. 3c. **Disposal of medical cannabis plant root balls.** Notwithstanding Minnesota
245.6 Rules, part 4770.1200, subpart 2, item C, a manufacturer is not required to grind root balls
245.7 of medical cannabis plants or incorporate them with a greater quantity of nonconsumable
245.8 solid waste before transporting root balls to another location for disposal. For purposes of
245.9 this subdivision, "root ball" means a compact mass of roots formed by a plant and any
245.10 attached growing medium.

245.11 Sec. 85. Minnesota Statutes 2020, section 152.31, is amended to read:

245.12 **152.31 DATA PRACTICES.**

245.13 (a) Government data in patient files maintained by the commissioner and the health care
245.14 practitioner, and data submitted to or by a medical cannabis manufacturer, are private data
245.15 on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in
245.16 section 13.02, subdivision 9, but may be used for purposes of complying with chapter 13
245.17 and complying with a request from the legislative auditor or the state auditor in the
245.18 performance of official duties. The provisions of section 13.05, subdivision 11, apply to a
245.19 registration agreement entered between the commissioner and a medical cannabis
245.20 manufacturer under section 152.25.

245.21 (b) Not public data maintained by the commissioner may not be used for any purpose
245.22 not provided for in sections 152.22 to 152.37, and may not be combined or linked in any
245.23 manner with any other list, dataset, or database.

245.24 (c) The commissioner may execute data sharing arrangements with the commissioner
245.25 of agriculture to verify licensing, inspection, and compliance information related to hemp
245.26 growers and hemp processors under chapter 18K.

245.27 Sec. 86. Minnesota Statutes 2020, section 152.32, subdivision 3, is amended to read:

245.28 **Subd. 3. Discrimination prohibited.** (a) No school or landlord may refuse to enroll or
245.29 lease to and may not otherwise penalize a person solely for the person's status as a patient
245.30 enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so
245.31 would violate federal law or regulations or cause the school or landlord to lose a monetary
245.32 or licensing-related benefit under federal law or regulations.

246.1 (b) For the purposes of medical care, including organ transplants, a registry program
246.2 enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the
246.3 equivalent of the authorized use of any other medication used at the discretion of a physician
246.4 or advanced practice registered nurse and does not constitute the use of an illicit substance
246.5 or otherwise disqualify a patient from needed medical care.

246.6 (c) Unless a failure to do so would violate federal law or regulations or cause an employer
246.7 to lose a monetary or licensing-related benefit under federal law or regulations, an employer
246.8 may not discriminate against a person in hiring, termination, or any term or condition of
246.9 employment, or otherwise penalize a person, if the discrimination is based upon either of
246.10 the following:

246.11 (1) the person's status as a patient enrolled in the registry program under sections 152.22
246.12 to 152.37; or

246.13 (2) a patient's positive drug test for cannabis components or metabolites, unless the
246.14 patient used, possessed, or was impaired by medical cannabis on the premises of the place
246.15 of employment or during the hours of employment.

246.16 (d) An employee who is required to undergo employer drug testing pursuant to section
246.17 181.953 may present verification of enrollment in the patient registry as part of the employee's
246.18 explanation under section 181.953, subdivision 6.

246.19 (e) A person shall not be denied custody of a minor child or visitation rights or parenting
246.20 time with a minor child solely based on the person's status as a patient enrolled in the registry
246.21 program under sections 152.22 to 152.37. There shall be no presumption of neglect or child
246.22 endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's
246.23 behavior is such that it creates an unreasonable danger to the safety of the minor as
246.24 established by clear and convincing evidence.

246.25 (f) This subdivision applies to any person enrolled in a Tribal medical cannabis program
246.26 to the same extent as if the person was enrolled in the registry program under sections 152.22
246.27 to 152.37.

246.28 Sec. 87. Minnesota Statutes 2020, section 171.07, is amended by adding a subdivision to
246.29 read:

246.30 Subd. 3b. **Identification card for homeless youth.** (a) A homeless youth, as defined in
246.31 section 256K.45, subdivision 1a, who meets the requirements of this subdivision may obtain
246.32 a noncompliant identification card, notwithstanding section 171.06, subdivision 3.

246.33 (b) An applicant under this subdivision must:

- 247.1 (1) provide the applicant's full name, date of birth, and sex;
- 247.2 (2) provide the applicant's height in feet and inches, weight in pounds, and eye color;
- 247.3 (3) submit a certified copy of a birth certificate issued by a government bureau of vital
- 247.4 statistics or equivalent agency in the applicant's state of birth, which must bear the raised
- 247.5 or authorized seal of the issuing government entity; and
- 247.6 (4) submit a statement verifying that the applicant is a homeless youth who resides in
- 247.7 Minnesota that is signed by:
- 247.8 (i) an employee of a human services agency receiving public funding to provide services
- 247.9 to homeless youth, runaway youth, youth with mental illness, or youth with substance use
- 247.10 disorders; or
- 247.11 (ii) staff at a school who provide services to homeless youth or a school social worker.
- 247.12 (c) For a noncompliant identification card under this subdivision:
- 247.13 (1) the commissioner must not impose a fee, surcharge, or filing fee under section 171.06,
- 247.14 subdivision 2; and
- 247.15 (2) a driver's license agent must not impose a filing fee under section 171.061, subdivision
- 247.16 4.
- 247.17 (d) Minnesota Rules, parts 7410.0400 and 7410.0410, or successor rules, do not apply
- 247.18 for an identification card under this subdivision.
- 247.19 **EFFECTIVE DATE.** This section is effective the day following final enactment for
- 247.20 application and issuance of Minnesota identification cards on and after January 1, 2022.
- 247.21 Sec. 88. Minnesota Statutes 2020, section 256.98, subdivision 1, is amended to read:
- 247.22 Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the
- 247.23 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,
- 247.24 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program
- 247.25 formerly codified in sections 256.72 to 256.871, chapter 256B, 256D, 256I, 256J, 256K, or
- 247.26 256L, child care assistance programs, and emergency assistance programs under section
- 247.27 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses
- 247.28 (1) to (5):
- 247.29 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a
- 247.30 willfully false statement or representation, by intentional concealment of any material fact,
- 247.31 or by impersonation or other fraudulent device, assistance or the continued receipt of

248.1 assistance, to include child care assistance or ~~vouchers~~ food benefits produced according
248.2 to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365,
248.3 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater
248.4 than that to which the person is entitled;

248.5 (2) knowingly aids or abets in buying or in any way disposing of the property of a
248.6 recipient or applicant of assistance without the consent of the county agency; or

248.7 (3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments
248.8 to which the individual is not entitled as a provider of subsidized child care, or by furnishing
248.9 or concurring in a willfully false claim for child care assistance.

248.10 (b) The continued receipt of assistance to which the person is not entitled or greater than
248.11 that to which the person is entitled as a result of any of the acts, failure to act, or concealment
248.12 described in this subdivision shall be deemed to be continuing offenses from the date that
248.13 the first act or failure to act occurred.

248.14 Sec. 89. Minnesota Statutes 2020, section 256B.0625, subdivision 52, is amended to read:

248.15 Subd. 52. **Lead risk assessments.** (a) Effective October 1, 2007, or six months after
248.16 federal approval, whichever is later, medical assistance covers lead risk assessments provided
248.17 by a lead risk assessor who is licensed by the commissioner of health under section 144.9505
248.18 and employed by an assessing agency as defined in section 144.9501. Medical assistance
248.19 covers a onetime on-site investigation of a recipient's home or primary residence to determine
248.20 the existence of lead so long as the recipient is under the age of 21 and has a venous blood
248.21 lead level specified in section 144.9504, subdivision 2, paragraph ~~(a)~~ (b).

248.22 (b) Medical assistance reimbursement covers the lead risk assessor's time to complete
248.23 the following activities:

248.24 (1) gathering samples;

248.25 (2) interviewing family members;

248.26 (3) gathering data, including meter readings; and

248.27 (4) providing a report with the results of the investigation and options for reducing
248.28 lead-based paint hazards.

248.29 Medical assistance coverage of lead risk assessment does not include testing of
248.30 environmental substances such as water, paint, or soil or any other laboratory services.

248.31 Medical assistance coverage of lead risk assessments is not included in the capitated services

249.1 for children enrolled in health plans through the prepaid medical assistance program and
249.2 the MinnesotaCare program.

249.3 (c) Payment for lead risk assessment must be cost-based and must meet the criteria for
249.4 federal financial participation under the Medicaid program. The rate must be based on
249.5 allowable expenditures from cost information gathered. Under section 144.9507, subdivision
249.6 5, federal medical assistance funds may not replace existing funding for lead-related activities.
249.7 The nonfederal share of costs for services provided under this subdivision must be from
249.8 state or local funds and is the responsibility of the agency providing the risk assessment.
249.9 When the risk assessment is conducted by the commissioner of health, the state share must
249.10 be from appropriations to the commissioner of health for this purpose. Eligible expenditures
249.11 for the nonfederal share of costs may not be made from federal funds or funds used to match
249.12 other federal funds. Any federal disallowances are the responsibility of the agency providing
249.13 risk assessment services.

249.14 Sec. 90. Minnesota Statutes 2020, section 326.71, subdivision 4, is amended to read:

249.15 Subd. 4. **Asbestos-related work.** "Asbestos-related work" means the enclosure, removal,
249.16 or encapsulation of asbestos-containing material in a quantity that meets or exceeds 260
249.17 linear feet of friable asbestos-containing material on pipes, 160 square feet of friable
249.18 asbestos-containing material on other facility components, or, if linear feet or square feet
249.19 cannot be measured, a total of 35 cubic feet of friable asbestos-containing material on or
249.20 off all facility components in one facility. In the case of single or multifamily residences,
249.21 "asbestos-related work" also means the enclosure, removal, or encapsulation of greater than
249.22 ten but less than 260 linear feet of friable asbestos-containing material on pipes, greater
249.23 than six but less than 160 square feet of friable asbestos-containing material on other facility
249.24 components, or, if linear feet or square feet cannot be measured, greater than one cubic foot
249.25 but less than 35 cubic feet of friable asbestos-containing material on or off all facility
249.26 components in one facility. ~~This provision excludes asbestos-containing floor tiles and~~
249.27 ~~sheeting, roofing materials, siding, and all ceilings with asbestos-containing material in~~
249.28 ~~single family residences and buildings with no more than four dwelling units.~~
249.29 Asbestos-related work includes asbestos abatement area preparation; enclosure, removal,
249.30 or encapsulation operations; and an air quality monitoring specified in rule to assure that
249.31 the abatement and adjacent areas are not contaminated with asbestos fibers during the project
249.32 and after completion.

249.33 For purposes of this subdivision, the quantity of ~~asbestos-containing~~ asbestos-containing
249.34 material applies separately for every project.

250.1 Sec. 91. Minnesota Statutes 2020, section 326.75, subdivision 1, is amended to read:

250.2 Subdivision 1. **Licensing fee.** A person required to be licensed under section 326.72
250.3 shall, before receipt of the license and before causing asbestos-related work to be performed,
250.4 pay the commissioner an annual license fee of ~~\$400~~ \$105.

250.5 Sec. 92. Minnesota Statutes 2020, section 326.75, subdivision 2, is amended to read:

250.6 Subd. 2. **Certification fee.** An individual required to be certified as an asbestos worker
250.7 or asbestos site supervisor under section 326.73, subdivision 1, shall pay the commissioner
250.8 a certification fee of ~~\$50~~ \$52.50 before the issuance of the certificate. ~~The commissioner~~
250.9 ~~may establish by rule fees required before the issuance of~~ An individual required to be
250.10 certified as an asbestos inspector, asbestos management planner, and asbestos project
250.11 designer certificates required under section 326.73, subdivisions 2, 3, and 4, shall pay the
250.12 commissioner a certification fee of \$105 before the issuance of the certificate.

250.13 Sec. 93. Minnesota Statutes 2020, section 326.75, subdivision 3, is amended to read:

250.14 Subd. 3. **Permit fee.** Five calendar days before beginning asbestos-related work, a person
250.15 shall pay a project permit fee to the commissioner equal to ~~one~~ two percent of the total costs
250.16 of the asbestos-related work. For asbestos-related work performed in single or multifamily
250.17 residences, of greater than ten but less than 260 linear feet of asbestos-containing material
250.18 on pipes, or greater than six but less than 160 square feet of asbestos-containing material
250.19 on other facility components, a person shall pay a project permit fee of \$35 to the
250.20 commissioner.

250.21 Sec. 94. Laws 2020, Seventh Special Session chapter 1, article 6, section 12, subdivision
250.22 4, is amended to read:

250.23 Subd. 4. **Housing with services establishment registration; conversion to an assisted**
250.24 **living facility license.** (a) Housing with services establishments registered under chapter
250.25 144D, providing home care services according to chapter 144A to at least one resident, and
250.26 intending to provide assisted living services on or after August 1, 2021, must submit an
250.27 application for an assisted living facility license in accordance with section 144G.12 no
250.28 later than June 1, 2021. The commissioner shall consider the application in accordance with
250.29 section ~~144G.16~~ 144G.15.

250.30 (b) Notwithstanding the housing with services contract requirements identified in section
250.31 144D.04, any existing housing with services establishment registered under chapter 144D
250.32 that does not intend to convert its registration to an assisted living facility license under this

251.1 chapter must provide written notice to its residents at least 60 days before the expiration of
 251.2 its registration, or no later than May 31, 2021, whichever is earlier. The notice must:

251.3 (1) state that the housing with services establishment does not intend to convert to an
 251.4 assisted living facility;

251.5 (2) include the date when the housing with services establishment will no longer provide
 251.6 housing with services;

251.7 (3) include the name, e-mail address, and phone number of the individual associated
 251.8 with the housing with services establishment that the recipient of home care services may
 251.9 contact to discuss the notice;

251.10 (4) include the contact information consisting of the phone number, e-mail address,
 251.11 mailing address, and website for the Office of Ombudsman for Long-Term Care and the
 251.12 Office of Ombudsman for Mental Health and Developmental Disabilities; and

251.13 (5) for residents who receive home and community-based waiver services under section
 251.14 256B.49 and chapter 256S, also be provided to the resident's case manager at the same time
 251.15 that it is provided to the resident.

251.16 (c) A housing with services registrant that obtains an assisted living facility license, but
 251.17 does so under a different business name as a result of reincorporation, and continues to
 251.18 provide services to the recipient, is not subject to the 60-day notice required under paragraph
 251.19 (b). However, the provider must otherwise provide notice to the recipient as required under
 251.20 sections 144D.04 and 144D.045, as applicable, and section 144D.09.

251.21 (d) All registered housing with services establishments providing assisted living under
 251.22 sections 144G.01 to 144G.07 prior to August 1, 2021, must have an assisted living facility
 251.23 license under this chapter.

251.24 (e) Effective August 1, 2021, any housing with services establishment registered under
 251.25 chapter 144D that has not converted its registration to an assisted living facility license
 251.26 under this chapter is prohibited from providing assisted living services.

251.27 **EFFECTIVE DATE.** This section is effective retroactively from December 17, 2020.

251.28 Sec. 95. **ADDITIONAL MEMBER TO COVID-19 VACCINE ALLOCATION**
 251.29 **ADVISORY GROUP.**

251.30 The commissioner of health shall appoint an individual who is an expert on vaccine
 251.31 disinformation to the state COVID-19 Vaccine Allocation Advisory Group no later than
 251.32

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

252.2 Sec. 96. **FEDERAL SCHEDULE I EXEMPTION APPLICATION FOR MEDICAL**
252.3 **USE OF CANNABIS.**

252.4 By September 1, 2021, the commissioner of health shall apply to the Drug Enforcement
252.5 Administration's Office of Diversion Control for an exception under Code of Federal
252.6 Regulations, title 21, section 1307.03, and request formal written acknowledgment that the
252.7 listing of marijuana, marijuana extract, and tetrahydrocannabinols as controlled substances
252.8 in federal Schedule I does not apply to the protected activities in Minnesota Statutes, section
252.9 152.32, subdivision 2, pursuant to the medical cannabis program established under Minnesota
252.10 Statutes, sections 152.22 to 152.37. The application shall include the list of presumptions
252.11 in Minnesota Statutes, section 152.32, subdivision 1.

252.12 Sec. 97. **RECOMMENDATIONS; EXPANDED ACCESS TO DATA FROM**
252.13 **ALL-PAYER CLAIMS DATABASE.**

252.14 The commissioner of health shall develop recommendations to expand access to data
252.15 in the all-payer claims database under Minnesota Statutes, section 62U.04, to additional
252.16 outside entities for public health or research purposes. In the recommendations, the
252.17 commissioner must address an application process for outside entities to access the data,
252.18 how the department will exercise ongoing oversight over data use by outside entities,
252.19 purposes for which the data may be used by outside entities, establishment of a data access
252.20 committee to advise the department on selecting outside entities that may access the data,
252.21 and steps outside entities must take to protect data held by those entities from unauthorized
252.22 use. Following development of these recommendations, an outside entity that accesses data
252.23 in compliance with these recommendations may publish results that identify hospitals,
252.24 clinics, and medical practices so long as no individual health professionals are identified
252.25 and the commissioner finds the data to be accurate, valid, and suitable for publication for
252.26 such use. The commissioner shall submit these recommendations by December 15, 2021,
252.27 to the chairs and ranking minority members of the legislative committees with jurisdiction
252.28 over health policy and civil law.

252.29 Sec. 98. **SKIN LIGHTENING PRODUCTS PUBLIC AWARENESS AND**
252.30 **EDUCATION GRANT PROGRAM.**

252.31 Subdivision 1. **Establishment; purpose.** The commissioner of health shall develop a
252.32 grant program for the purpose of increasing public awareness and education on the health
252.33 dangers associated with using skin lightening creams and products that contain mercury

253.1 that are manufactured in other countries and brought into this country and sold illegally
253.2 online or in stores.

253.3 Subd. 2. **Grants authorized.** The commissioner shall award grants through a request
253.4 for proposal process to community-based, nonprofit organizations that serve ethnic
253.5 communities and that focus on public health outreach to Black, Indigenous, and people of
253.6 color communities on the issue of skin lightening products and chemical exposure from
253.7 these products. Priority in awarding grants shall be given to organizations that have
253.8 historically provided services to ethnic communities on the skin lightening and chemical
253.9 exposure issue for the past three years.

253.10 Subd. 3. **Grant allocation.** (a) Grantees must use the funds to conduct public awareness
253.11 and education activities that are culturally specific and community-based and focus on:

253.12 (1) the dangers of exposure to mercury through dermal absorption, inhalation,
253.13 hand-to-mouth contact, and through contact with individuals who have used these skin
253.14 lightening products;

253.15 (2) the signs and symptoms of mercury poisoning;

253.16 (3) the health effects of mercury poisoning, including the permanent effects on the central
253.17 nervous system and kidneys;

253.18 (4) the dangers of using these products or being exposed to these products during
253.19 pregnancy and breastfeeding to the mother and to the infant;

253.20 (5) knowing how to identify products that contain mercury; and

253.21 (6) proper disposal of the product if the product contains mercury.

253.22 (b) The grant application must include:

253.23 (1) a description of the purpose or project for which the grant funds will be used;

253.24 (2) a description of the objectives, a work plan, and a timeline for implementation; and

253.25 (3) the community or group the grant proposes to focus on.

253.26 Sec. 99. **TRAUMA-INFORMED GUN VIOLENCE REDUCTION; PILOT**
253.27 **PROGRAM.**

253.28 Subdivision 1. **Pilot program.** (a) The commissioner of health shall establish a pilot
253.29 program to aid in the reduction of trauma resulting from gun violence and address the root
253.30 causes of gun violence by making the following resources available to professionals and
253.31 organizations in health care, public health, mental health, social service, law enforcement,

254.1 and victim advocacy and other professionals who are most likely to encounter individuals
254.2 who have been victims, witnesses, or perpetrators of gun violence occurring in a community,
254.3 or in a domestic or other setting;

254.4 (1) training on recognizing trauma as both a result and a cause of gun violence;

254.5 (2) developing skills to address the effects of trauma on individuals and family members;

254.6 (3) investments in community-based organizations to enable high-quality, targeted
254.7 services to individuals in need. This may include resources for additional training, hiring
254.8 of specialized staff needed to address trauma-related issues, management information
254.9 systems to facilitate data collection, and expansion of existing programming;

254.10 (4) replication and expansion of effective community-based gun violence prevention
254.11 initiatives, such as Project Life, the Minneapolis Group Violence Intervention initiative, to
254.12 connect at-risk individuals to mental health services, job readiness programs, and employment
254.13 opportunities; and

254.14 (5) education campaigns and outreach materials to educate communities, organizations,
254.15 and the public about the relationship between trauma and gun violence.

254.16 (b) The pilot program shall address the traumatic effects of gun violence exposure using
254.17 a holistic treatment modality.

254.18 Subd. 2. **Program guidelines and protocols.** (a) The commissioner, with advice from
254.19 an advisory panel knowledgeable about gun violence and its traumatic impact, shall develop
254.20 protocols and program guidelines that address resources and training to be used by
254.21 professionals who encounter individuals who have perpetrated or been impacted by gun
254.22 violence. Educational, training, and outreach material must be culturally appropriate for the
254.23 community and provided in multiple languages for those with limited English language
254.24 proficiency. The materials developed must address necessary responses by local, state, and
254.25 other governmental entities tasked with addressing gun violence. The protocols must include
254.26 a method of informing affected communities and local governments representing those
254.27 communities on effective strategies to target community, domestic, and other forms of gun
254.28 violence.

254.29 (b) The commissioner may enter into contractual agreements with community-based
254.30 organizations or experts in the field to perform any of the activities under this section.

254.31 Subd. 3. **Report.** By November 15, 2021, the commissioner shall submit a report on the
254.32 progress of the pilot program to the chairs and ranking minority members of the committees
254.33 with jurisdiction over health and public safety.

255.1 Sec. 100. **REVISOR INSTRUCTION.**

255.2 The revisor of statutes shall amend the section headnote for Minnesota Statutes, section
255.3 62J.63, to read "HEALTH CARE PURCHASING AND PERFORMANCE
255.4 MEASUREMENT."

255.5 Sec. 101. **REPEALER.**

255.6 Minnesota Statutes 2020, sections 62J.63, subdivision 3; 144.0721, subdivision 1;
255.7 144.0722; 144.0724, subdivision 10; and 144.693, are repealed.

255.8 **ARTICLE 4**

255.9 **HEALTH-RELATED LICENSING BOARDS**

255.10 Section 1. Minnesota Statutes 2020, section 156.12, subdivision 2, is amended to read:

255.11 Subd. 2. **Authorized activities.** No provision of this chapter shall be construed to prohibit:

255.12 (a) a person from rendering necessary gratuitous assistance in the treatment of any animal
255.13 when the assistance does not amount to prescribing, testing for, or diagnosing, operating,
255.14 or vaccinating and when the attendance of a licensed veterinarian cannot be procured;

255.15 (b) a person who is a regular student in an accredited or approved college of veterinary
255.16 medicine from performing duties or actions assigned by instructors or preceptors or working
255.17 under the direct supervision of a licensed veterinarian;

255.18 (c) a veterinarian regularly licensed in another jurisdiction from consulting with a licensed
255.19 veterinarian in this state;

255.20 (d) the owner of an animal and the owner's regular employee from caring for and
255.21 administering to the animal belonging to the owner, except where the ownership of the
255.22 animal was transferred for purposes of circumventing this chapter;

255.23 (e) veterinarians who are in compliance with subdivision 6 and who are employed by
255.24 the University of Minnesota from performing their duties with the College of Veterinary
255.25 Medicine, College of Agriculture, Agricultural Experiment Station, Agricultural Extension
255.26 Service, Medical School, School of Public Health, or other unit within the university; or a
255.27 person from lecturing or giving instructions or demonstrations at the university or in
255.28 connection with a continuing education course or seminar to veterinarians or pathologists
255.29 at the University of Minnesota Veterinary Diagnostic Laboratory;

255.30 (f) any person from selling or applying any pesticide, insecticide or herbicide;

256.1 (g) any person from engaging in bona fide scientific research or investigations which
256.2 reasonably requires experimentation involving animals;

256.3 (h) any employee of a licensed veterinarian from performing duties other than diagnosis,
256.4 prescription or surgical correction under the direction and supervision of the veterinarian,
256.5 who shall be responsible for the performance of the employee;

256.6 (i) a graduate of a foreign college of veterinary medicine from working under the direct
256.7 personal instruction, control, or supervision of a veterinarian faculty member of the College
256.8 of Veterinary Medicine, University of Minnesota in order to complete the requirements
256.9 necessary to obtain an ECFVG or PAVE certificate;

256.10 (j) a licensed chiropractor registered under section 148.01, subdivision 1a, from practicing
256.11 animal chiropractic; or

256.12 (k) a person certified by the Emergency Medical Services Regulatory Board under
256.13 chapter 144E from providing emergency medical care to a police dog wounded in the line
256.14 of duty.

256.15 ARTICLE 5

256.16 PRESCRIPTION DRUGS

256.17 Section 1. [62J.841] DEFINITIONS.

256.18 Subdivision 1. Scope. For purposes of sections 62J.841 to 62J.845, the following
256.19 definitions apply.

256.20 Subd. 2. Consumer Price Index. "Consumer Price Index" means the Consumer Price
256.21 Index, Annual Average, for All Urban Consumers, CPI-U: U.S. City Average, All Items,
256.22 reported by the United States Department of Labor, Bureau of Labor Statistics, or its
256.23 successor or, if the index is discontinued, an equivalent index reported by a federal authority
256.24 or, if no such index is reported, "Consumer Price Index" means a comparable index chosen
256.25 by the Bureau of Labor Statistics.

256.26 Subd. 3. Generic or off-patent drug. "Generic or off-patent drug" means any prescription
256.27 drug for which any exclusive marketing rights granted under the Federal Food, Drug, and
256.28 Cosmetic Act, section 351 of the federal Public Health Service Act, and federal patent law
256.29 have expired, including any drug-device combination product for the delivery of a generic
256.30 drug.

256.31 Subd. 4. Manufacturer. "Manufacturer" has the meaning provided in section 151.01,
256.32 subdivision 14a.

257.1 Subd. 5. **Prescription drug.** "Prescription drug" means a drug for human use subject
257.2 to United States Code, title 21, section 353(b)(1).

257.3 Subd. 6. **Wholesale acquisition cost.** "Wholesale acquisition cost" has the meaning
257.4 provided in United States Code, title 42, section 1395w-3a.

257.5 Subd. 7. **Wholesale distributor.** "Wholesale distributor" has the meaning provided in
257.6 section 151.441, subdivision 14.

257.7 Sec. 2. **[62J.842] EXCESSIVE PRICE INCREASES PROHIBITED.**

257.8 Subdivision 1. **Prohibition.** No manufacturer shall impose, or cause to be imposed, an
257.9 excessive price increase, whether directly or through a wholesale distributor, pharmacy, or
257.10 similar intermediary, on the sale of any generic or off-patent drug sold, dispensed, or
257.11 delivered to any consumer in the state.

257.12 Subd. 2. **Excessive price increase.** A price increase is excessive for purposes of this
257.13 section when:

257.14 (1) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds:

257.15 (i) 15 percent of the wholesale acquisition cost over the immediately preceding calendar
257.16 year; or

257.17 (ii) 40 percent of the wholesale acquisition cost over the immediately preceding three
257.18 calendar years; and

257.19 (2) the price increase, adjusted for inflation utilizing the Consumer Price Index, exceeds
257.20 \$30 for:

257.21 (i) a 30-day supply of the drug; or

257.22 (ii) a course of treatment lasting less than 30 days.

257.23 Subd. 3. **Exemption.** It is not a violation of this section for a wholesale distributor or
257.24 pharmacy to increase the price of a generic or off-patent drug if the price increase is directly
257.25 attributable to additional costs for the drug imposed on the wholesale distributor or pharmacy
257.26 by the manufacturer of the drug.

257.27 Sec. 3. **[62J.843] REGISTERED AGENT AND OFFICE WITHIN THE STATE.**

257.28 Any manufacturer that sells, distributes, delivers, or offers for sale any generic or
257.29 off-patent drug in the state is required to maintain a registered agent and office within the
257.30 state.

258.1 Sec. 4. **[62J.844] ENFORCEMENT.**

258.2 **Subdivision 1. Notification.** The commissioner of management and budget and any
258.3 other state agency that provides or purchases a pharmacy benefit except the Department of
258.4 Human Services, and any entity under contract with a state agency to provide a pharmacy
258.5 benefit other than an entity under contract with the Department of Human Services, shall
258.6 notify the manufacturer of a generic or off-patent drug, the attorney general, and the Board
258.7 of Pharmacy of any price increase that is in violation of section 62J.842.

258.8 **Subd. 2. Submission of drug cost statement and other information by manufacturer;**
258.9 **investigation by attorney general.** (a) Within 45 days of receiving a notice under subdivision
258.10 1, the manufacturer of the generic or off-patent drug shall submit a drug cost statement to
258.11 the attorney general. The statement must:

258.12 (1) itemize the cost components related to production of the drug;

258.13 (2) identify the circumstances and timing of any increase in materials or manufacturing
258.14 costs that caused any increase during the preceding calendar year, or preceding three calendar
258.15 years as applicable, in the price of the drug; and

258.16 (3) provide any other information that the manufacturer believes to be relevant to a
258.17 determination of whether a violation of section 62J.842 has occurred.

258.18 (b) The attorney general may investigate whether a violation of section 62J.842 has
258.19 occurred, is occurring, or is about to occur, in accordance with section 8.31, subdivision 2.

258.20 **Subd. 3. Petition to court.** (a) On petition of the attorney general, a court may issue an
258.21 order:

258.22 (1) compelling the manufacturer of a generic or off-patent drug to:

258.23 (i) provide the drug cost statement required under subdivision 2, paragraph (a); and

258.24 (ii) answer interrogatories, produce records or documents, or be examined under oath,
258.25 as required by the attorney general under subdivision 2, paragraph (b);

258.26 (2) restraining or enjoining a violation of sections 62J.841 to 62J.845, including issuing
258.27 an order requiring that drug prices be restored to levels that comply with section 62J.842;

258.28 (3) requiring the manufacturer to provide an accounting to the attorney general of all
258.29 revenues resulting from a violation of section 62J.842;

258.30 (4) requiring the manufacturer to repay to all consumers, including any third-party payers,
258.31 any money acquired as a result of a price increase that violates section 62J.842;

259.1 (5) notwithstanding section 16A.151, requiring that all revenues generated from a
259.2 violation of section 62J.842 be remitted to the state and deposited into a special fund, to be
259.3 used for initiatives to reduce the cost to consumers of acquiring prescription drugs, if a
259.4 manufacturer is unable to determine the individual transactions necessary to provide the
259.5 repayments described in clause (4);

259.6 (6) imposing a civil penalty of up to \$10,000 per day for each violation of section 62J.842;

259.7 (7) providing for the attorney general's recovery of its costs and disbursements incurred
259.8 in bringing an action against a manufacturer found in violation of section 62J.842, including
259.9 the costs of investigation and reasonable attorney's fees; and

259.10 (8) providing any other appropriate relief, including any other equitable relief as
259.11 determined by the court.

259.12 (b) For purposes of paragraph (a), clause (6), every individual transaction in violation
259.13 of section 62J.842 shall be considered a separate violation.

259.14 Subd. 4. **Private right of action.** Any action brought pursuant to section 8.31, subdivision
259.15 3a, by a person injured by a violation of this section is for the benefit of the public.

259.16 Sec. 5. **[62J.845] PROHIBITION ON WITHDRAWAL OF GENERIC OR**
259.17 **OFF-PATENT DRUGS FOR SALE.**

259.18 Subdivision 1. **Prohibition.** A manufacturer of a generic or off-patent drug is prohibited
259.19 from withdrawing that drug from sale or distribution within this state for the purpose of
259.20 avoiding the prohibition on excessive price increases under section 62J.842.

259.21 Subd. 2. **Notice to board and attorney general.** Any manufacturer that intends to
259.22 withdraw a generic or off-patent drug from sale or distribution within the state shall provide
259.23 a written notice of withdrawal to the Board of Pharmacy and the attorney general, at least
259.24 180 days prior to the withdrawal.

259.25 Subd. 3. **Financial penalty.** The attorney general shall assess a penalty of \$500,000 on
259.26 any manufacturer of a generic or off-patent drug that it determines has failed to comply
259.27 with the requirements of this section.

259.28 Sec. 6. **[62J.846] SEVERABILITY.**

259.29 If any provision of sections 62J.841 to 62J.845 or the application thereof to any person
259.30 or circumstance is held invalid for any reason in a court of competent jurisdiction, the

260.1 invalidity does not affect other provisions or any other application of sections 62J.841 to
260.2 62J.845 that can be given effect without the invalid provision or application.

260.3 Sec. 7. Minnesota Statutes 2020, section 62Q.81, is amended by adding a subdivision to
260.4 read:

260.5 Subd. 6. **Prescription drug benefits.** (a) A health plan company that offers individual
260.6 health plans must ensure that no fewer than 25 percent of the individual health plans the
260.7 company offers in each geographic area that the health plan company services at each level
260.8 of coverage described in subdivision 1, paragraph (b), clause (3), applies a predeductible,
260.9 flat-dollar amount co-payment structure to the entire drug benefit, including all tiers.

260.10 (b) A health plan company that offers small group health plans must ensure that no fewer
260.11 than 25 percent of small group health plans the company offers in each geographic area that
260.12 the health plan company services at each level of coverage described in subdivision 1,
260.13 paragraph (b), clause (3), applies a predeductible, flat-dollar amount co-payment structure
260.14 to the entire drug benefit, including all tiers.

260.15 (c) The highest allowable co-payment for the highest cost drug tier for health plans
260.16 offered pursuant to this subdivision must be no greater than 1/12 of the plan's out-of-pocket
260.17 maximum for an individual.

260.18 (d) The flat-dollar amount co-payment tier structure for prescription drugs under this
260.19 subdivision must be graduated and proportionate.

260.20 (e) All individual and small group health plans offered pursuant to this subdivision must
260.21 be:

260.22 (1) clearly and appropriately named to aid the purchaser in the selection process;

260.23 (2) marketed in the same manner as other health plans offered by the health plan company;

260.24 and

260.25 (3) offered for purchase to any individual or small group.

260.26 (f) This subdivision does not apply to catastrophic plans, grandfathered plans, large
260.27 group health plans, health savings accounts (HSAs), qualified high deductible health benefit
260.28 plans, limited health benefit plans, or short-term limited-duration health insurance policies.

260.29 (g) Health plan companies must meet the requirements in this subdivision separately for
260.30 plans offered through MNsure under chapter 62V and plans offered outside of MNsure.

260.31 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to individual
260.32 and small group health plans offered, issued, or renewed on or after that date.

261.1 Sec. 8. **[62Q.83] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND**
261.2 **MANAGEMENT.**

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

261.5 (b) "Drug" has the meaning given in section 151.01, subdivision 5.

261.6 (c) "Enrollee contract term" means the 12-month term during which benefits associated
261.7 with health plan company products are in effect. For managed care plans and county-based
261.8 purchasing plans under section 256B.69 and chapter 256L, enrollee contract term means a
261.9 single calendar quarter.

261.10 (d) "Formulary" means a list of prescription drugs that have been developed by clinical
261.11 and pharmacy experts and represents the health plan company's medically appropriate and
261.12 cost-effective prescription drugs approved for use.

261.13 (e) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and
261.14 includes an entity that performs pharmacy benefits management for the health plan company.

261.15 (f) "Pharmacy benefits management" means the administration or management of
261.16 prescription drug benefits provided by the health plan company for the benefit of its enrollees
261.17 and may include but is not limited to procurement of prescription drugs, clinical formulary
261.18 development and management services, claims processing, and rebate contracting and
261.19 administration.

261.20 (g) "Prescription" has the meaning given in section 151.01, subdivision 16a.

261.21 Subd. 2. Prescription drug benefit disclosure. (a) A health plan company that provides
261.22 prescription drug benefit coverage and uses a formulary must make its formulary and related
261.23 benefit information available by electronic means and, upon request, in writing at least 30
261.24 days prior to annual renewal dates.

261.25 (b) Formularies must be organized and disclosed consistent with the most recent version
261.26 of the United States Pharmacopeia's Model Guidelines.

261.27 (c) For each item or category of items on the formulary, the specific enrollee benefit
261.28 terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

261.29 Subd. 3. Formulary changes. (a) Once a formulary has been established, a health plan
261.30 company may, at any time during the enrollee's contract term:

261.31 (1) expand its formulary by adding drugs to the formulary;

261.32 (2) reduce co-payments or coinsurance; or

262.1 (3) move a drug to a benefit category that reduces an enrollee's cost.

262.2 (b) A health plan company may remove a brand name drug from its formulary or place
262.3 a brand name drug in a benefit category that increases an enrollee's cost only upon the
262.4 addition to the formulary of a generic or multisource brand name drug rated as therapeutically
262.5 equivalent according to the Food and Drug Administration (FDA) Orange Book or a biologic
262.6 drug rated as interchangeable according to the FDA Purple Book at a lower cost to the
262.7 enrollee and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

262.8 (c) A health plan company may change utilization review requirements or move drugs
262.9 to a benefit category that increases an enrollee's cost during the enrollee's contract term
262.10 upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees, provided
262.11 that these changes do not apply to enrollees who are currently taking the drugs affected by
262.12 these changes for the duration of the enrollee's contract term.

262.13 (d) A health plan company may remove any drugs from its formulary that have been
262.14 deemed unsafe by the FDA; that have been withdrawn by either the FDA or the product
262.15 manufacturer; or when an independent source of research, clinical guidelines, or
262.16 evidence-based standards has issued drug-specific warnings or recommended changes in
262.17 drug usage.

262.18 Sec. 9. [62W.0751] ALTERNATIVE BIOLOGICAL PRODUCTS.

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

262.21 (b) "Biological product" has the meaning given in section 151.01, subdivision 40.

262.22 (c) "Biosimilar" or "biosimilar product" has the meaning given in section 151.01,
262.23 subdivision 43.

262.24 (d) "Interchangeable biological product" has the meaning given in section 151.01,
262.25 subdivision 41.

262.26 (e) "Reference biological product" has the meaning given in section 151.01, subdivision
262.27 44.

262.28 Subd. 2. **Pharmacy and provider choice related to dispensing reference biological**
262.29 **products, interchangeable biological products, or biosimilar products.** (a) A pharmacy
262.30 benefit manager or health carrier must not require or demonstrate a preference for a pharmacy
262.31 or health care provider to prescribe or dispense a single biological product for which there
262.32 is a United States Food and Drug Administration-approved biosimilar or interchangeable

263.1 biological product relative to a reference biological product, except as provided in paragraph
263.2 (b).

263.3 (b) If a pharmacy benefit manager or health carrier elects coverage of a product listed
263.4 in paragraph (a), it must also elect equivalent coverage for at least three reference, biosimilar,
263.5 or interchangeable biological products, or the total number of products that have been
263.6 approved by the United States Food and Drug Administration relative to the reference
263.7 product if less than three, for which the wholesale acquisition cost is less than the wholesale
263.8 acquisition cost of the product listed in paragraph (a).

263.9 (c) A pharmacy benefit manager or health carrier must not impose limits on access to a
263.10 product required to be covered under paragraph (b) that are more restrictive than limits
263.11 imposed on access to a product listed in paragraph (a), or that otherwise have the same
263.12 effect as giving preferred status to a product listed in paragraph (a) over the product required
263.13 to be covered under paragraph (b).

263.14 (d) This section does not apply to coverage provided through a public health care program
263.15 under chapter 256B or 256L, or health plan coverage through the State Employee Group
263.16 Insurance Plan (SEGIP) under chapter 43A.

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

263.18 Sec. 10. Minnesota Statutes 2020, section 62W.11, is amended to read:

263.19 **62W.11 GAG CLAUSE PROHIBITION.**

263.20 (a) No contract between a pharmacy benefit manager or health carrier and a pharmacy
263.21 or pharmacist shall prohibit, restrict, or penalize a pharmacy or pharmacist from disclosing
263.22 to an enrollee any health care information that the pharmacy or pharmacist deems appropriate
263.23 regarding the nature of treatment; the risks or alternatives; the availability of alternative
263.24 therapies, consultations, or tests; the decision of utilization reviewers or similar persons to
263.25 authorize or deny services; the process that is used to authorize or deny health care services
263.26 or benefits; or information on financial incentives and structures used by the health carrier
263.27 or pharmacy benefit manager.

263.28 (b) A pharmacy or pharmacist must provide to an enrollee information regarding the
263.29 enrollee's total cost for each prescription drug dispensed where part or all of the cost of the
263.30 prescription is being paid or reimbursed by the employer-sponsored plan or by a health
263.31 carrier or pharmacy benefit manager, in accordance with section 151.214, subdivision 1.

263.32 (c) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
263.33 pharmacy from discussing information regarding the total cost for pharmacy services for a

264.1 prescription drug, including the patient's co-payment amount ~~and~~, the pharmacy's own usual
264.2 and customary price ~~of~~ for the prescription drug, the pharmacy's acquisition cost for the
264.3 prescription drug, and the amount the pharmacy is being reimbursed by the pharmacy benefit
264.4 manager or health carrier for the prescription drug.

264.5 (d) A pharmacy benefit manager must not prohibit a pharmacist or pharmacy from
264.6 discussing with a health carrier the amount the pharmacy is being paid or reimbursed for a
264.7 prescription drug by the pharmacy benefit manager or the pharmacy's acquisition cost for
264.8 a prescription drug.

264.9 ~~(d)~~ (e) A pharmacy benefit manager or health carrier must not prohibit a pharmacist or
264.10 pharmacy from discussing the availability of any therapeutically equivalent alternative
264.11 prescription drugs or alternative methods for purchasing the prescription drug, including
264.12 but not limited to paying out-of-pocket the pharmacy's usual and customary price when that
264.13 amount is less expensive to the enrollee than the amount the enrollee is required to pay for
264.14 the prescription drug under the enrollee's health plan.

264.15 Sec. 11. Minnesota Statutes 2020, section 62W.12, is amended to read:

264.16 **62W.12 POINT OF SALE.**

264.17 (a) No pharmacy benefit manager or health carrier shall require an enrollee to make a
264.18 payment at the point of sale for a covered prescription drug in an amount greater than the
264.19 lesser of:

264.20 (1) the applicable co-payment for the prescription drug;

264.21 (2) the allowable claim amount for the prescription drug; ~~or~~

264.22 (3) the amount an enrollee would pay for the prescription drug if the enrollee purchased
264.23 the prescription drug without using a health plan or any other source of prescription drug
264.24 benefits or discounts; or

264.25 (4) the net price of the prescription drug plus the dispensing fee.

264.26 (b) For purposes of this section, "net price" means the pharmacy benefit manager's or
264.27 health carrier's cost for a prescription drug after applying any rebates or discounts received
264.28 by or accrued directly or indirectly to the pharmacy benefit manager or health carrier from
264.29 a drug manufacturer.

264.30 **EFFECTIVE DATE.** This section is effective for health plans offered, issued, or
264.31 renewed on or after January 1, 2022.

265.1 Sec. 12. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
265.2 read:

265.3 Subd. 43. **Biosimilar product.** "Biosimilar" or "interchangeable biological product"
265.4 means a biological product that the United States Food and Drug Administration has licensed,
265.5 and determined to be "biosimilar" under United States Code, title 42, section 262(i)(2).

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

265.7 Sec. 13. Minnesota Statutes 2020, section 151.01, is amended by adding a subdivision to
265.8 read:

265.9 Subd. 44. **Reference biological product.** "Reference biological product" means the
265.10 single biological product for which the United States Food and Drug Administration has
265.11 approved an initial biological product license application, against which other biological
265.12 products are evaluated for licensure as biosimilar products or interchangeable biological
265.13 products.

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

265.15 Sec. 14. Minnesota Statutes 2020, section 151.071, subdivision 1, is amended to read:

265.16 Subdivision 1. **Forms of disciplinary action.** When the board finds that a licensee,
265.17 registrant, or applicant has engaged in conduct prohibited under subdivision 2, it may do
265.18 one or more of the following:

265.19 (1) deny the issuance of a license or registration;

265.20 (2) refuse to renew a license or registration;

265.21 (3) revoke the license or registration;

265.22 (4) suspend the license or registration;

265.23 (5) impose limitations, conditions, or both on the license or registration, including but
265.24 not limited to: the limitation of practice to designated settings; the limitation of the scope
265.25 of practice within designated settings; the imposition of retraining or rehabilitation
265.26 requirements; the requirement of practice under supervision; the requirement of participation
265.27 in a diversion program such as that established pursuant to section 214.31 or the conditioning
265.28 of continued practice on demonstration of knowledge or skills by appropriate examination
265.29 or other review of skill and competence;

265.30 (6) impose a civil penalty not exceeding \$10,000 for each separate violation, except that
265.31 a civil penalty not exceeding \$25,000 may be imposed for each separate violation of section

266.1 62J.842, the amount of the civil penalty to be fixed so as to deprive a licensee or registrant
266.2 of any economic advantage gained by reason of the violation, to discourage similar violations
266.3 by the licensee or registrant or any other licensee or registrant, or to reimburse the board
266.4 for the cost of the investigation and proceeding, including but not limited to, fees paid for
266.5 services provided by the Office of Administrative Hearings, legal and investigative services
266.6 provided by the Office of the Attorney General, court reporters, witnesses, reproduction of
266.7 records, board members' per diem compensation, board staff time, and travel costs and
266.8 expenses incurred by board staff and board members; and

266.9 (7) reprimand the licensee or registrant.

266.10 Sec. 15. Minnesota Statutes 2020, section 151.071, subdivision 2, is amended to read:

266.11 Subd. 2. **Grounds for disciplinary action.** The following conduct is prohibited and is
266.12 grounds for disciplinary action:

266.13 (1) failure to demonstrate the qualifications or satisfy the requirements for a license or
266.14 registration contained in this chapter or the rules of the board. The burden of proof is on
266.15 the applicant to demonstrate such qualifications or satisfaction of such requirements;

266.16 (2) obtaining a license by fraud or by misleading the board in any way during the
266.17 application process or obtaining a license by cheating, or attempting to subvert the licensing
266.18 examination process. Conduct that subverts or attempts to subvert the licensing examination
266.19 process includes, but is not limited to: (i) conduct that violates the security of the examination
266.20 materials, such as removing examination materials from the examination room or having
266.21 unauthorized possession of any portion of a future, current, or previously administered
266.22 licensing examination; (ii) conduct that violates the standard of test administration, such as
266.23 communicating with another examinee during administration of the examination, copying
266.24 another examinee's answers, permitting another examinee to copy one's answers, or
266.25 possessing unauthorized materials; or (iii) impersonating an examinee or permitting an
266.26 impersonator to take the examination on one's own behalf;

266.27 (3) for a pharmacist, pharmacy technician, pharmacist intern, applicant for a pharmacist
266.28 or pharmacy license, or applicant for a pharmacy technician or pharmacist intern registration,
266.29 conviction of a felony reasonably related to the practice of pharmacy. Conviction as used
266.30 in this subdivision includes a conviction of an offense that if committed in this state would
266.31 be deemed a felony without regard to its designation elsewhere, or a criminal proceeding
266.32 where a finding or verdict of guilt is made or returned but the adjudication of guilt is either
266.33 withheld or not entered thereon. The board may delay the issuance of a new license or

267.1 registration if the applicant has been charged with a felony until the matter has been
267.2 adjudicated;

267.3 (4) for a facility, other than a pharmacy, licensed or registered by the board, if an owner
267.4 or applicant is convicted of a felony reasonably related to the operation of the facility. The
267.5 board may delay the issuance of a new license or registration if the owner or applicant has
267.6 been charged with a felony until the matter has been adjudicated;

267.7 (5) for a controlled substance researcher, conviction of a felony reasonably related to
267.8 controlled substances or to the practice of the researcher's profession. The board may delay
267.9 the issuance of a registration if the applicant has been charged with a felony until the matter
267.10 has been adjudicated;

267.11 (6) disciplinary action taken by another state or by one of this state's health licensing
267.12 agencies:

267.13 (i) revocation, suspension, restriction, limitation, or other disciplinary action against a
267.14 license or registration in another state or jurisdiction, failure to report to the board that
267.15 charges or allegations regarding the person's license or registration have been brought in
267.16 another state or jurisdiction, or having been refused a license or registration by any other
267.17 state or jurisdiction. The board may delay the issuance of a new license or registration if an
267.18 investigation or disciplinary action is pending in another state or jurisdiction until the
267.19 investigation or action has been dismissed or otherwise resolved; and

267.20 (ii) revocation, suspension, restriction, limitation, or other disciplinary action against a
267.21 license or registration issued by another of this state's health licensing agencies, failure to
267.22 report to the board that charges regarding the person's license or registration have been
267.23 brought by another of this state's health licensing agencies, or having been refused a license
267.24 or registration by another of this state's health licensing agencies. The board may delay the
267.25 issuance of a new license or registration if a disciplinary action is pending before another
267.26 of this state's health licensing agencies until the action has been dismissed or otherwise
267.27 resolved;

267.28 (7) for a pharmacist, pharmacy, pharmacy technician, or pharmacist intern, violation of
267.29 any order of the board, of any of the provisions of this chapter or any rules of the board or
267.30 violation of any federal, state, or local law or rule reasonably pertaining to the practice of
267.31 pharmacy;

267.32 (8) for a facility, other than a pharmacy, licensed by the board, violations of any order
267.33 of the board, of any of the provisions of this chapter or the rules of the board or violation
267.34 of any federal, state, or local law relating to the operation of the facility;

268.1 (9) engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the
268.2 public, or demonstrating a willful or careless disregard for the health, welfare, or safety of
268.3 a patient; or pharmacy practice that is professionally incompetent, in that it may create
268.4 unnecessary danger to any patient's life, health, or safety, in any of which cases, proof of
268.5 actual injury need not be established;

268.6 (10) aiding or abetting an unlicensed person in the practice of pharmacy, except that it
268.7 is not a violation of this clause for a pharmacist to supervise a properly registered pharmacy
268.8 technician or pharmacist intern if that person is performing duties allowed by this chapter
268.9 or the rules of the board;

268.10 (11) for an individual licensed or registered by the board, adjudication as mentally ill
268.11 or developmentally disabled, or as a chemically dependent person, a person dangerous to
268.12 the public, a sexually dangerous person, or a person who has a sexual psychopathic
268.13 personality, by a court of competent jurisdiction, within or without this state. Such
268.14 adjudication shall automatically suspend a license for the duration thereof unless the board
268.15 orders otherwise;

268.16 (12) for a pharmacist or pharmacy intern, engaging in unprofessional conduct as specified
268.17 in the board's rules. In the case of a pharmacy technician, engaging in conduct specified in
268.18 board rules that would be unprofessional if it were engaged in by a pharmacist or pharmacist
268.19 intern or performing duties specifically reserved for pharmacists under this chapter or the
268.20 rules of the board;

268.21 (13) for a pharmacy, operation of the pharmacy without a pharmacist present and on
268.22 duty except as allowed by a variance approved by the board;

268.23 (14) for a pharmacist, the inability to practice pharmacy with reasonable skill and safety
268.24 to patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
268.25 of material or as a result of any mental or physical condition, including deterioration through
268.26 the aging process or loss of motor skills. In the case of registered pharmacy technicians,
268.27 pharmacist interns, or controlled substance researchers, the inability to carry out duties
268.28 allowed under this chapter or the rules of the board with reasonable skill and safety to
268.29 patients by reason of illness, use of alcohol, drugs, narcotics, chemicals, or any other type
268.30 of material or as a result of any mental or physical condition, including deterioration through
268.31 the aging process or loss of motor skills;

268.32 (15) for a pharmacist, pharmacy, pharmacist intern, pharmacy technician, medical gas
268.33 dispenser, or controlled substance researcher, revealing a privileged communication from
268.34 or relating to a patient except when otherwise required or permitted by law;

269.1 (16) for a pharmacist or pharmacy, improper management of patient records, including
269.2 failure to maintain adequate patient records, to comply with a patient's request made pursuant
269.3 to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

269.4 (17) fee splitting, including without limitation:

269.5 (i) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate,
269.6 kickback, or other form of remuneration, directly or indirectly, for the referral of patients;

269.7 (ii) referring a patient to any health care provider as defined in sections 144.291 to
269.8 144.298 in which the licensee or registrant has a financial or economic interest as defined
269.9 in section 144.6521, subdivision 3, unless the licensee or registrant has disclosed the
269.10 licensee's or registrant's financial or economic interest in accordance with section 144.6521;
269.11 and

269.12 (iii) any arrangement through which a pharmacy, in which the prescribing practitioner
269.13 does not have a significant ownership interest, fills a prescription drug order and the
269.14 prescribing practitioner is involved in any manner, directly or indirectly, in setting the price
269.15 for the filled prescription that is charged to the patient, the patient's insurer or pharmacy
269.16 benefit manager, or other person paying for the prescription or, in the case of veterinary
269.17 patients, the price for the filled prescription that is charged to the client or other person
269.18 paying for the prescription, except that a veterinarian and a pharmacy may enter into such
269.19 an arrangement provided that the client or other person paying for the prescription is notified,
269.20 in writing and with each prescription dispensed, about the arrangement, unless such
269.21 arrangement involves pharmacy services provided for livestock, poultry, and agricultural
269.22 production systems, in which case client notification would not be required;

269.23 (18) engaging in abusive or fraudulent billing practices, including violations of the
269.24 federal Medicare and Medicaid laws or state medical assistance laws or rules;

269.25 (19) engaging in conduct with a patient that is sexual or may reasonably be interpreted
269.26 by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning
269.27 to a patient;

269.28 (20) failure to make reports as required by section 151.072 or to cooperate with an
269.29 investigation of the board as required by section 151.074;

269.30 (21) knowingly providing false or misleading information that is directly related to the
269.31 care of a patient unless done for an accepted therapeutic purpose such as the dispensing and
269.32 administration of a placebo;

270.1 (22) aiding suicide or aiding attempted suicide in violation of section 609.215 as
270.2 established by any of the following:

270.3 (i) a copy of the record of criminal conviction or plea of guilty for a felony in violation
270.4 of section 609.215, subdivision 1 or 2;

270.5 (ii) a copy of the record of a judgment of contempt of court for violating an injunction
270.6 issued under section 609.215, subdivision 4;

270.7 (iii) a copy of the record of a judgment assessing damages under section 609.215,
270.8 subdivision 5; or

270.9 (iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2.
270.10 The board must investigate any complaint of a violation of section 609.215, subdivision 1
270.11 or 2;

270.12 (23) for a pharmacist, practice of pharmacy under a lapsed or nonrenewed license. For
270.13 a pharmacist intern, pharmacy technician, or controlled substance researcher, performing
270.14 duties permitted to such individuals by this chapter or the rules of the board under a lapsed
270.15 or nonrenewed registration. For a facility required to be licensed under this chapter, operation
270.16 of the facility under a lapsed or nonrenewed license or registration; ~~and~~

270.17 (24) for a pharmacist, pharmacist intern, or pharmacy technician, termination or discharge
270.18 from the health professionals services program for reasons other than the satisfactory
270.19 completion of the program; and

270.20 (25) for a manufacturer, a violation of section 62J.842 or section 62J.845.

270.21 Sec. 16. **[151.335] DELIVERY THROUGH COMMON CARRIER; COMPLIANCE**
270.22 **WITH TEMPERATURE REQUIREMENTS.**

270.23 In addition to complying with the requirements of Minnesota Rules, part 6800.3000, a
270.24 mail order or specialty pharmacy that employs the United States Postal Service or other
270.25 common carrier to deliver a filled prescription directly to a patient must ensure that the drug
270.26 is delivered in compliance with temperature requirements established by the manufacturer
270.27 of the drug. The pharmacy must develop written policies and procedures that are consistent
270.28 with United States Pharmacopeia, chapters 1079 and 1118, and with nationally recognized
270.29 standards issued by standard-setting or accreditation organizations recognized by the board
270.30 through guidance. The policies and procedures must be provided to the board upon request.

271.1 Sec. 17. Minnesota Statutes 2020, section 151.555, subdivision 1, is amended to read:

271.2 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this
271.3 subdivision have the meanings given.

271.4 (b) "Central repository" means a wholesale distributor that meets the requirements under
271.5 subdivision 3 and enters into a contract with the Board of Pharmacy in accordance with this
271.6 section.

271.7 (c) "Distribute" means to deliver, other than by administering or dispensing.

271.8 (d) "Donor" means:

271.9 (1) a health care facility as defined in this subdivision;

271.10 (2) a skilled nursing facility licensed under chapter 144A;

271.11 (3) an assisted living facility registered under chapter 144D where there is centralized
271.12 storage of drugs and 24-hour on-site licensed nursing coverage provided seven days a week;

271.13 (4) a pharmacy licensed under section 151.19, and located either in the state or outside
271.14 the state;

271.15 (5) a drug wholesaler licensed under section 151.47;

271.16 (6) a drug manufacturer licensed under section 151.252; or

271.17 (7) an individual at least 18 years of age, provided that the drug or medical supply that
271.18 is donated was obtained legally and meets the requirements of this section for donation.

271.19 (e) "Drug" means any prescription drug that has been approved for medical use in the
271.20 United States, is listed in the United States Pharmacopoeia or National Formulary, and
271.21 meets the criteria established under this section for donation; or any over-the-counter
271.22 medication that meets the criteria established under this section for donation. This definition
271.23 includes cancer drugs and antirejection drugs, but does not include controlled substances,
271.24 as defined in section 152.01, subdivision 4, or a prescription drug that can only be dispensed
271.25 to a patient registered with the drug's manufacturer in accordance with federal Food and
271.26 Drug Administration requirements.

271.27 (f) "Health care facility" means:

271.28 (1) a physician's office or health care clinic where licensed practitioners provide health
271.29 care to patients;

271.30 (2) a hospital licensed under section 144.50;

271.31 (3) a pharmacy licensed under section 151.19 and located in Minnesota; or

272.1 (4) a nonprofit community clinic, including a federally qualified health center; a rural
272.2 health clinic; public health clinic; or other community clinic that provides health care utilizing
272.3 a sliding fee scale to patients who are low-income, uninsured, or underinsured.

272.4 (g) "Local repository" means a health care facility that elects to accept donated drugs
272.5 and medical supplies and meets the requirements of subdivision 4.

272.6 (h) "Medical supplies" or "supplies" means any prescription and nonprescription medical
272.7 supplies needed to administer a prescription drug.

272.8 (i) "Original, sealed, unopened, tamper-evident packaging" means packaging that is
272.9 sealed, unopened, and tamper-evident, including a manufacturer's original unit dose or
272.10 unit-of-use container, a repackager's original unit dose or unit-of-use container, or unit-dose
272.11 packaging prepared by a licensed pharmacy according to the standards of Minnesota Rules,
272.12 part 6800.3750.

272.13 (j) "Practitioner" has the meaning given in section 151.01, subdivision 23, except that
272.14 it does not include a veterinarian.

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

272.16 Sec. 18. Minnesota Statutes 2020, section 151.555, subdivision 7, is amended to read:

272.17 Subd. 7. **Standards and procedures for inspecting and storing donated prescription**
272.18 **drugs and supplies.** (a) A pharmacist or authorized practitioner who is employed by or
272.19 under contract with the central repository or a local repository shall inspect all donated
272.20 prescription drugs and supplies before the drug or supply is dispensed to determine, to the
272.21 extent reasonably possible in the professional judgment of the pharmacist or practitioner,
272.22 that the drug or supply is not adulterated or misbranded, has not been tampered with, is safe
272.23 and suitable for dispensing, has not been subject to a recall, and meets the requirements for
272.24 donation. The pharmacist or practitioner who inspects the drugs or supplies shall sign an
272.25 inspection record stating that the requirements for donation have been met. If a local
272.26 repository receives drugs and supplies from the central repository, the local repository does
272.27 not need to reinspect the drugs and supplies.

272.28 (b) The central repository and local repositories shall store donated drugs and supplies
272.29 in a secure storage area under environmental conditions appropriate for the drug or supply
272.30 being stored. Donated drugs and supplies may not be stored with nondonated inventory. ~~If~~
272.31 ~~donated drugs or supplies are not inspected immediately upon receipt, a repository must~~
272.32 ~~quarantine the donated drugs or supplies separately from all dispensing stock until the~~
272.33 ~~donated drugs or supplies have been inspected and (1) approved for dispensing under the~~

273.1 ~~program; (2) disposed of pursuant to paragraph (e); or (3) returned to the donor pursuant to~~
273.2 ~~paragraph (d).~~

273.3 (c) The central repository and local repositories shall dispose of all prescription drugs
273.4 and medical supplies that are not suitable for donation in compliance with applicable federal
273.5 and state statutes, regulations, and rules concerning hazardous waste.

273.6 (d) In the event that controlled substances or prescription drugs that can only be dispensed
273.7 to a patient registered with the drug's manufacturer are shipped or delivered to a central or
273.8 local repository for donation, the shipment delivery must be documented by the repository
273.9 and returned immediately to the donor or the donor's representative that provided the drugs.

273.10 (e) Each repository must develop drug and medical supply recall policies and procedures.
273.11 If a repository receives a recall notification, the repository shall destroy all of the drug or
273.12 medical supply in its inventory that is the subject of the recall and complete a record of
273.13 destruction form in accordance with paragraph (f). If a drug or medical supply that is the
273.14 subject of a Class I or Class II recall has been dispensed, the repository shall immediately
273.15 notify the recipient of the recalled drug or medical supply. A drug that potentially is subject
273.16 to a recall need not be destroyed if its packaging bears a lot number and that lot of the drug
273.17 is not subject to the recall. If no lot number is on the drug's packaging, it must be destroyed.

273.18 (f) A record of destruction of donated drugs and supplies that are not dispensed under
273.19 subdivision 8, are subject to a recall under paragraph (e), or are not suitable for donation
273.20 shall be maintained by the repository for at least ~~five~~ two years. For each drug or supply
273.21 destroyed, the record shall include the following information:

273.22 (1) the date of destruction;

273.23 (2) the name, strength, and quantity of the drug destroyed; and

273.24 (3) the name of the person or firm that destroyed the drug.

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

273.26 Sec. 19. Minnesota Statutes 2020, section 151.555, subdivision 11, is amended to read:

273.27 Subd. 11. **Forms and record-keeping requirements.** (a) The following forms developed
273.28 for the administration of this program shall be utilized by the participants of the program
273.29 and shall be available on the board's website:

273.30 (1) intake application form described under subdivision 5;

273.31 (2) local repository participation form described under subdivision 4;

274.1 (3) local repository withdrawal form described under subdivision 4;

274.2 (4) drug repository donor form described under subdivision 6;

274.3 (5) record of destruction form described under subdivision 7; and

274.4 (6) drug repository recipient form described under subdivision 8.

274.5 (b) All records, including drug inventory, inspection, and disposal of donated prescription
274.6 drugs and medical supplies, must be maintained by a repository for a minimum of ~~five~~ two
274.7 years. Records required as part of this program must be maintained pursuant to all applicable
274.8 practice acts.

274.9 (c) Data collected by the drug repository program from all local repositories shall be
274.10 submitted quarterly or upon request to the central repository. Data collected may consist of
274.11 the information, records, and forms required to be collected under this section.

274.12 (d) The central repository shall submit reports to the board as required by the contract
274.13 or upon request of the board.

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

274.15 Sec. 20. Minnesota Statutes 2020, section 151.555, is amended by adding a subdivision
274.16 to read:

274.17 **Subd. 14. Cooperation.** The central repository, as approved by the Board of Pharmacy,
274.18 may enter into an agreement with another state that has an established drug repository or
274.19 drug donation program if the other state's program includes regulations to ensure the purity,
274.20 integrity, and safety of the drugs and supplies donated, to permit the central repository to
274.21 offer to another state program inventory that is not needed by a Minnesota resident and to
274.22 accept inventory from another state program to be distributed to local repositories and
274.23 dispensed to Minnesota residents in accordance with this program.

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

274.25 Sec. 21. Minnesota Statutes 2020, section 256B.69, subdivision 6, is amended to read:

274.26 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the
274.27 health care coordination for eligible individuals. Demonstration providers:

274.28 (1) shall authorize and arrange for the provision of all needed health services including
274.29 but not limited to the full range of services listed in sections 256B.02, subdivision 8, and
274.30 256B.0625 in order to ensure appropriate health care is delivered to enrollees.

274.31 Notwithstanding section 256B.0621, demonstration providers that provide nursing home

275.1 and community-based services under this section shall provide relocation service coordination
275.2 to enrolled persons age 65 and over;

275.3 (2) shall accept the prospective, per capita payment from the commissioner in return for
275.4 the provision of comprehensive and coordinated health care services for eligible individuals
275.5 enrolled in the program;

275.6 (3) may contract with other health care and social service practitioners to provide services
275.7 to enrollees; and

275.8 (4) shall institute recipient grievance procedures according to the method established
275.9 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved
275.10 through this process shall be appealable to the commissioner as provided in subdivision 11.

275.11 (b) Demonstration providers must comply with the standards for claims settlement under
275.12 section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and
275.13 social service practitioners to provide services to enrollees. A demonstration provider must
275.14 pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b),
275.15 within 30 business days of the date of acceptance of the claim.

275.16 (c) Managed care plans and county-based purchasing plans must comply with section
275.17 62Q.83.

275.18 **Sec. 22. STUDY OF PHARMACY AND PROVIDER CHOICE OF BIOLOGICAL**
275.19 **PRODUCTS.**

275.20 The commissioner of health, within the limits of existing resources, shall analyze the
275.21 effect of Minnesota Statutes, section 62W.0751, on the net price for different payors of
275.22 biological products, interchangeable biological products, and biosimilar products. The
275.23 commissioner of health shall report findings to the chairs and ranking minority members
275.24 of the legislative committees with jurisdiction over health and human services policy and
275.25 finance, and insurance, by December 15, 2023.

275.26 **Sec. 23. STUDY OF TEMPERATURE MONITORING.**

275.27 The Board of Pharmacy shall conduct a study to determine the appropriateness and
275.28 feasibility of requiring mail order and specialty pharmacies to enclose in each medication's
275.29 packaging a method by which the patient can easily detect improper storage or temperature
275.30 variations that may have occurred during the delivery of a medication. The board shall
275.31 report the results of the study by January 15, 2022, to the chairs and ranking minority
275.32 members of the legislative committees with jurisdiction over health finance and policy.

ARTICLE 6

HEALTH INSURANCE

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Section 1. Minnesota Statutes 2020, section 62A.04, subdivision 2, is amended to read:

Subd. 2. **Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

277.1 After this policy has been in force for a period of two years during the lifetime of the
277.2 insured (excluding any period during which the insured is disabled), it shall become
277.3 incontestable as to the statements contained in the application.

277.4 (b) No claim for loss incurred or disability (as defined in the policy) commencing after
277.5 two years from the date of issue of this policy shall be reduced or denied on the ground that
277.6 a disease or physical condition not excluded from coverage by name or specific description
277.7 effective on the date of loss had existed prior to the effective date of coverage of this policy.

277.8 (3)(a) Except as required for qualified health plans sold through MNsure to individuals
277.9 receiving advance payments of the premium tax credit, a provision as follows:

277.10 GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly
277.11 premium policies, "10" for monthly premium policies and "31" for all other policies) days
277.12 will be granted for the payment of each premium falling due after the first premium, during
277.13 which grace period the policy shall continue in force.

277.14 A policy which contains a cancellation provision may add, at the end of the above
277.15 provision,

277.16 subject to the right of the insurer to cancel in accordance with the cancellation provision
277.17 hereof.

277.18 A policy in which the insurer reserves the right to refuse any renewal shall have, at the
277.19 beginning of the above provision,

277.20 Unless not less than five days prior to the premium due date the insurer has delivered
277.21 to the insured or has mailed to the insured's last address as shown by the records of the
277.22 insurer written notice of its intention not to renew this policy beyond the period for which
277.23 the premium has been accepted.

277.24 (b) For ~~qualified individual and small group health plans sold through MNsure to~~
277.25 ~~individuals receiving advance payments of the premium tax credit~~, a grace period provision
277.26 must be included that complies with ~~the Affordable Care Act and is no less restrictive than~~
277.27 ~~the grace period required by the Affordable Care Act~~ section 62A.65, subdivision 2a.

277.28 (4) A provision as follows:

277.29 REINSTATEMENT: If any renewal premium be not paid within the time granted the
277.30 insured for payment, a subsequent acceptance of premium by the insurer or by any agent
277.31 duly authorized by the insurer to accept such premium, without requiring in connection
277.32 therewith an application for reinstatement, shall reinstate the policy. If the insurer or such
277.33 agent requires an application for reinstatement and issues a conditional receipt for the

278.1 premium tendered, the policy will be reinstated upon approval of such application by the
278.2 insurer or, lacking such approval, upon the forty-fifth day following the date of such
278.3 conditional receipt unless the insurer has previously notified the insured in writing of its
278.4 disapproval of such application. For health plans described in section 62A.011, subdivision
278.5 3, clause (10), an insurer must accept payment of a renewal premium and reinstate the
278.6 policy, if the insured applies for reinstatement no later than 60 days after the due date for
278.7 the premium payment, unless:

278.8 (1) the insured has in the interim left the state or the insurer's service area; or

278.9 (2) the insured has applied for reinstatement on two or more prior occasions.

278.10 The reinstated policy shall cover only loss resulting from such accidental injury as may
278.11 be sustained after the date of reinstatement and loss due to such sickness as may begin more
278.12 than ten days after such date. In all other respects the insured and insurer shall have the
278.13 same rights thereunder as they had under the policy immediately before the due date of the
278.14 defaulted premium, subject to any provisions endorsed hereon or attached hereto in
278.15 connection with the reinstatement. Any premium accepted in connection with a reinstatement
278.16 shall be applied to a period for which premium has not been previously paid, but not to any
278.17 period more than 60 days prior to the date of reinstatement. The last sentence of the above
278.18 provision may be omitted from any policy which the insured has the right to continue in
278.19 force subject to its terms by the timely payment of premiums (1) until at least age 50, or,
278.20 (2) in the case of a policy issued after age 44, for at least five years from its date of issue.

278.21 (5) A provision as follows:

278.22 NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20
278.23 days after the occurrence or commencement of any loss covered by the policy, or as soon
278.24 thereafter as is reasonably possible. Notice given by or on behalf of the insured or the
278.25 beneficiary to the insurer at (insert the location of such office as the insurer may designate
278.26 for the purpose), or to any authorized agent of the insurer, with information sufficient to
278.27 identify the insured, shall be deemed notice to the insurer.

278.28 In a policy providing a loss-of-time benefit which may be payable for at least two years,
278.29 an insurer may at its option insert the following between the first and second sentences of
278.30 the above provision:

278.31 Subject to the qualifications set forth below, if the insured suffers loss of time on account
278.32 of disability for which indemnity may be payable for at least two years, the insured shall,
278.33 at least once in every six months after having given notice of claim, give to the insurer
278.34 notice of continuance of said disability, except in the event of legal incapacity. The period

279.1 of six months following any filing of proof by the insured or any payment by the insurer
279.2 on account of such claim or any denial of liability in whole or in part by the insurer shall
279.3 be excluded in applying this provision. Delay in the giving of such notice shall not impair
279.4 the insured's right to any indemnity which would otherwise have accrued during the period
279.5 of six months preceding the date on which such notice is actually given.

279.6 (6) A provision as follows:

279.7 CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the
279.8 claimant such forms as are usually furnished by it for filing proofs of loss. If such forms
279.9 are not furnished within 15 days after the giving of such notice the claimant shall be deemed
279.10 to have complied with the requirements of this policy as to proof of loss upon submitting,
279.11 within the time fixed in the policy for filing proofs of loss, written proof covering the
279.12 occurrence, the character and the extent of the loss for which claim is made.

279.13 (7) A provision as follows:

279.14 PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said
279.15 office in case of claim for loss for which this policy provides any periodic payment contingent
279.16 upon continuing loss within 90 days after the termination of the period for which the insurer
279.17 is liable and in case of claim for any other loss within 90 days after the date of such loss.
279.18 Failure to furnish such proof within the time required shall not invalidate nor reduce any
279.19 claim if it was not reasonably possible to give proof within such time, provided such proof
279.20 is furnished as soon as reasonably possible and in no event, except in the absence of legal
279.21 capacity, later than one year from the time proof is otherwise required.

279.22 (8) A provision as follows:

279.23 TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss
279.24 other than loss for which this policy provides periodic payment will be paid immediately
279.25 upon receipt of due written proof of such loss. Subject to due written proof of loss, all
279.26 accrued indemnities for loss for which this policy provides periodic payment will be paid
279.27 (insert period for payment which must not be less frequently than monthly) and any
279.28 balance remaining unpaid upon the termination of liability will be paid immediately upon
279.29 receipt of due written proof.

279.30 (9) A provision as follows:

279.31 PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with
279.32 the beneficiary designation and the provisions respecting such payment which may be
279.33 prescribed herein and effective at the time of payment. If no such designation or provision

280.1 is then effective, such indemnity shall be payable to the estate of the insured. Any other
280.2 accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid
280.3 either to such beneficiary or to such estate. All other indemnities will be payable to the
280.4 insured.

280.5 The following provisions, or either of them, may be included with the foregoing provision
280.6 at the option of the insurer:

280.7 If any indemnity of this policy shall be payable to the estate of the insured, or to an
280.8 insured or beneficiary who is a minor or otherwise not competent to give a valid release,
280.9 the insurer may pay such indemnity, up to an amount not exceeding \$..... (insert an amount
280.10 which shall not exceed \$1,000), to any relative by blood or connection by marriage of the
280.11 insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any
280.12 payment made by the insurer in good faith pursuant to this provision shall fully discharge
280.13 the insurer to the extent of such payment.

280.14 Subject to any written direction of the insured in the application or otherwise all or a
280.15 portion of any indemnities provided by this policy on account of hospital, nursing, medical,
280.16 or surgical services may, at the insurer's option and unless the insured requests otherwise
280.17 in writing not later than the time of filing proofs of such loss, be paid directly to the hospital
280.18 or person rendering such services; but it is not required that the service be rendered by a
280.19 particular hospital or person.

280.20 (10) A provision as follows:

280.21 **PHYSICAL EXAMINATIONS AND AUTOPSY:** The insurer at its own expense shall
280.22 have the right and opportunity to examine the person of the insured when and as often as it
280.23 may reasonably require during the pendency of a claim hereunder and to make an autopsy
280.24 in case of death where it is not forbidden by law.

280.25 (11) A provision as follows:

280.26 **LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this
280.27 policy prior to the expiration of 60 days after written proof of loss has been furnished in
280.28 accordance with the requirements of this policy. No such action shall be brought after the
280.29 expiration of three years after the time written proof of loss is required to be furnished.

280.30 (12) A provision as follows:

280.31 **CHANGE OF BENEFICIARY:** Unless the insured makes an irrevocable designation
280.32 of beneficiary, the right to change of beneficiary is reserved to the insured and the consent
280.33 of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this

281.1 policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.
281.2 The first clause of this provision, relating to the irrevocable designation of beneficiary, may
281.3 be omitted at the insurer's option.

281.4 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
281.5 sold, issued, or renewed on or after that date.

281.6 Sec. 2. Minnesota Statutes 2020, section 62A.10, is amended by adding a subdivision to
281.7 read:

281.8 Subd. 5. **Prohibition on waiting periods that exceed 90 days.** (a) For purposes of this
281.9 subdivision, "waiting period" means the period that must pass before coverage becomes
281.10 effective for an individual who is otherwise eligible to enroll under the terms of a group
281.11 health plan.

281.12 (b) A health carrier offering a group health plan must not apply a waiting period that
281.13 exceeds 90 days, with exceptions for the circumstances described in paragraphs (c) to (e).
281.14 A health carrier does not violate this subdivision solely because an individual is permitted
281.15 to take additional time to elect coverage beyond the end of the 90-day waiting period.

281.16 (c) If a group health plan conditions eligibility on an employee working full time or
281.17 regularly having a specified number of service hours per period, and the plan is unable to
281.18 determine whether a newly hired employee is full time or reasonably expected to regularly
281.19 work the specific number of hours per period, the plan may take a reasonable period of
281.20 time, not to exceed 12 months beginning on any date between the employee's start date and
281.21 the first day of the first calendar month after the employee's start date, to determine whether
281.22 the employee meets the plan's eligibility condition.

281.23 (d) If a group health plan conditions eligibility on an employee having completed a
281.24 cumulative number of service hours, the cumulative hours-of-service requirement must not
281.25 exceed 1,200 hours.

281.26 (e) An orientation period may be added to the 90-day waiting period if the orientation
281.27 period is one month or less. The one-month period is determined by adding one calendar
281.28 month and subtracting one calendar day, measured from an employee's start date in a position
281.29 that is otherwise eligible for coverage.

281.30 (f) A group health plan may treat an employee whose employment has terminated and
281.31 is later rehired as newly eligible upon rehire and require the rehired employee to meet the
281.32 plan's eligibility criteria and waiting period again, if doing so is reasonable under the
281.33 circumstances. Treating an employee as rehired is reasonable if the employee has a break

282.1 in service of at least 13 weeks, or at least 26 weeks if the employer is an educational
282.2 institution.

282.3 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
282.4 sold, issued, or renewed on or after that date.

282.5 Sec. 3. Minnesota Statutes 2020, section 62A.65, subdivision 1, is amended to read:

282.6 Subdivision 1. **Applicability.** No health carrier, as defined in section 62A.011, shall
282.7 offer, sell, issue, or renew any individual health plan, as defined in section 62A.011, to a
282.8 Minnesota resident except in compliance with this section. ~~This section does not apply to~~
282.9 ~~the Comprehensive Health Association established in section 62E.10.~~ A health carrier must
282.10 only offer, sell, issue, or renew individual health plans on a guaranteed issue basis and at a
282.11 premium rate that does not vary based on the health status of the individual.

282.12 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
282.13 sold, issued, or renewed on or after that date.

282.14 Sec. 4. Minnesota Statutes 2020, section 62A.65, is amended by adding a subdivision to
282.15 read:

282.16 Subd. 2a. **Grace period for nonpayment of premium.** (a) Notwithstanding any other
282.17 law to the contrary, an individual health plan may be canceled for nonpayment of premiums,
282.18 but must include a grace period as described in this subdivision.

282.19 (b) The grace period must be three consecutive months. During the grace period, the
282.20 health carrier must:

282.21 (1) pay all claims for services that would have been covered if the premium had been
282.22 paid, which are provided to the enrollee during the first month of the grace period, and may
282.23 pend claims for services provided to an enrollee in the second and third months of the grace
282.24 period; and

282.25 (2) notify health care providers of the possibility of denied claims when an enrollee is
282.26 in the second and third month of the grace period.

282.27 (c) In order to stop a cancellation, an enrollee must pay all outstanding premiums before
282.28 the end of the grace period.

282.29 (d) If a health plan is canceled under this subdivision, the final day of the enrollment is
282.30 the last day of the first month of the three-month grace period.

283.1 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
283.2 sold, issued, or renewed on or after that date.

283.3 Sec. 5. Minnesota Statutes 2020, section 62D.095, subdivision 2, is amended to read:

283.4 Subd. 2. **Co-payments.** A health maintenance contract may impose a co-payment and
283.5 coinsurance consistent with ~~the provisions of the Affordable Care Act as defined under~~
283.6 ~~section 62A.011, subdivision 1a~~ state and federal law.

283.7 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
283.8 sold, issued, or renewed on or after that date.

283.9 Sec. 6. Minnesota Statutes 2020, section 62D.095, subdivision 3, is amended to read:

283.10 Subd. 3. **Deductibles.** A health maintenance contract may impose a deductible consistent
283.11 with ~~the provisions of the Affordable Care Act as defined under section 62A.011, subdivision~~
283.12 ~~1a~~ state and federal law.

283.13 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
283.14 sold, issued, or renewed on or after that date.

283.15 Sec. 7. Minnesota Statutes 2020, section 62D.095, subdivision 4, is amended to read:

283.16 Subd. 4. **Annual out-of-pocket maximums.** A health maintenance contract may impose
283.17 an annual out-of-pocket maximum consistent with the provisions of ~~the Affordable Care~~
283.18 ~~Act as defined under section 62A.011, subdivision 1a~~ section 62Q.677, subdivision 6a.

283.19 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
283.20 sold, issued, or renewed on or after that date.

283.21 Sec. 8. Minnesota Statutes 2020, section 62D.095, subdivision 5, is amended to read:

283.22 Subd. 5. **Exceptions.** No co-payments or deductibles may be imposed on preventive
283.23 ~~health care items and services consistent with the provisions of the Affordable Care Act as~~
283.24 ~~defined under section 62A.011, subdivision 1a,~~ as defined in section 62Q.46, subdivision
283.25 1.

283.26 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
283.27 sold, issued, or renewed on or after that date.

284.1 Sec. 9. Minnesota Statutes 2020, section 62Q.01, subdivision 2a, is amended to read:

284.2 Subd. 2a. **Dependent child to the limiting age.** "Dependent child to the limiting age"
284.3 or "dependent children to the limiting age" means those individuals who are eligible and
284.4 covered as a dependent child under the terms of a health plan who have not yet attained 26
284.5 years of age. A health plan company must not deny or restrict eligibility for a dependent
284.6 child to the limiting age based on financial dependency, residency, marital status, or student
284.7 status. For coverage under plans offered by the Minnesota Comprehensive Health
284.8 Association, dependent to the limiting age means dependent as defined in section 62A.302,
284.9 subdivision 3. Notwithstanding the provisions in this subdivision, a health plan may include:

284.10 (1) eligibility requirements regarding the absence of other health plan coverage as
284.11 ~~permitted by the Affordable Care Act~~ for grandfathered plan coverage; or

284.12 (2) an age greater than 26 in its policy, contract, or certificate of coverage.

284.13 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
284.14 sold, issued, or renewed on or after that date.

284.15 Sec. 10. **[62Q.097] REQUIREMENTS FOR TIMELY PROVIDER**
284.16 **CREDENTIALING.**

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

284.18 (b) "Clean application for provider credentialing" or "clean application" means an
284.19 application for provider credentialing submitted by a health care provider to a health plan
284.20 company that is complete, is in the format required by the health plan company, and includes
284.21 all information and substantiation required by the health plan company and does not require
284.22 evaluation of any identified potential quality or safety concern.

284.23 (c) "Provider credentialing" means the process undertaken by a health plan company to
284.24 evaluate and approve a health care provider's education, training, residency, licenses,
284.25 certifications, and history of significant quality or safety concerns in order to approve the
284.26 health care provider to provide health care services to patients at a clinic or facility.

284.27 **Subd. 2. Time limit for credentialing determination.** A health plan company that
284.28 receives an application for provider credentialing must:

284.29 (1) if the application is determined to be a clean application for provider credentialing
284.30 and if the health care provider submitting the application or the clinic or facility at which
284.31 the health care provider provides services requests the information, affirm that the health
284.32 care provider's application is a clean application and notify the health care provider or clinic

285.1 or facility of the date by which the health plan company will make a determination on the
285.2 health care provider's application;

285.3 (2) if the application is determined not to be a clean application, inform the health care
285.4 provider of the application's deficiencies or missing information or substantiation within
285.5 three business days after the health plan company determines the application is not a clean
285.6 application; and

285.7 (3) make a determination on the health care provider's clean application within 45 days
285.8 after receiving the clean application unless the health plan company identifies a substantive
285.9 quality or safety concern in the course of provider credentialing that requires further
285.10 investigation. Upon notice to the health care provider, clinic, or facility, the health plan
285.11 company is allowed 30 additional days to investigate any quality or safety concerns.

285.12 **EFFECTIVE DATE; APPLICATION.** This section applies to applications for provider
285.13 credentialing submitted to a health plan company on or after January 1, 2022.

285.14 Sec. 11. Minnesota Statutes 2020, section 62Q.46, is amended to read:

285.15 **62Q.46 PREVENTIVE ITEMS AND SERVICES.**

285.16 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and
285.17 services" ~~has the meaning specified in the Affordable Care Act~~ means the items and services
285.18 categorized as preventive under subdivision 1a.

285.19 (b) A health plan company must provide coverage for preventive items and services at
285.20 a participating provider without imposing cost-sharing requirements, including a deductible,
285.21 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that
285.22 has a network of providers from excluding coverage or imposing cost-sharing requirements
285.23 for preventive items or services that are delivered by an out-of-network provider.

285.24 (c) A health plan company is not required to provide coverage for any items or services
285.25 specified in any recommendation or guideline described in paragraph (a) if the
285.26 recommendation or guideline is no longer included as a preventive item or service as defined
285.27 in paragraph (a). Annually, a health plan company must determine whether any additional
285.28 items or services must be covered without cost-sharing requirements or whether any items
285.29 or services are no longer required to be covered.

285.30 (d) Nothing in this section prevents a health plan company from using reasonable medical
285.31 management techniques to determine the frequency, method, treatment, or setting for a
285.32 preventive item or service to the extent not specified in the recommendation or guideline.

286.1 (e) This section does not apply to grandfathered plans.

286.2 (f) This section does not apply to plans offered by the Minnesota Comprehensive Health
286.3 Association.

286.4 **Subd. 1a. Preventive items and services.** The commissioner of commerce must provide
286.5 health plan companies with information regarding which items and services must be
286.6 categorized as preventive.

286.7 **Subd. 2. Coverage for office visits in conjunction with preventive items and**
286.8 **services.** (a) A health plan company may impose cost-sharing requirements with respect to
286.9 an office visit if a preventive item or service is billed separately or is tracked separately as
286.10 individual encounter data from the office visit.

286.11 (b) A health plan company must not impose cost-sharing requirements with respect to
286.12 an office visit if a preventive item or service is not billed separately or is not tracked
286.13 separately as individual encounter data from the office visit and the primary purpose of the
286.14 office visit is the delivery of the preventive item or service.

286.15 (c) A health plan company may impose cost-sharing requirements with respect to an
286.16 office visit if a preventive item or service is not billed separately or is not tracked separately
286.17 as individual encounter data from the office visit and the primary purpose of the office visit
286.18 is not the delivery of the preventive item or service.

286.19 **Subd. 3. Additional services not prohibited.** Nothing in this section prohibits a health
286.20 plan company from providing coverage for preventive items and services in addition to
286.21 those specified in ~~the Affordable Care Act~~ subdivision 1a, or from denying coverage for
286.22 preventive items and services that are not recommended as preventive items and services
286.23 under ~~the Affordable Care Act~~ subdivision 1a. A health plan company may impose
286.24 cost-sharing requirements for a treatment not described in ~~the Affordable Care Act~~
286.25 subdivision 1a even if the treatment results from a preventive item or service described in
286.26 ~~the Affordable Care Act~~ subdivision 1a.

286.27 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
286.28 sold, issued, or renewed on or after that date.

286.29 **Sec. 12. [62Q.472] SCREENING AND TESTING FOR OPIOIDS.**

286.30 (a) A health plan company shall not place a lifetime or annual limit on screenings and
286.31 urinalysis testing for opioids for an enrollee in an inpatient or outpatient substance use
286.32 disorder treatment program when ordered by a health care provider and performed by an
286.33 accredited clinical laboratory. A health plan company is not prohibited from conducting a

287.1 medical necessity review when screenings or urinalysis testing for an enrollee exceeds 24
287.2 tests in any 12-month period.

287.3 (b) This section does not apply to managed care plans or county-based purchasing plans
287.4 when the plan is providing coverage to public health care program enrollees under chapter
287.5 256B or 256L.

287.6 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to health
287.7 plans offered, issued, or renewed on or after that date.

287.8 Sec. 13. **[62Q.521] COVERAGE OF CONTRACEPTIVES AND CONTRACEPTIVE**
287.9 **SERVICES.**

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

287.11 (b) "Closely held for-profit entity" means an entity that:

287.12 (1) is not a nonprofit entity;

287.13 (2) has more than 50 percent of the value of its ownership interest owned directly or
287.14 indirectly by five or fewer individuals, or has an ownership structure that is substantially
287.15 similar; and

287.16 (3) has no publicly traded ownership interest, having any class of common equity
287.17 securities required to be registered under United States Code, title 15, section 781.

287.18 For purposes of this paragraph:

287.19 (i) ownership interests owned by a corporation, partnership, estate, or trust are considered
287.20 owned proportionately by that entity's shareholders, partners, or beneficiaries;

287.21 (ii) ownership interests owned by a nonprofit entity are considered owned by a single
287.22 owner;

287.23 (iii) ownership interests owned by an individual are considered owned, directly or
287.24 indirectly, by or for the individual's family. For purposes of this item, "family" means
287.25 brothers and sisters, including half-brothers and half-sisters, a spouse, ancestors, and lineal
287.26 descendants; and

287.27 (iv) if an individual or entity holds an option to purchase an ownership interest, the
287.28 individual or entity is considered to be the owner of those ownership interests.

287.29 (c) "Contraceptive" means a drug, device, or other product approved by the Food and
287.30 Drug Administration to prevent unintended pregnancy.

288.1 (d) "Contraceptive service" means consultation, examination, procedure, and medical
288.2 service related to the prevention of unintended pregnancy. This includes but is not limited
288.3 to voluntary sterilization procedures, patient education, counseling on contraceptives, and
288.4 follow-up services related to contraceptives or contraceptive services, management of side
288.5 effects, counseling for continued adherence, and device insertion or removal.

288.6 (e) "Eligible organization" means an organization that opposes providing coverage for
288.7 some or all contraceptives or contraceptive services on account of religious objections and
288.8 that is:

288.9 (1) organized as a nonprofit entity and holds itself as a religious employer; or

288.10 (2) organized and operates as a closely held for-profit entity, and the organization's
288.11 highest governing body has adopted, under the organization's applicable rules of governance
288.12 and consistent with state law, a resolution or similar action establishing that it objects to
288.13 covering some or all contraceptives or contraceptive services on account of the owners'
288.14 sincerely held religious beliefs.

288.15 (f) "Medical necessity" includes but is not limited to considerations such as severity of
288.16 side effects, difference in permanence and reversibility of a contraceptive or contraceptive
288.17 service, and ability to adhere to the appropriate use of the contraceptive method or service,
288.18 as determined by the attending provider.

288.19 (g) "Religious employer" means an organization that is organized and operates as a
288.20 nonprofit entity and meets the requirements of section 6033(a)(3)(A)(i) or (iii) of the Internal
288.21 Revenue Code of 1986, as amended.

288.22 (h) "Therapeutic equivalent version" means a drug, device, or product that can be expected
288.23 to have the same clinical effect and safety profile when administered to a patient under the
288.24 conditions specified in the labeling, and that:

288.25 (1) is approved as safe and effective;

288.26 (2) is a pharmaceutical equivalent, (i) containing identical amounts of the same active
288.27 drug ingredient in the same dosage form and route of administration, and (ii) meeting
288.28 compendial or other applicable standards of strength, quality, purity, and identity;

288.29 (3) is bioequivalent in that:

288.30 (i) the drug, device, or product does not present a known or potential bioequivalence
288.31 problem and meets an acceptable in vitro standard; or

289.1 (ii) if the drug, device, or product does present a known or potential bioequivalence
289.2 problem, it is shown to meet an appropriate bioequivalence standard;

289.3 (4) is adequately labeled; and

289.4 (5) is manufactured in compliance with current manufacturing practice regulations.

289.5 Subd. 2. **Required coverage; cost-sharing prohibited.** (a) A health plan must provide
289.6 coverage for all prescription contraceptives and contraceptive services.

289.7 (b) A health plan company must not impose cost-sharing requirements, including co-pays,
289.8 deductibles, or co-insurance, for contraceptives or contraceptive services.

289.9 (c) Notwithstanding paragraph (b), a health plan that is a high-deductible health plan in
289.10 conjunction with a health savings account must include cost-sharing for contraceptives and
289.11 contraceptive services at the minimum level necessary to preserve the enrollee's ability to
289.12 make tax exempt contributions and withdrawals from the health savings account, as provided
289.13 by section 223 of the Internal Revenue Code of 1986, as amended.

289.14 (d) A health plan company must not impose any referral requirements, restrictions, or
289.15 delays for contraceptives or contraceptive services.

289.16 (e) If more than one therapeutic equivalent version of a contraceptive is approved by
289.17 the FDA, a health plan must cover at least one therapeutic equivalent version, but is not
289.18 required to cover all therapeutic equivalent versions.

289.19 (f) For each health plan, a health plan company must list the contraceptives and
289.20 contraceptive services that are covered without cost-sharing in a manner that is easily
289.21 accessible to enrollees, health care providers, and representatives of health care providers.
289.22 The list for each health plan must be promptly updated to reflect changes to the coverage.

289.23 (g) If an enrollee's attending provider recommends a particular contraceptive or
289.24 contraceptive service based on a determination of medical necessity for that enrollee, the
289.25 health plan must cover that contraceptive or contraceptive service without cost-sharing. The
289.26 health plan company issuing the health plan must defer to the attending provider's
289.27 determination that the particular contraceptive or contraceptive service is medically necessary
289.28 for the enrollee.

289.29 Subd. 3. **Religious employers; exempt.** (a) A religious employer is not required to cover
289.30 contraceptives or contraceptive services if the employer has religious objections to the
289.31 coverage. A religious employer that chooses not to provide coverage for some or all
289.32 contraceptives and contraceptive services must notify employees as part of the hiring process
289.33 and all employees at least 30 days before:

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

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

290.3 (b) If the religious employer provides coverage for some contraceptives or contraceptive
290.4 services, the notice must provide a list of the contraceptives or contraceptive services the
290.5 employer refuses to cover.

290.6 Subd. 4. Accommodation for eligible organizations. (a) A health plan established or
290.7 maintained by an eligible organization complies with the requirements of subdivision 2 to
290.8 provide coverage of contraceptives and contraceptive services if the eligible organization
290.9 provides notice to any health plan company the eligible organization contracts with that it
290.10 is an eligible organization and that the eligible organization has a religious objection to
290.11 coverage for all or a subset of contraceptives or contraceptive services.

290.12 (b) The notice from an eligible organization to a health plan company under paragraph
290.13 (a) must include the name of the eligible organization, a statement that it objects to coverage
290.14 for some or all of contraceptives or contraceptive services, including a list of the contraceptive
290.15 services the eligible organization objects to, if applicable, and the health plan name. The
290.16 notice must be executed by a person authorized to provide notice on behalf of the eligible
290.17 organization.

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

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

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

290.23 (d) A health plan company that receives a copy of the notice under paragraph (a) with
290.24 respect to a health plan established or maintained by an eligible organization must:

290.25 (1) expressly exclude coverage for some or all contraceptives or contraceptive services
290.26 from the health plan and provide separate payments for any contraceptive or contraceptive
290.27 service required to be covered under subdivision 2 for enrollees as long as the enrollee
290.28 remains enrolled in the health plan; or

290.29 (2) arrange for an issuer or other entity to provide payments for contraceptive services
290.30 for plan participants and beneficiaries without imposing any cost-sharing requirements, or
290.31 imposing a premium fee or other charge, or any portion thereof directly or indirectly, on
290.32 the eligible organization, the group health plan, or plan participants or beneficiaries.

291.1 (e) The health plan company must not impose any cost-sharing requirements, including
291.2 co-pays, deductibles, or co-insurance, or directly or indirectly impose any premium, fee, or
291.3 other charge for contraceptive services or contraceptives on the eligible organization, health
291.4 plan, or enrollee.

291.5 (f) On January 1, 2022, and every year thereafter a health plan company must notify the
291.6 commissioner, in a manner to be determined by the commissioner, regarding the number
291.7 of eligible organizations granted an accommodation under this subdivision.

291.8 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to coverage
291.9 offered, sold, issued, or renewed on or after that date.

291.10 Sec. 14. **[62Q.522] COVERAGE FOR PRESCRIPTION CONTRACEPTIVES;**
291.11 **SUPPLY REQUIREMENTS.**

291.12 Subdivision 1. **Scope of coverage.** Except as otherwise provided in section 62Q.521,
291.13 subdivision 3, all health plans that provide prescription coverage must comply with the
291.14 requirements of this section.

291.15 Subd. 2. **Definition.** For purposes of this section, "prescription contraceptive" means
291.16 any drug or device that requires a prescription and is approved by the Food and Drug
291.17 Administration to prevent pregnancy. Prescription contraceptive does not include an
291.18 emergency contraceptive drug that prevents pregnancy when administered after sexual
291.19 contact.

291.20 Subd. 3. **Required coverage.** (a) Health plan coverage for a prescription contraceptive
291.21 must provide a 12-month supply for any prescription contraceptive, regardless of whether
291.22 the enrollee was covered by the health plan at the time of the first dispensing.

291.23 (b) The prescribing health care provider must determine the appropriate number of
291.24 months to prescribe the prescription contraceptives for, up to 12 months.

291.25 **EFFECTIVE DATE.** This section is effective January 1, 2022, and applies to coverage
291.26 offered, sold, issued, or renewed on or after that date.

291.27 Sec. 15. Minnesota Statutes 2020, section 62Q.677, is amended by adding a subdivision
291.28 to read:

291.29 Subd. 6a. **Out-of-pocket annual maximum.** By October of each year, the commissioner
291.30 of commerce must determine the maximum annual out-of-pocket limits applicable to
291.31 individual health plans and small group health plans.

292.1 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
292.2 sold, issued, or renewed on or after that date.

292.3 Sec. 16. Minnesota Statutes 2020, section 62Q.81, is amended to read:

292.4 **62Q.81 ESSENTIAL HEALTH BENEFIT PACKAGE REQUIREMENTS.**

292.5 Subdivision 1. **Essential health benefits package.** (a) Health plan companies offering
292.6 individual and small group health plans must include the essential health benefits package
292.7 ~~required under section 1302(a) of the Affordable Care Act and~~ as described in this
292.8 subdivision.

292.9 (b) The essential health benefits package means insurance coverage that:

292.10 (1) provides the essential health benefits ~~as outlined in the Affordable Care Act~~ described
292.11 in subdivision 4;

292.12 (2) limits cost-sharing for ~~such~~ the coverage ~~in accordance with the Affordable Care~~
292.13 ~~Act~~, as described in subdivision 2; and

292.14 (3) ~~subject to subdivision 3;~~ provides bronze, silver, gold, or platinum level of coverage
292.15 ~~in accordance with the Affordable Care Act,~~ as described in subdivision 3.

292.16 Subd. 2. **Cost-sharing; coverage for enrollees under the age of 21.** (a) Cost-sharing
292.17 includes (1) deductibles, coinsurance, co-payments, or similar charges, and (2) qualified
292.18 medical expenses, as defined in section 223(d)(2) of the Internal Revenue Code of 1986,
292.19 as amended. Cost-sharing does not include premiums, balance billing from non-network
292.20 providers, or spending for noncovered services.

292.21 (b) Cost-sharing per year for individual health plans is limited to the amount allowed
292.22 under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986, as amended, increased
292.23 by an amount equal to the product of that amount and the premium adjustment percentage.
292.24 The premium adjustment percentage is the percentage that the average per capita premium
292.25 for health insurance coverage in the United States for the preceding calendar year exceeds
292.26 the average per capita premium for 2017. If the amount of the increase is not a multiple of
292.27 \$50, the increases must be rounded to the next lowest multiple of \$50.

292.28 (c) Cost-sharing per year for small group health plans is limited to twice the amount
292.29 allowed under paragraph (b).

292.30 (d) If a health plan company offers health plans in any level of coverage specified under
292.31 section 1302(d) of the Affordable Care Act, as described in subdivision 1, paragraph (b),

293.1 ~~clause (3)~~ 3, the health plan company shall also offer coverage in that level to individuals
293.2 who have not attained 21 years of age as of the beginning of a policy year.

293.3 Subd. 3. **Levels of coverage; alternative compliance for catastrophic plans.** (a) A
293.4 health plan in the bronze level must provide a level of coverage designed to provide benefits
293.5 that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided
293.6 under the plan.

293.7 (b) A health plan in the silver level must provide a level of coverage designed to provide
293.8 benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits
293.9 provided under the plan.

293.10 (c) A health plan in the gold level must provide a level of coverage designed to provide
293.11 benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits
293.12 provided under the plan.

293.13 (d) A health plan in the platinum level must provide a level of coverage designed to
293.14 provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of
293.15 the benefits provided under the plan.

293.16 (e) A health plan company that does not provide an individual or small group health
293.17 plan in the bronze, silver, gold, or platinum level of coverage, as described in subdivision
293.18 1, paragraph (b), clause (3), shall be treated as meeting meets the requirements of this section
293.19 1302(d) of the Affordable Care Act with respect to any policy plan year if the health plan
293.20 company provides a catastrophic plan that meets the following requirements of section
293.21 1302(e) of the Affordable Care Act.:

293.22 (1) enrollment in the health plan is limited only to individuals that:

293.23 (i) have not attained age 30 before the beginning of the plan year;

293.24 (ii) are unable to access affordable coverage; or

293.25 (iii) are experiencing a hardship in reference to the individual's capability to access
293.26 coverage; and

293.27 (2) the health plan provides:

293.28 (i) essential health benefits, except that the plan does not provide benefits for any plan
293.29 year until the individual has incurred cost-sharing expenses in an amount equal to the
293.30 limitation in effect under subdivision 2; and

293.31 (ii) coverage for at least three primary care visits.

294.1 Subd. 4. **Essential health benefits; definition.** (a) For purposes of this section, "essential
294.2 health benefits" ~~has the meaning given under section 1302(b) of the Affordable Care Act~~
294.3 ~~and includes~~ means:

294.4 (1) ambulatory patient services;

294.5 (2) emergency services;

294.6 (3) hospitalization;

294.7 (4) laboratory services;

294.8 (5) maternity and newborn care;

294.9 (6) mental health and substance use disorder services, including behavioral health
294.10 treatment;

294.11 (7) pediatric services, including oral and vision care;

294.12 (8) prescription drugs;

294.13 (9) preventive and wellness services and chronic disease management;

294.14 (10) rehabilitative and habilitative services and devices; and

294.15 (11) additional essential health benefits included in the ~~EHB benchmark plan, as defined~~
294.16 ~~under the Affordable Care Act~~ health plan described in paragraph (c).

294.17 (b) If a service provider does not have a contractual relationship with the health plan to
294.18 provide services, emergency services must be provided without imposing any prior
294.19 authorization requirement or limitation on coverage that is more restrictive than the
294.20 requirements or limitations that apply to emergency services received from providers who
294.21 have a contractual relationship with the health plan. If services are provided out-of-network,
294.22 the cost-sharing must be equivalent to services provided in-network.

294.23 (c) The scope of essential health benefits under paragraph (a) must be equal to the scope
294.24 of benefits provided under a typical employer plan.

294.25 (d) Essential health benefits must:

294.26 (1) reflect an appropriate balance among the categories to ensure benefits are not unduly
294.27 weighted toward any category;

294.28 (2) not make coverage decisions, determine reimbursement rates, establish incentive
294.29 programs, or design benefits in a manner that discriminates against individuals on the basis
294.30 of age, disability, or expected length of life;

295.1 (3) account for the health care needs of diverse segments of the population, including
295.2 women, children, persons with disabilities, and other groups; and

295.3 (4) ensure that health benefits established as essential are not subject to denial against
295.4 the individual's wishes on the basis of the individual's age or expected length of life or of
295.5 the individual's present or predicted disability, degree of medical dependency, or quality of
295.6 life.

295.7 Subd. 5. **Exception.** This section does not apply to a dental plan ~~described in section~~
295.8 ~~1311(d)(2)(B)(ii) of the Affordable Care Act~~ that is limited in scope and provides pediatric
295.9 dental benefits.

295.10 **EFFECTIVE DATE.** This section is effective January 1, 2022, for health plans offered,
295.11 sold, issued, or renewed on or after that date.

295.12 Sec. 17. Minnesota Statutes 2020, section 256B.0625, subdivision 10, is amended to read:

295.13 Subd. 10. **Laboratory and, x-ray, and opioid screening services.** (a) Medical assistance
295.14 covers laboratory and x-ray services.

295.15 (b) Medical assistance covers screening and urinalysis tests for opioids without lifetime
295.16 or annual limits.

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

295.18 Sec. 18. Minnesota Statutes 2020, section 256B.0625, subdivision 13, is amended to read:

295.19 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
295.20 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
295.21 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
295.22 dispensing physician, or by a physician, a physician assistant, or an advanced practice
295.23 registered nurse employed by or under contract with a community health board as defined
295.24 in section 145A.02, subdivision 5, for the purposes of communicable disease control.

295.25 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
295.26 unless authorized by the commissioner or as provided in paragraph (h).

295.27 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
295.28 ingredient" is defined as a substance that is represented for use in a drug and when used in
295.29 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
295.30 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
295.31 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and

296.1 excipients which are included in the medical assistance formulary. Medical assistance covers
296.2 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
296.3 when the compounded combination is specifically approved by the commissioner or when
296.4 a commercially available product:

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

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

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

296.10 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
296.11 a licensed practitioner or by a licensed pharmacist who meets standards established by the
296.12 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family
296.13 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
296.14 with documented vitamin deficiencies, vitamins for children under the age of seven and
296.15 pregnant or nursing women, and any other over-the-counter drug identified by the
296.16 commissioner, in consultation with the Formulary Committee, as necessary, appropriate,
296.17 and cost-effective for the treatment of certain specified chronic diseases, conditions, or
296.18 disorders, and this determination shall not be subject to the requirements of chapter 14. A
296.19 pharmacist may prescribe over-the-counter medications as provided under this paragraph
296.20 for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter
296.21 drugs under this paragraph, licensed pharmacists must consult with the recipient to determine
296.22 necessity, provide drug counseling, review drug therapy for potential adverse interactions,
296.23 and make referrals as needed to other health care professionals.

296.24 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
296.25 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
296.26 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
296.27 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
296.28 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
296.29 individuals, medical assistance may cover drugs from the drug classes listed in United States
296.30 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
296.31 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
296.32 not be covered.

296.33 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
296.34 Program and dispensed by 340B covered entities and ambulatory pharmacies under common

297.1 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
297.2 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

297.3 (g) Notwithstanding paragraph (a), medical assistance covers self-administered hormonal
297.4 contraceptives prescribed and dispensed by a licensed pharmacist in accordance with section
297.5 151.37, subdivision 14; nicotine replacement medications prescribed and dispensed by a
297.6 licensed pharmacist in accordance with section 151.37, subdivision 15; and opiate antagonists
297.7 used for the treatment of an acute opiate overdose prescribed and dispensed by a licensed
297.8 pharmacist in accordance with section 151.37, subdivision 16.

297.9 (h) Medical assistance coverage for a prescription contraceptive must provide a 12-month
297.10 supply for any prescription contraceptive. The prescribing health care provider must
297.11 determine the appropriate number of months to prescribe the prescription contraceptives,
297.12 up to 12 months. For the purposes of this paragraph, "prescription contraceptive" means
297.13 any drug or device that requires a prescription and is approved by the Food and Drug
297.14 Administration to prevent pregnancy. Prescription contraceptive does not include an
297.15 emergency contraceptive drug approved to prevent pregnancy when administered after
297.16 sexual contact.

297.17 **EFFECTIVE DATE.** This section applies to medical assistance and MinnesotaCare
297.18 coverage effective January 1, 2022.

297.19 Sec. 19. **COMMISSIONER OF COMMERCE; DETERMINATION OF**
297.20 **PREVENTIVE ITEMS AND SERVICES.**

297.21 The commissioner of commerce must determine the items and services that are preventive
297.22 under Minnesota Statutes, section 62Q.46, subdivision 1a. Items and services that are
297.23 preventive must include:

297.24 (1) evidence-based items or services that have in effect a rating of A or B pursuant to
297.25 the recommendations of the United States Preventive Services Task Force in effect January
297.26 1, 2021, and with respect to the individual involved;

297.27 (2) immunizations for routine use in children, adolescents, and adults that have in effect
297.28 a recommendation from the Advisory Committee on Immunization Practices of the Centers
297.29 for Disease Control and Prevention with respect to the individual involved. For the purposes
297.30 of this clause, a recommendation from the Advisory Committee on Immunization Practices
297.31 of the Centers for Disease Control and Prevention is considered in effect after it has been
297.32 adopted by the Director of the Centers for Disease Control and Prevention and a

298.1 recommendation is considered to be for routine use if it is listed on the Immunization
298.2 Schedules of the Centers for Disease Control and Prevention;

298.3 (3) with respect to infants, children, and adolescents, evidence-informed preventive care
298.4 and screenings provided for in comprehensive guidelines supported by the Health Resources
298.5 and Services Administration; and

298.6 (4) with respect to women, additional preventive care and screenings not described in
298.7 clause (1), as provided for in comprehensive guidelines supported by the Health Resources
298.8 and Services Administration.

298.9 **ARTICLE 7**

298.10 **TELEHEALTH**

298.11 Section 1. **[62A.673] COVERAGE OF SERVICES PROVIDED THROUGH**
298.12 **TELEHEALTH.**

298.13 Subdivision 1. Citation. This section may be cited as the "Minnesota Telehealth Act."

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

298.16 (b) "Distant site" means a site at which a health care provider is located while providing
298.17 health care services or consultations by means of telehealth.

298.18 (c) "Health care provider" means a health care professional who is licensed or registered
298.19 by the state to perform health care services within the provider's scope of practice and in
298.20 accordance with state law. A health care provider includes a mental health professional as
298.21 defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; a mental health
298.22 practitioner as defined under section 245.462, subdivision 17, or 245.4871, subdivision 26;
298.23 a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor
298.24 under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision
298.25 8.

298.26 (d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

298.27 (e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan
298.28 includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental
298.29 plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed
298.30 to pay benefits directly to the policy holder.

298.31 (f) "Originating site" means a site at which a patient is located at the time health care
298.32 services are provided to the patient by means of telehealth. For purposes of store-and-forward

299.1 transfer, the originating site also means the location at which a health care provider transfers
299.2 or transmits information to the distant site.

299.3 (g) "Store-and-forward transfer" means the asynchronous electronic transfer of a patient's
299.4 medical information or data from an originating site to a distant site for the purposes of
299.5 diagnostic and therapeutic assistance in the care of a patient.

299.6 (h) "Telehealth" means the delivery of health care services or consultations through the
299.7 use of real-time, two-way interactive audio and visual or audio-only communications to
299.8 provide or support health care delivery and facilitate the assessment, diagnosis, consultation,
299.9 treatment, education, and care management of a patient's health care. Telehealth includes
299.10 the application of secure video conferencing, store-and-forward transfers, and synchronous
299.11 interactions between a patient located at an originating site and a health care provider located
299.12 at a distant site. Telehealth includes audio-only communication between a health care
299.13 provider and a patient if the communication is a scheduled appointment and the standard
299.14 of care for the service can be met through the use of audio-only communication. Telehealth
299.15 does not include communication between health care providers or between a health care
299.16 provider and a patient that consists solely of an e-mail or facsimile transmission. Telehealth
299.17 does not include communication between health care providers that consists solely of a
299.18 telephone conversation.

299.19 (i) "Telemonitoring services" means the remote monitoring of clinical data related to
299.20 the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits
299.21 the data electronically to a health care provider for analysis. Telemonitoring is intended to
299.22 collect an enrollee's health-related data for the purpose of assisting a health care provider
299.23 in assessing and monitoring the enrollee's medical condition or status.

299.24 Subd. 3. Coverage of telehealth. (a) A health plan sold, issued, or renewed by a health
299.25 carrier in Minnesota must (1) cover benefits delivered through telehealth in the same manner
299.26 as any other benefits covered under the health plan, and (2) comply with this section.

299.27 (b) Coverage for services delivered through telehealth must not be limited on the basis
299.28 of geography, location, or distance for travel.

299.29 (c) A health carrier must not create a separate provider network or provide incentives
299.30 to enrollees to use a separate provider network to deliver services through telehealth that
299.31 does not include network providers who provide in-person care to patients for the same
299.32 service.

299.33 (d) A health carrier may require a deductible, co-payment, or coinsurance payment for
299.34 a health care service provided through telehealth, provided that the deductible, co-payment,

300.1 or coinsurance payment is not in addition to, and does not exceed, the deductible, co-payment,
300.2 or coinsurance applicable for the same service provided through in-person contact.

300.3 (e) Nothing in this section:

300.4 (1) requires a health carrier to provide coverage for services that are not medically
300.5 necessary or are not covered under the enrollee's health plan; or

300.6 (2) prohibits a health carrier from:

300.7 (i) establishing criteria that a health care provider must meet to demonstrate the safety
300.8 or efficacy of delivering a particular service through telehealth for which the health carrier
300.9 does not already reimburse other health care providers for delivering the service through
300.10 telehealth;

300.11 (ii) establishing reasonable medical management techniques, provided the criteria or
300.12 techniques are not unduly burdensome or unreasonable for the particular service; or

300.13 (iii) requiring documentation or billing practices designed to protect the health carrier
300.14 or patient from fraudulent claims, provided the practices are not unduly burdensome or
300.15 unreasonable for the particular service.

300.16 (f) Nothing in this section requires the use of telehealth when a health care provider
300.17 determines that the delivery of a health care service through telehealth is not appropriate or
300.18 when an enrollee chooses not to receive a health care service through telehealth.

300.19 **Subd. 4. Parity between telehealth and in-person services.** (a) A health carrier must
300.20 not restrict or deny coverage of a health care service that is covered under a health plan
300.21 solely:

300.22 (1) because the health care service provided by the health care provider through telehealth
300.23 is not provided through in-person contact; or

300.24 (2) based on the communication technology or application used to deliver the health
300.25 care service through telehealth, provided the technology or application complies with this
300.26 section and is appropriate for the particular service.

300.27 (b) Prior authorization may be required for health care services delivered through
300.28 telehealth only if prior authorization is required before the delivery of the same service
300.29 through in-person contact.

300.30 (c) A health carrier may require a utilization review for services delivered through
300.31 telehealth, provided the utilization review is conducted in the same manner and uses the

301.1 same clinical review criteria as a utilization review for the same services delivered through
301.2 in-person contact.

301.3 Subd. 5. **Reimbursement for services delivered through telehealth.** (a) A health carrier
301.4 must reimburse the health care provider for services delivered through telehealth on the
301.5 same basis and at the same rate as the health carrier would apply to those services if the
301.6 services had been delivered by the health care provider through in-person contact.

301.7 (b) A health carrier must not deny or limit reimbursement based solely on a health care
301.8 provider delivering the service or consultation through telehealth instead of through in-person
301.9 contact.

301.10 (c) A health carrier must not deny or limit reimbursement based solely on the technology
301.11 and equipment used by the health care provider to deliver the health care service or
301.12 consultation through telehealth, provided the technology and equipment used by the provider
301.13 meets the requirements of this section and is appropriate for the particular service.

301.14 Subd. 6. **Telehealth equipment.** (a) A health carrier must not require a health care
301.15 provider to use specific telecommunications technology and equipment as a condition of
301.16 coverage under this section, provided the health care provider uses telecommunications
301.17 technology and equipment that complies with current industry interoperable standards and
301.18 complies with standards required under the federal Health Insurance Portability and
301.19 Accountability Act of 1996, Public Law 104-191, and regulations promulgated under that
301.20 Act, unless authorized under this section.

301.21 (b) A health carrier must provide coverage for health care services delivered through
301.22 telehealth by means of the use of audio-only telephone communication if the communication
301.23 is a scheduled appointment and the standard of care for that particular service can be met
301.24 through the use of audio-only communication.

301.25 Subd. 7. **Telemonitoring services.** A health carrier must provide coverage for
301.26 telemonitoring services if:

301.27 (1) the telemonitoring service is medically appropriate based on the enrollee's medical
301.28 condition or status;

301.29 (2) the enrollee is cognitively and physically capable of operating the monitoring device
301.30 or equipment, or the enrollee has a caregiver who is willing and able to assist with the
301.31 monitoring device or equipment; and

301.32 (3) the enrollee resides in a setting that is suitable for telemonitoring and not in a setting
301.33 that has health care staff on site.

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

302.2 Sec. 2. Minnesota Statutes 2020, section 147.033, is amended to read:

302.3 **147.033 PRACTICE OF TELEMEDICINE TELEHEALTH.**

302.4 Subdivision 1. **Definition.** For the purposes of this section, "~~telemedicine~~" means the
302.5 ~~delivery of health care services or consultations while the patient is at an originating site~~
302.6 ~~and the licensed health care provider is at a distant site. A communication between licensed~~
302.7 ~~health care providers that consists solely of a telephone conversation, e-mail, or facsimile~~
302.8 ~~transmission does not constitute telemedicine consultations or services. A communication~~
302.9 ~~between a licensed health care provider and a patient that consists solely of an e-mail or~~
302.10 ~~facsimile transmission does not constitute telemedicine consultations or services.~~
302.11 ~~Telemedicine may be provided by means of real-time two-way interactive audio, and visual~~
302.12 ~~communications, including the application of secure video conferencing or store-and-forward~~
302.13 ~~technology to provide or support health care delivery, that facilitate the assessment, diagnosis,~~
302.14 ~~consultation, treatment, education, and care management of a patient's health care.~~
302.15 "telehealth" has the meaning given in section 62A.673, subdivision 2, paragraph (h).

302.16 Subd. 2. **Physician-patient relationship.** A physician-patient relationship may be
302.17 established through ~~telemedicine~~ telehealth.

302.18 Subd. 3. **Standards of practice and conduct.** A physician providing health care services
302.19 by ~~telemedicine~~ telehealth in this state shall be held to the same standards of practice and
302.20 conduct as provided in this chapter for in-person health care services.

302.21 Sec. 3. Minnesota Statutes 2020, section 151.37, subdivision 2, is amended to read:

302.22 Subd. 2. **Prescribing and filing.** (a) A licensed practitioner in the course of professional
302.23 practice only, may prescribe, administer, and dispense a legend drug, and may cause the
302.24 same to be administered by a nurse, a physician assistant, or medical student or resident
302.25 under the practitioner's direction and supervision, and may cause a person who is an
302.26 appropriately certified, registered, or licensed health care professional to prescribe, dispense,
302.27 and administer the same within the expressed legal scope of the person's practice as defined
302.28 in Minnesota Statutes. A licensed practitioner may prescribe a legend drug, without reference
302.29 to a specific patient, by directing a licensed dietitian or licensed nutritionist, pursuant to
302.30 section 148.634; a nurse, pursuant to section 148.235, subdivisions 8 and 9; physician
302.31 assistant; medical student or resident; or pharmacist according to section 151.01, subdivision
302.32 27, to adhere to a particular practice guideline or protocol when treating patients whose
302.33 condition falls within such guideline or protocol, and when such guideline or protocol

303.1 specifies the circumstances under which the legend drug is to be prescribed and administered.
303.2 An individual who verbally, electronically, or otherwise transmits a written, oral, or electronic
303.3 order, as an agent of a prescriber, shall not be deemed to have prescribed the legend drug.
303.4 This paragraph applies to a physician assistant only if the physician assistant meets the
303.5 requirements of ~~section 147A.18~~ sections 147A.02 and 147A.09.

303.6 (b) The commissioner of health, if a licensed practitioner, or a person designated by the
303.7 commissioner who is a licensed practitioner, may prescribe a legend drug to an individual
303.8 or by protocol for mass dispensing purposes where the commissioner finds that the conditions
303.9 triggering section 144.4197 or 144.4198, subdivision 2, paragraph (b), exist. The
303.10 commissioner, if a licensed practitioner, or a designated licensed practitioner, may prescribe,
303.11 dispense, or administer a legend drug or other substance listed in subdivision 10 to control
303.12 tuberculosis and other communicable diseases. The commissioner may modify state drug
303.13 labeling requirements, and medical screening criteria and documentation, where time is
303.14 critical and limited labeling and screening are most likely to ensure legend drugs reach the
303.15 maximum number of persons in a timely fashion so as to reduce morbidity and mortality.

303.16 (c) A licensed practitioner that dispenses for profit a legend drug that is to be administered
303.17 orally, is ordinarily dispensed by a pharmacist, and is not a vaccine, must file with the
303.18 practitioner's licensing board a statement indicating that the practitioner dispenses legend
303.19 drugs for profit, the general circumstances under which the practitioner dispenses for profit,
303.20 and the types of legend drugs generally dispensed. It is unlawful to dispense legend drugs
303.21 for profit after July 31, 1990, unless the statement has been filed with the appropriate
303.22 licensing board. For purposes of this paragraph, "profit" means (1) any amount received by
303.23 the practitioner in excess of the acquisition cost of a legend drug for legend drugs that are
303.24 purchased in prepackaged form, or (2) any amount received by the practitioner in excess
303.25 of the acquisition cost of a legend drug plus the cost of making the drug available if the
303.26 legend drug requires compounding, packaging, or other treatment. The statement filed under
303.27 this paragraph is public data under section 13.03. This paragraph does not apply to a licensed
303.28 doctor of veterinary medicine or a registered pharmacist. Any person other than a licensed
303.29 practitioner with the authority to prescribe, dispense, and administer a legend drug under
303.30 paragraph (a) shall not dispense for profit. To dispense for profit does not include dispensing
303.31 by a community health clinic when the profit from dispensing is used to meet operating
303.32 expenses.

303.33 (d) A prescription drug order for the following drugs is not valid, unless it can be
303.34 established that the prescription drug order was based on a documented patient evaluation,

304.1 including an examination, adequate to establish a diagnosis and identify underlying conditions
304.2 and contraindications to treatment:

304.3 (1) controlled substance drugs listed in section 152.02, subdivisions 3 to 5;

304.4 (2) drugs defined by the Board of Pharmacy as controlled substances under section
304.5 152.02, subdivisions 7, 8, and 12;

304.6 (3) muscle relaxants;

304.7 (4) centrally acting analgesics with opioid activity;

304.8 (5) drugs containing butalbital; or

304.9 (6) phosphodiesterase type 5 inhibitors when used to treat erectile dysfunction.

304.10 ~~For purposes of prescribing drugs listed in clause (6), the requirement for a documented~~
304.11 ~~patient evaluation, including an examination, may be met through the use of telemedicine,~~
304.12 ~~as defined in section 147.033, subdivision 1.~~

304.13 (e) For the purposes of paragraph (d), the requirement for an examination shall be met
304.14 if:

304.15 (1) an in-person examination has been completed in any of the following circumstances:

304.16 ~~(1)~~ (i) the prescribing practitioner examines the patient at the time the prescription or
304.17 drug order is issued;

304.18 ~~(2)~~ (ii) the prescribing practitioner has performed a prior examination of the patient;

304.19 ~~(3)~~ (iii) another prescribing practitioner practicing within the same group or clinic as
304.20 the prescribing practitioner has examined the patient;

304.21 ~~(4)~~ (iv) a consulting practitioner to whom the prescribing practitioner has referred the
304.22 patient has examined the patient; or

304.23 ~~(5)~~ (v) the referring practitioner has performed an examination in the case of a consultant
304.24 practitioner issuing a prescription or drug order when providing services by means of
304.25 telemedicine; or

304.26 (2) the prescription order is for a drug listed in paragraph (d), clause (6), or for medication
304.27 assisted therapy for a substance use disorder, and the prescribing practitioner has completed
304.28 an examination of the patient via telehealth as defined in section 62A.673, subdivision 2,
304.29 paragraph (h).

304.30 (f) Nothing in paragraph (d) or (e) prohibits a licensed practitioner from prescribing a
304.31 drug through the use of a guideline or protocol pursuant to paragraph (a).

305.1 (g) Nothing in this chapter prohibits a licensed practitioner from issuing a prescription
305.2 or dispensing a legend drug in accordance with the Expedited Partner Therapy in the
305.3 Management of Sexually Transmitted Diseases guidance document issued by the United
305.4 States Centers for Disease Control.

305.5 (h) Nothing in paragraph (d) or (e) limits prescription, administration, or dispensing of
305.6 legend drugs through a public health clinic or other distribution mechanism approved by
305.7 the commissioner of health or a community health board in order to prevent, mitigate, or
305.8 treat a pandemic illness, infectious disease outbreak, or intentional or accidental release of
305.9 a biological, chemical, or radiological agent.

305.10 (i) No pharmacist employed by, under contract to, or working for a pharmacy located
305.11 within the state and licensed under section 151.19, subdivision 1, may dispense a legend
305.12 drug based on a prescription that the pharmacist knows, or would reasonably be expected
305.13 to know, is not valid under paragraph (d).

305.14 (j) No pharmacist employed by, under contract to, or working for a pharmacy located
305.15 outside the state and licensed under section 151.19, subdivision 1, may dispense a legend
305.16 drug to a resident of this state based on a prescription that the pharmacist knows, or would
305.17 reasonably be expected to know, is not valid under paragraph (d).

305.18 (k) Nothing in this chapter prohibits the commissioner of health, if a licensed practitioner,
305.19 or, if not a licensed practitioner, a designee of the commissioner who is a licensed
305.20 practitioner, from prescribing legend drugs for field-delivered therapy in the treatment of
305.21 a communicable disease according to the Centers For Disease Control and Prevention Partner
305.22 Services Guidelines.

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

305.24 Sec. 4. Minnesota Statutes 2020, section 245G.01, subdivision 13, is amended to read:

305.25 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive ~~and visual~~
305.26 communication between a client and a treatment service provider and includes services
305.27 delivered in person or via ~~telemedicine~~ telehealth with priority being given to interactive
305.28 audio and visual communication, if available. Meetings required by section 245G.22,
305.29 subdivision 4, must be conducted by interactive video and visual communication.

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

306.1 Sec. 5. Minnesota Statutes 2020, section 245G.01, subdivision 26, is amended to read:

306.2 Subd. 26. ~~Telemedicine~~ **Telehealth.** ~~"Telemedicine"~~ "Telehealth" means the delivery
306.3 of a substance use disorder treatment service while the client is at an originating site and
306.4 the ~~licensed~~ health care provider is at a distant site via telehealth as defined in section
306.5 256B.0625, subdivision 3b, and as specified in section 254B.05, subdivision 5, paragraph
306.6 (f).

306.7 Sec. 6. Minnesota Statutes 2020, section 245G.06, subdivision 1, is amended to read:

306.8 Subdivision 1. **General.** Each client must have a person-centered individual treatment
306.9 plan developed by an alcohol and drug counselor within ten days from the day of service
306.10 initiation for a residential program and within five calendar days on which a treatment
306.11 session has been provided from the day of service initiation for a client in a nonresidential
306.12 program. Opioid treatment programs must complete the individual treatment plan within
306.13 21 days from the day of service initiation. The individual treatment plan must be signed by
306.14 the client and the alcohol and drug counselor and document the client's involvement in the
306.15 development of the plan. The individual treatment plan is developed upon the qualified staff
306.16 member's dated signature. Treatment planning must include ongoing assessment of client
306.17 needs. An individual treatment plan must be updated based on new information gathered
306.18 about the client's condition, the client's level of participation, and on whether methods
306.19 identified have the intended effect. A change to the plan must be signed by the client and
306.20 the alcohol and drug counselor. If the client chooses to have family or others involved in
306.21 treatment services, the client's individual treatment plan must include how the family or
306.22 others will be involved in the client's treatment. If a client is receiving treatment services
306.23 or an assessment via telehealth and the license holder documents the reason the client's
306.24 signature cannot be obtained, the alcohol and drug counselor may document the client's
306.25 verbal approval or electronic written approval of the treatment plan or change to the treatment
306.26 plan in lieu of the client's signature.

306.27 Sec. 7. Minnesota Statutes 2020, section 254A.19, subdivision 5, is amended to read:

306.28 Subd. 5. **Assessment via ~~telemedicine~~ telehealth.** Notwithstanding Minnesota Rules,
306.29 part 9530.6615, subpart 3, item A, a chemical use assessment may be conducted via
306.30 ~~telemedicine~~ telehealth as defined in section 256B.0625, subdivision 3b.

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

307.1 Sec. 8. Minnesota Statutes 2020, section 254B.05, subdivision 5, is amended to read:

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

307.4 (b) Eligible substance use disorder treatment services include:

307.5 (1) outpatient treatment services that are licensed according to sections 245G.01 to
307.6 245G.17, or applicable tribal license;

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

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

307.11 (4) peer recovery support services provided according to section 245G.07, subdivision
307.12 2, clause (8);

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

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

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

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

307.22 (9) hospital-based treatment services that are licensed according to sections 245G.01 to
307.23 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to
307.24 144.56;

307.25 (10) adolescent treatment programs that are licensed as outpatient treatment programs
307.26 according to sections 245G.01 to 245G.18 or as residential treatment programs according
307.27 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or
307.28 applicable tribal license;

307.29 (11) high-intensity residential treatment services that are licensed according to sections
307.30 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of
307.31 clinical services each week provided by a state-operated vendor or to clients who have been

308.1 civilly committed to the commissioner, present the most complex and difficult care needs,
308.2 and are a potential threat to the community; and

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

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

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

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

308.8 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
308.9 9503; or

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

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

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

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

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

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

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

308.22 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
308.23 whom are of that specific background, except when the common social background of the
308.24 individuals served is a traumatic brain injury or cognitive disability and the program employs
308.25 treatment staff who have the necessary professional training, as approved by the
308.26 commissioner, to serve clients with the specific disabilities that the program is designed to
308.27 serve;

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

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

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

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

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

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

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

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

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

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

309.27 (f) Subject to federal approval, chemical dependency services that are otherwise covered
309.28 as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as
309.29 defined in section 256B.0625, subdivision 3b. The use of ~~two-way interactive video~~ telehealth
309.30 to deliver services must be medically appropriate to the condition and needs of the person
309.31 being served. Reimbursement shall be at the same rates and under the same conditions that
309.32 would otherwise apply to direct face-to-face services. ~~The interactive video equipment and~~
309.33 ~~connection must comply with Medicare standards in effect at the time the service is provided.~~

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

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

310.10 Sec. 9. Minnesota Statutes 2020, section 256B.0621, subdivision 10, is amended to read:

310.11 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
310.12 management under this subdivision. Case managers may bill according to the following
310.13 criteria:

310.14 (1) for relocation targeted case management, case managers may bill for direct case
310.15 management activities, including face-to-face contact, telephone contact, and interactive
310.16 video contact ~~according to section 256B.0924, subdivision 4a~~, in the lesser of:

310.17 (i) 180 days preceding an eligible recipient's discharge from an institution; or

310.18 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

310.19 (2) for home care targeted case management, case managers may bill for direct case
310.20 management activities, including face-to-face and telephone contacts; and

310.21 (3) billings for targeted case management services under this subdivision shall not
310.22 duplicate payments made under other program authorities for the same purpose.

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

310.25 Sec. 10. Minnesota Statutes 2020, section 256B.0625, subdivision 3b, is amended to read:

310.26 Subd. 3b. ~~Telemedicine~~ Telehealth services. (a) Medical assistance covers medically
310.27 necessary services and consultations delivered by a ~~licensed~~ health care provider ~~via~~
310.28 ~~telemedicine~~ through telehealth in the same manner as if the service or consultation was
310.29 ~~delivered in person through in-person contact. Coverage is limited to three telemedicine~~
310.30 ~~services per enrollee per calendar week, except as provided in paragraph (f).~~ Telemedicine

311.1 Services or consultations delivered through telehealth shall be paid at the full allowable
311.2 rate.

311.3 (b) The commissioner ~~shall~~ may establish criteria that a health care provider must attest
311.4 to in order to demonstrate the safety or efficacy of delivering a particular service ~~via~~
311.5 ~~telemedicine~~ through telehealth. The attestation may include that the health care provider:

311.6 (1) has identified the categories or types of services the health care provider will provide
311.7 ~~via telemedicine~~ through telehealth;

311.8 (2) has written policies and procedures specific to ~~telemedicine~~ services delivered through
311.9 telehealth that are regularly reviewed and updated;

311.10 (3) has policies and procedures that adequately address patient safety before, during,
311.11 and after the ~~telemedicine~~ service is ~~rendered~~ delivered through telehealth;

311.12 (4) has established protocols addressing how and when to discontinue telemedicine
311.13 services; and

311.14 (5) has an established quality assurance process related to ~~telemedicine~~ delivering services
311.15 through telehealth.

311.16 (c) As a condition of payment, a licensed health care provider must document each
311.17 occurrence of a health service ~~provided by telemedicine~~ delivered through telehealth to a
311.18 medical assistance enrollee. Health care service records for services ~~provided by telemedicine~~
311.19 delivered through telehealth must meet the requirements set forth in Minnesota Rules, part
311.20 9505.2175, subparts 1 and 2, and must document:

311.21 (1) the type of service ~~provided by telemedicine~~ delivered through telehealth;

311.22 (2) the time the service began and the time the service ended, including an a.m. and p.m.
311.23 designation;

311.24 (3) the ~~licensed~~ health care provider's basis for determining that ~~telemedicine~~ telehealth
311.25 is an appropriate and effective means for delivering the service to the enrollee;

311.26 (4) the mode of transmission ~~of~~ used to deliver the telemedicine service through telehealth
311.27 and records evidencing that a particular mode of transmission was utilized;

311.28 (5) the location of the originating site and the distant site;

311.29 (6) if the claim for payment is based on a physician's ~~telemedicine~~ consultation with
311.30 another physician through telehealth, the written opinion from the consulting physician
311.31 providing the ~~telemedicine~~ telehealth consultation; and

312.1 (7) compliance with the criteria attested to by the health care provider in accordance
312.2 with paragraph (b).

312.3 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
312.4 ~~"telemedicine" is defined as the delivery of health care services or consultations while the~~
312.5 ~~patient is at an originating site and the licensed health care provider is at a distant site. A~~
312.6 ~~communication between licensed health care providers, or a licensed health care provider~~
312.7 ~~and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission~~
312.8 ~~does not constitute telemedicine consultations or services. Telemedicine may be provided~~
312.9 ~~by means of real-time two-way, interactive audio and visual communications, including the~~
312.10 ~~application of secure video conferencing or store-and-forward technology to provide or~~
312.11 ~~support health care delivery, which facilitate the assessment, diagnosis, consultation,~~
312.12 ~~treatment, education, and care management of a patient's health care.:~~

312.13 (1) "telehealth" means the delivery of health care services or consultations through the
312.14 use of real-time, two-way interactive audio and visual or audio-only communications to
312.15 provide or support health care delivery and facilitate the assessment, diagnosis, consultation,
312.16 treatment, education, and care management of a patient's health care. Telehealth includes
312.17 the application of secure video conferencing, store-and-forward transfers, and synchronous
312.18 interactions between a patient located at an originating site and a health care provider located
312.19 at a distant site. Unless interactive visual and audio communication is specifically required,
312.20 telehealth includes audio-only communication between a health care provider and a patient,
312.21 if the communication is a scheduled appointment with the health care provider and the
312.22 standard of care for the service can be met through the use of audio-only communication.
312.23 Telehealth does not include communication between health care providers, or communication
312.24 between a health care provider and a patient that consists solely of an e-mail or facsimile
312.25 transmission;

312.26 (e) ~~For purposes of this section, "licensed (2) "health care provider" means a licensed~~
312.27 ~~health care provider under section 62A.671, subdivision 6 as defined under section 62A.673,~~
312.28 ~~a community paramedic as defined under section 144E.001, subdivision 5f, or a mental~~
312.29 ~~health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision~~
312.30 ~~26, working under the general supervision of a mental health professional, and a community~~
312.31 ~~health worker who meets the criteria under subdivision 49, paragraph (a); "health care~~
312.32 ~~provider" is defined under section 62A.671, subdivision 3; a mental health certified peer~~
312.33 specialist under section 256B.0615, subdivision 5, a mental health certified family peer
312.34 specialist under section 256B.0616, subdivision 5, a mental health rehabilitation worker
312.35 under section 256B.0623, subdivision 5, paragraph (a), clause (4), and paragraph (b), a

313.1 mental health behavioral aide under section 256B.0943, subdivision 7, paragraph (b), clause
313.2 (3), a treatment coordinator under section 245G.11, subdivision 7, an alcohol and drug
313.3 counselor under section 245G.11, subdivision 5, a recovery peer under section 245G.11,
313.4 subdivision 8, and a mental health case manager under section 245.462, subdivision 4; and

313.5 (3) "originating site" is defined under section 62A.671, subdivision 7, "distant site," and
313.6 "store-and-forward transfer" have the meanings given in section 62A.673, subdivision 2.

313.7 ~~(f) The limit on coverage of three telemedicine services per enrollee per calendar week~~
313.8 ~~does not apply if:~~

313.9 ~~(1) the telemedicine services provided by the licensed health care provider are for the~~
313.10 ~~treatment and control of tuberculosis; and~~

313.11 ~~(2) the services are provided in a manner consistent with the recommendations and best~~
313.12 ~~practices specified by the Centers for Disease Control and Prevention and the commissioner~~
313.13 ~~of health.~~

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

313.17 Sec. 11. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
313.18 to read:

313.19 Subd. 3h. **Telemonitoring services.** (a) Medical assistance covers telemonitoring services
313.20 if a recipient:

313.21 (1) has been diagnosed and is receiving services for at least one of the following chronic
313.22 conditions: hypertension, cancer, congestive heart failure, chronic obstructive pulmonary
313.23 disease, asthma, or diabetes;

313.24 (2) requires at least five times per week monitoring to manage the chronic condition, as
313.25 ordered by the recipient's health care provider;

313.26 (3) has had two or more emergency room or inpatient hospitalization stays within the
313.27 last 12 months due to the chronic condition or the recipient's health care provider has
313.28 identified that telemonitoring services would likely prevent the recipient's admission or
313.29 readmission to a hospital, emergency room, or nursing facility;

313.30 (4) is cognitively and physically capable of operating the monitoring device or equipment,
313.31 or the recipient has a caregiver who is willing and able to assist with the monitoring device
313.32 or equipment; and

314.1 (5) resides in a setting that is suitable for telemonitoring and not in a setting that has
314.2 health care staff on site.

314.3 (b) For purposes of this subdivision, "telemonitoring services" means the remote
314.4 monitoring of data related to a recipient's vital signs or biometric data by a monitoring
314.5 device or equipment that transmits the data electronically to a provider for analysis. The
314.6 assessment and monitoring of the health data transmitted by telemonitoring must be
314.7 performed by one of the following licensed health care professionals: physician, podiatrist,
314.8 registered nurse, advanced practice registered nurse, physician assistant, respiratory therapist,
314.9 or licensed professional working under the supervision of a medical director.

314.10 Sec. 12. Minnesota Statutes 2020, section 256B.0625, subdivision 13h, is amended to
314.11 read:

314.12 Subd. 13h. **Medication therapy management services.** (a) Medical assistance covers
314.13 medication therapy management services for a recipient taking prescriptions to treat or
314.14 prevent one or more chronic medical conditions. For purposes of this subdivision,
314.15 "medication therapy management" means the provision of the following pharmaceutical
314.16 care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's
314.17 medications:

314.18 (1) performing or obtaining necessary assessments of the patient's health status;

314.19 (2) formulating a medication treatment plan, which may include prescribing medications
314.20 or products in accordance with section 151.37, subdivision 14, 15, or 16;

314.21 (3) monitoring and evaluating the patient's response to therapy, including safety and
314.22 effectiveness;

314.23 (4) performing a comprehensive medication review to identify, resolve, and prevent
314.24 medication-related problems, including adverse drug events;

314.25 (5) documenting the care delivered and communicating essential information to the
314.26 patient's other primary care providers;

314.27 (6) providing verbal education and training designed to enhance patient understanding
314.28 and appropriate use of the patient's medications;

314.29 (7) providing information, support services, and resources designed to enhance patient
314.30 adherence with the patient's therapeutic regimens; and

314.31 (8) coordinating and integrating medication therapy management services within the
314.32 broader health care management services being provided to the patient.

315.1 Nothing in this subdivision shall be construed to expand or modify the scope of practice of
315.2 the pharmacist as defined in section 151.01, subdivision 27.

315.3 (b) To be eligible for reimbursement for services under this subdivision, a pharmacist
315.4 must meet the following requirements:

315.5 (1) have a valid license issued by the Board of Pharmacy of the state in which the
315.6 medication therapy management service is being performed;

315.7 (2) have graduated from an accredited college of pharmacy on or after May 1996, or
315.8 completed a structured and comprehensive education program approved by the Board of
315.9 Pharmacy and the American Council of Pharmaceutical Education for the provision and
315.10 documentation of pharmaceutical care management services that has both clinical and
315.11 didactic elements; and

315.12 ~~(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or~~
315.13 ~~have developed a structured patient care process that is offered in a private or semiprivate~~
315.14 ~~patient care area that is separate from the commercial business that also occurs in the setting,~~
315.15 ~~or in home settings, including long-term care settings, group homes, and facilities providing~~
315.16 ~~assisted living services, but excluding skilled nursing facilities; and~~

315.17 ~~(4)~~ (3) make use of an electronic patient record system that meets state standards.

315.18 (c) For purposes of reimbursement for medication therapy management services, the
315.19 commissioner may enroll individual pharmacists as medical assistance providers. The
315.20 commissioner may also establish ~~contact requirements between the pharmacist and recipient,~~
315.21 ~~including limiting~~ limits on the number of reimbursable consultations per recipient.

315.22 ~~(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing~~
315.23 ~~within a reasonable geographic distance of the patient, a pharmacist who meets the~~
315.24 ~~requirements may provide~~ The Medication therapy management services may be provided
315.25 via two-way interactive video telehealth as defined in subdivision 3b and may be delivered
315.26 into a patient's residence. Reimbursement shall be at the same rates and under the same
315.27 conditions that would otherwise apply to the services provided. To qualify for reimbursement
315.28 under this paragraph, the pharmacist providing the services must meet the requirements of
315.29 paragraph (b), ~~and must be located within an ambulatory care setting that meets the~~
315.30 ~~requirements of paragraph (b), clause (3).~~ The patient must also be located within an
315.31 ambulatory care setting that meets the requirements of paragraph (b), clause (3). ~~Services~~
315.32 ~~provided under this paragraph may not be transmitted into the patient's residence.~~

316.1 ~~(e) Medication therapy management services may be delivered into a patient's residence~~
316.2 ~~via secure interactive video if the medication therapy management services are performed~~
316.3 ~~electronically during a covered home care visit by an enrolled provider. Reimbursement~~
316.4 ~~shall be at the same rates and under the same conditions that would otherwise apply to the~~
316.5 ~~services provided. To qualify for reimbursement under this paragraph, the pharmacist~~
316.6 ~~providing the services must meet the requirements of paragraph (b) and must be located~~
316.7 ~~within an ambulatory care setting that meets the requirements of paragraph (b), clause (3).~~

316.8 Sec. 13. Minnesota Statutes 2020, section 256B.0625, subdivision 20, is amended to read:

316.9 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
316.10 state agency, medical assistance covers case management services to persons with serious
316.11 and persistent mental illness and children with severe emotional disturbance. Services
316.12 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
316.13 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
316.14 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

316.15 (b) Entities meeting program standards set out in rules governing family community
316.16 support services as defined in section 245.4871, subdivision 17, are eligible for medical
316.17 assistance reimbursement for case management services for children with severe emotional
316.18 disturbance when these services meet the program standards in Minnesota Rules, parts
316.19 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

316.20 (c) Medical assistance and MinnesotaCare payment for mental health case management
316.21 shall be made on a monthly basis. In order to receive payment for an eligible child, the
316.22 provider must document at least a face-to-face contact or a contact by interactive video that
316.23 meets the requirements of subdivision 20b with the child, the child's parents, or the child's
316.24 legal representative. To receive payment for an eligible adult, the provider must document:

316.25 (1) at least a face-to-face contact, or a contact by interactive video that meets the
316.26 requirements of subdivision 20b, with the adult or the adult's legal representative or a contact
316.27 by interactive video that meets the requirements of subdivision 20b; or

316.28 (2) at least a telephone contact with the adult or the adult's legal representative and
316.29 document a face-to-face contact or a contact by interactive video that meets the requirements
316.30 of subdivision 20b with the adult or the adult's legal representative within the preceding
316.31 two months.

316.32 (d) Payment for mental health case management provided by county or state staff shall
316.33 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph

317.1 (b), with separate rates calculated for child welfare and mental health, and within mental
317.2 health, separate rates for children and adults.

317.3 (e) Payment for mental health case management provided by Indian health services or
317.4 by agencies operated by Indian tribes may be made according to this section or other relevant
317.5 federally approved rate setting methodology.

317.6 (f) Payment for mental health case management provided by vendors who contract with
317.7 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
317.8 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
317.9 service to other payers. If the service is provided by a team of contracted vendors, the county
317.10 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
317.11 shall determine how to distribute the rate among its members. No reimbursement received
317.12 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
317.13 or tribe for advance funding provided by the county or tribe to the vendor.

317.14 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
317.15 and county or state staff, the costs for county or state staff participation in the team shall be
317.16 included in the rate for county-provided services. In this case, the contracted vendor, the
317.17 tribal agency, and the county may each receive separate payment for services provided by
317.18 each entity in the same month. In order to prevent duplication of services, each entity must
317.19 document, in the recipient's file, the need for team case management and a description of
317.20 the roles of the team members.

317.21 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
317.22 mental health case management shall be provided by the recipient's county of responsibility,
317.23 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
317.24 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
317.25 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
317.26 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
317.27 the recipient's county of responsibility.

317.28 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
317.29 and MinnesotaCare include mental health case management. When the service is provided
317.30 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
317.31 share.

317.32 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
317.33 that does not meet the reporting or other requirements of this section. The county of
317.34 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,

318.1 is responsible for any federal disallowances. The county or tribe may share this responsibility
318.2 with its contracted vendors.

318.3 (k) The commissioner shall set aside a portion of the federal funds earned for county
318.4 expenditures under this section to repay the special revenue maximization account under
318.5 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

318.6 (1) the costs of developing and implementing this section; and

318.7 (2) programming the information systems.

318.8 (l) Payments to counties and tribal agencies for case management expenditures under
318.9 this section shall only be made from federal earnings from services provided under this
318.10 section. When this service is paid by the state without a federal share through fee-for-service,
318.11 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
318.12 shall include the federal earnings, the state share, and the county share.

318.13 (m) Case management services under this subdivision do not include therapy, treatment,
318.14 legal, or outreach services.

318.15 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
318.16 and the recipient's institutional care is paid by medical assistance, payment for case
318.17 management services under this subdivision is limited to the lesser of:

318.18 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
318.19 than six months in a calendar year; or

318.20 (2) the limits and conditions which apply to federal Medicaid funding for this service.

318.21 (o) Payment for case management services under this subdivision shall not duplicate
318.22 payments made under other program authorities for the same purpose.

318.23 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
318.24 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
318.25 mental health targeted case management services must actively support identification of
318.26 community alternatives for the recipient and discharge planning.

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

319.1 Sec. 14. Minnesota Statutes 2020, section 256B.0625, subdivision 20b, is amended to
319.2 read:

319.3 Subd. 20b. ~~Mental health~~ **Targeted case management face-to-face contact through**
319.4 **interactive video.** ~~(a) Subject to federal approval, contact made for targeted case management~~
319.5 ~~by interactive video shall be eligible for payment if:~~

319.6 ~~(1) the person receiving targeted case management services is residing in:~~

319.7 ~~(i) a hospital;~~

319.8 ~~(ii) a nursing facility; or~~

319.9 ~~(iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging~~
319.10 ~~establishment or lodging establishment that provides supportive services or health supervision~~
319.11 ~~services according to section 157.17 that is staffed 24 hours a day, seven days a week;~~

319.12 ~~(2) interactive video is in the best interests of the person and is deemed appropriate by~~
319.13 ~~the person receiving targeted case management or the person's legal guardian, the case~~
319.14 ~~management provider, and the provider operating the setting where the person is residing;~~

319.15 ~~(3) the use of interactive video is approved as part of the person's written personal service~~
319.16 ~~or case plan, taking into consideration the person's vulnerability and active personal~~
319.17 ~~relationships; and~~

319.18 ~~(4) interactive video is used for up to, but not more than, 50 percent of the minimum~~
319.19 ~~required face-to-face contact.~~ (a) Minimum required face-to-face contacts for targeted case
319.20 management may be provided through interactive video if interactive video is in the best
319.21 interests of the person and is deemed appropriate by the person receiving targeted case
319.22 management or the person's legal guardian and the case management provider.

319.23 (b) The person receiving targeted case management or the person's legal guardian has
319.24 the right to choose and consent to the use of interactive video under this subdivision and
319.25 has the right to refuse the use of interactive video at any time.

319.26 (c) The commissioner ~~shall~~ may establish criteria that a targeted case management
319.27 provider must attest to in order to demonstrate the safety or efficacy of ~~delivering the service~~
319.28 meeting the minimum face-to-face contact requirements for targeted case management via
319.29 interactive video. ~~The attestation may include that the case management provider has:~~

319.30 ~~(1) written policies and procedures specific to interactive video services that are regularly~~
319.31 ~~reviewed and updated;~~

320.1 ~~(2) policies and procedures that adequately address client safety before, during, and after~~
320.2 ~~the interactive video services are rendered;~~

320.3 ~~(3) established protocols addressing how and when to discontinue interactive video~~
320.4 ~~services; and~~

320.5 ~~(4) established a quality assurance process related to interactive video services.~~

320.6 (d) As a condition of payment, the targeted case management provider must document
320.7 the following for each occurrence of targeted case management provided by interactive
320.8 video for the purpose of face-to-face contact:

320.9 (1) the time the ~~service~~ contact began and the time the ~~service~~ contact ended, including
320.10 an a.m. and p.m. designation;

320.11 (2) the basis for determining that interactive video is an appropriate and effective means
320.12 for ~~delivering the service to~~ contacting the person receiving targeted case management
320.13 services;

320.14 (3) the mode of transmission of the interactive video services and records evidencing
320.15 that a particular mode of transmission was utilized; and

320.16 (4) the location of the originating site and the distant site; and.

320.17 ~~(5) compliance with the criteria attested to by the targeted case management provider~~
320.18 ~~as provided in paragraph (e).~~

320.19 (e) Interactive video must not be used to meet minimum face-to-face contact requirements
320.20 for children who are in out-of-home placement or receiving case management services for
320.21 child protection reasons.

320.22 (f) For the purposes of this section, "interactive video" means real-time, two-way
320.23 interactive audio and visual communications.

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

320.26 Sec. 15. Minnesota Statutes 2020, section 256B.0625, subdivision 46, is amended to read:

320.27 Subd. 46. **Mental health ~~telemedicine~~ telehealth.** ~~Effective January 1, 2006, and Subject~~
320.28 ~~to federal approval, mental health services that are otherwise covered by medical assistance~~
320.29 ~~as direct face-to-face services may be provided via ~~two-way interactive video~~ telehealth as~~
320.30 ~~defined in subdivision 3b. Use of ~~two-way interactive video~~ telehealth to deliver services~~
320.31 ~~must be medically appropriate to the condition and needs of the person being served.~~

321.1 Reimbursement is at the same rates and under the same conditions that would otherwise
321.2 apply to the service. ~~The interactive video equipment and connection must comply with~~
321.3 ~~Medicare standards in effect at the time the service is provided.~~

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

321.7 Sec. 16. Minnesota Statutes 2020, section 256B.0911, subdivision 1a, is amended to read:

321.8 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

321.9 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
321.10 services" means:

321.11 (1) intake for and access to assistance in identifying services needed to maintain an
321.12 individual in the most inclusive environment;

321.13 (2) providing recommendations for and referrals to cost-effective community services
321.14 that are available to the individual;

321.15 (3) development of an individual's person-centered community support plan;

321.16 (4) providing information regarding eligibility for Minnesota health care programs;

321.17 (5) ~~face-to-face~~ long-term care consultation assessments conducted according to
321.18 subdivision 3a, which may be completed in a hospital, nursing facility, intermediate care
321.19 facility for persons with developmental disabilities (ICF/DDs), regional treatment centers,
321.20 or the person's current or planned residence;

321.21 (6) determination of home and community-based waiver and other service eligibility as
321.22 required under chapter 256S and sections 256B.0913, 256B.092, and 256B.49, including
321.23 level of care determination for individuals who need an institutional level of care as
321.24 determined under subdivision 4e, based on a long-term care consultation assessment and
321.25 community support plan development, appropriate referrals to obtain necessary diagnostic
321.26 information, and including an eligibility determination for consumer-directed community
321.27 supports;

321.28 (7) providing recommendations for institutional placement when there are no
321.29 cost-effective community services available;

321.30 (8) providing access to assistance to transition people back to community settings after
321.31 institutional admission;

322.1 (9) providing information about competitive employment, with or without supports, for
322.2 school-age youth and working-age adults and referrals to the Disability Hub and Disability
322.3 Benefits 101 to ensure that an informed choice about competitive employment can be made.
322.4 For the purposes of this subdivision, "competitive employment" means work in the
322.5 competitive labor market that is performed on a full-time or part-time basis in an integrated
322.6 setting, and for which an individual is compensated at or above the minimum wage, but not
322.7 less than the customary wage and level of benefits paid by the employer for the same or
322.8 similar work performed by individuals without disabilities;

322.9 (10) providing information about independent living to ensure that an informed choice
322.10 about independent living can be made; and

322.11 (11) providing information about self-directed services and supports, including
322.12 self-directed funding options, to ensure that an informed choice about self-directed options
322.13 can be made.

322.14 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
322.15 and 3a, "long-term care consultation services" also means:

322.16 (1) service eligibility determination for the following state plan services:

322.17 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

322.18 (ii) consumer support grants under section 256.476; or

322.19 (iii) community first services and supports under section 256B.85;

322.20 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
322.21 gaining access to:

322.22 (i) relocation targeted case management services available under section 256B.0621,
322.23 subdivision 2, clause (4);

322.24 (ii) case management services targeted to vulnerable adults or developmental disabilities
322.25 under section 256B.0924; and

322.26 (iii) case management services targeted to people with developmental disabilities under
322.27 Minnesota Rules, part 9525.0016;

322.28 (3) determination of eligibility for semi-independent living services under section
322.29 252.275; and

322.30 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
322.31 and (3).

323.1 (c) "Long-term care options counseling" means the services provided by sections 256.01,
323.2 subdivision 24, and 256.975, subdivision 7, and also includes telephone assistance and
323.3 follow up once a long-term care consultation assessment has been completed.

323.4 (d) "Minnesota health care programs" means the medical assistance program under this
323.5 chapter and the alternative care program under section 256B.0913.

323.6 (e) "Lead agencies" means counties administering or tribes and health plans under
323.7 contract with the commissioner to administer long-term care consultation services.

323.8 (f) "Person-centered planning" is a process that includes the active participation of a
323.9 person in the planning of the person's services, including in making meaningful and informed
323.10 choices about the person's own goals, talents, and objectives, as well as making meaningful
323.11 and informed choices about the services the person receives, the settings in which the person
323.12 receives the services, and the setting in which the person lives.

323.13 (g) "Informed choice" means a voluntary choice of services, settings, living arrangement,
323.14 and work by a person from all available service and setting options based on accurate and
323.15 complete information concerning all available service and setting options and concerning
323.16 the person's own preferences, abilities, goals, and objectives. In order for a person to make
323.17 an informed choice, all available options must be developed and presented to the person in
323.18 a way the person can understand to empower the person to make fully informed choices.

323.19 (h) "Available service and setting options" or "available options," with respect to the
323.20 home and community-based waivers under chapter 256S and sections 256B.092 and 256B.49,
323.21 means all services and settings defined under the waiver plan for which a waiver applicant
323.22 or waiver participant is eligible.

323.23 (i) "Independent living" means living in a setting that is not controlled by a provider.

323.24 Sec. 17. Minnesota Statutes 2020, section 256B.0911, subdivision 3a, is amended to read:

323.25 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
323.26 planning, or other assistance intended to support community-based living, including persons
323.27 who need assessment in order to determine waiver or alternative care program eligibility,
323.28 must be visited by a long-term care consultation team within 20 calendar days after the date
323.29 on which an assessment was requested or recommended. Upon statewide implementation
323.30 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
323.31 requesting personal care assistance services. The commissioner shall provide at least a
323.32 90-day notice to lead agencies prior to the effective date of this requirement. ~~Face-to-face~~
323.33 Assessments must be conducted according to paragraphs (b) to ~~(i)~~ (q).

324.1 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
324.2 assessors to conduct the assessment. For a person with complex health care needs, a public
324.3 health or registered nurse from the team must be consulted.

324.4 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
324.5 be used to complete a comprehensive, conversation-based, person-centered assessment.
324.6 The assessment must include the health, psychological, functional, environmental, and
324.7 social needs of the individual necessary to develop a person-centered community support
324.8 plan that meets the individual's needs and preferences.

324.9 (d) Except as provided in paragraph (q), the assessment must be conducted by a certified
324.10 assessor in a face-to-face conversational interview with the person being assessed. The
324.11 person's legal representative must provide input during the assessment process and may do
324.12 so remotely if requested. At the request of the person, other individuals may participate in
324.13 the assessment to provide information on the needs, strengths, and preferences of the person
324.14 necessary to develop a community support plan that ensures the person's health and safety.
324.15 Except for legal representatives or family members invited by the person, persons
324.16 participating in the assessment may not be a provider of service or have any financial interest
324.17 in the provision of services. For persons who are to be assessed for elderly waiver customized
324.18 living or adult day services under chapter 256S, with the permission of the person being
324.19 assessed or the person's designated or legal representative, the client's current or proposed
324.20 provider of services may submit a copy of the provider's nursing assessment or written
324.21 report outlining its recommendations regarding the client's care needs. The person conducting
324.22 the assessment must notify the provider of the date by which this information is to be
324.23 submitted. This information shall be provided to the person conducting the assessment prior
324.24 to the assessment. For a person who is to be assessed for waiver services under section
324.25 256B.092 or 256B.49, with the permission of the person being assessed or the person's
324.26 designated legal representative, the person's current provider of services may submit a
324.27 written report outlining recommendations regarding the person's care needs the person
324.28 completed in consultation with someone who is known to the person and has interaction
324.29 with the person on a regular basis. The provider must submit the report at least 60 days
324.30 before the end of the person's current service agreement. The certified assessor must consider
324.31 the content of the submitted report prior to finalizing the person's assessment or reassessment.

324.32 (e) The certified assessor and the individual responsible for developing the coordinated
324.33 service and support plan must complete the community support plan and the coordinated
324.34 service and support plan no more than 60 calendar days from the assessment visit. The
324.35 person or the person's legal representative must be provided with a written community

325.1 support plan within the timelines established by the commissioner, regardless of whether
325.2 the person is eligible for Minnesota health care programs.

325.3 (f) For a person being assessed for elderly waiver services under chapter 256S, a provider
325.4 who submitted information under paragraph (d) shall receive the final written community
325.5 support plan when available and the Residential Services Workbook.

325.6 (g) The written community support plan must include:

325.7 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

325.8 (2) the individual's options and choices to meet identified needs, including:

325.9 (i) all available options for case management services and providers;

325.10 (ii) all available options for employment services, settings, and providers;

325.11 (iii) all available options for living arrangements;

325.12 (iv) all available options for self-directed services and supports, including self-directed
325.13 budget options; and

325.14 (v) service provided in a non-disability-specific setting;

325.15 (3) identification of health and safety risks and how those risks will be addressed,
325.16 including personal risk management strategies;

325.17 (4) referral information; and

325.18 (5) informal caregiver supports, if applicable.

325.19 For a person determined eligible for state plan home care under subdivision 1a, paragraph
325.20 (b), clause (1), the person or person's representative must also receive a copy of the home
325.21 care service plan developed by the certified assessor.

325.22 (h) A person may request assistance in identifying community supports without
325.23 participating in a complete assessment. Upon a request for assistance identifying community
325.24 support, the person must be transferred or referred to long-term care options counseling
325.25 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
325.26 telephone assistance and follow up.

325.27 (i) The person has the right to make the final decision:

325.28 (1) between institutional placement and community placement after the recommendations
325.29 have been provided, except as provided in section 256.975, subdivision 7a, paragraph (d);

326.1 (2) between community placement in a setting controlled by a provider and living
326.2 independently in a setting not controlled by a provider;

326.3 (3) between day services and employment services; and

326.4 (4) regarding available options for self-directed services and supports, including
326.5 self-directed funding options.

326.6 (j) The lead agency must give the person receiving long-term care consultation services
326.7 or the person's legal representative, materials, and forms supplied by the commissioner
326.8 containing the following information:

326.9 (1) written recommendations for community-based services and consumer-directed
326.10 options;

326.11 (2) documentation that the most cost-effective alternatives available were offered to the
326.12 individual. For purposes of this clause, "cost-effective" means community services and
326.13 living arrangements that cost the same as or less than institutional care. For an individual
326.14 found to meet eligibility criteria for home and community-based service programs under
326.15 chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally
326.16 approved waiver plan for each program;

326.17 (3) the need for and purpose of preadmission screening conducted by long-term care
326.18 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
326.19 nursing facility placement. If the individual selects nursing facility placement, the lead
326.20 agency shall forward information needed to complete the level of care determinations and
326.21 screening for developmental disability and mental illness collected during the assessment
326.22 to the long-term care options counselor using forms provided by the commissioner;

326.23 (4) the role of long-term care consultation assessment and support planning in eligibility
326.24 determination for waiver and alternative care programs, and state plan home care, case
326.25 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
326.26 and (b);

326.27 (5) information about Minnesota health care programs;

326.28 (6) the person's freedom to accept or reject the recommendations of the team;

326.29 (7) the person's right to confidentiality under the Minnesota Government Data Practices
326.30 Act, chapter 13;

326.31 (8) the certified assessor's decision regarding the person's need for institutional level of
326.32 care as determined under criteria established in subdivision 4e and the certified assessor's

327.1 decision regarding eligibility for all services and programs as defined in subdivision 1a,
327.2 paragraphs (a), clause (6), and (b);

327.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
327.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
327.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
327.6 or the lead agency's final decisions regarding public programs eligibility according to section
327.7 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right
327.8 to the person and must visually point out where in the document the right to appeal is stated;
327.9 and

327.10 (10) documentation that available options for employment services, independent living,
327.11 and self-directed services and supports were described to the individual.

327.12 (k) ~~Face-to-face~~ Assessment completed as part of an eligibility determination for multiple
327.13 programs for the alternative care, elderly waiver, developmental disabilities, community
327.14 access for disability inclusion, community alternative care, and brain injury waiver programs
327.15 under chapter 256S and sections 256B.0913, 256B.092, and 256B.49 is valid to establish
327.16 service eligibility for no more than 60 calendar days after the date of assessment.

327.17 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
327.18 to the date of assessment. If an assessment was completed more than 60 days before the
327.19 effective waiver or alternative care program eligibility start date, assessment and support
327.20 plan information must be updated and documented in the department's Medicaid Management
327.21 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
327.22 state plan services, the effective date of eligibility for programs included in paragraph (k)
327.23 cannot be prior to the date the most recent updated assessment is completed.

327.24 (m) If an eligibility update is completed within 90 days of the previous ~~face-to-face~~
327.25 assessment and documented in the department's Medicaid Management Information System
327.26 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
327.27 of the previous ~~face-to-face~~ assessment when all other eligibility requirements are met.

327.28 (n) At the time of reassessment, the certified assessor shall assess each person receiving
327.29 waiver residential supports and services currently residing in a community residential setting,
327.30 licensed adult foster care home that is either not the primary residence of the license holder
327.31 or in which the license holder is not the primary caregiver, family adult foster care residence,
327.32 customized living setting, or supervised living facility to determine if that person would
327.33 prefer to be served in a community-living setting as defined in section 256B.49, subdivision
327.34 23, in a setting not controlled by a provider, or to receive integrated community supports

328.1 as described in section 245D.03, subdivision 1, paragraph (c), clause (8). The certified
328.2 assessor shall offer the person, through a person-centered planning process, the option to
328.3 receive alternative housing and service options.

328.4 (o) At the time of reassessment, the certified assessor shall assess each person receiving
328.5 waiver day services to determine if that person would prefer to receive employment services
328.6 as described in section 245D.03, subdivision 1, paragraph (c), clauses (5) to (7). The certified
328.7 assessor shall describe to the person through a person-centered planning process the option
328.8 to receive employment services.

328.9 (p) At the time of reassessment, the certified assessor shall assess each person receiving
328.10 non-self-directed waiver services to determine if that person would prefer an available
328.11 service and setting option that would permit self-directed services and supports. The certified
328.12 assessor shall describe to the person through a person-centered planning process the option
328.13 to receive self-directed services and supports.

328.14 (q) All assessments performed according to this subdivision must be face-to-face unless
328.15 the assessment is a reassessment meeting the requirements of this paragraph. Subject to
328.16 federal approval, remote reassessments conducted by interactive video or telephone may
328.17 substitute for face-to-face reassessments for services provided by alternative care under
328.18 section 256B.0913, the elderly waiver under chapter 256S, the developmental disabilities
328.19 waiver under section 256B.092, and the community access for disability inclusion,
328.20 community alternative care, and brain injury waiver programs under section 256B.49.
328.21 Remote reassessments may be substituted for two consecutive reassessments if followed
328.22 by a face-to-face reassessment. A remote reassessment is permitted only if the person being
328.23 reassessed, the person's legal representative, and the lead agency case manager all agree
328.24 that there is no change in the person's condition, there is no need for a change in service,
328.25 and that a remote reassessment is appropriate. The person being reassessed, or the person's
328.26 legal representative, has the right to refuse a remote reassessment at any time. During a
328.27 remote reassessment, if the certified assessor determines in the assessor's sole judgment
328.28 that a remote reassessment is inappropriate, the certified assessor shall suspend the remote
328.29 reassessment and schedule a face-to-face reassessment to complete the reassessment. All
328.30 other requirements of a face-to-face reassessment apply to a remote reassessment.

328.31 Sec. 18. Minnesota Statutes 2020, section 256B.0911, subdivision 3f, is amended to read:

328.32 Subd. 3f. **Long-term care reassessments and community support plan updates.** (a)
328.33 Prior to a ~~face-to-face~~ reassessment, the certified assessor must review the person's most
328.34 recent assessment. Reassessments must be tailored using the professional judgment of the

329.1 assessor to the person's known needs, strengths, preferences, and circumstances.
329.2 Reassessments provide information to support the person's informed choice and opportunities
329.3 to express choice regarding activities that contribute to quality of life, as well as information
329.4 and opportunity to identify goals related to desired employment, community activities, and
329.5 preferred living environment. Reassessments require a review of the most recent assessment,
329.6 review of the current coordinated service and support plan's effectiveness, monitoring of
329.7 services, and the development of an updated person-centered community support plan.
329.8 Reassessments must verify continued eligibility, offer alternatives as warranted, and provide
329.9 an opportunity for quality assurance of service delivery. ~~Face-to-face~~ Reassessments must
329.10 be conducted annually or as required by federal and state laws and rules. For reassessments,
329.11 the certified assessor and the individual responsible for developing the coordinated service
329.12 and support plan must ensure the continuity of care for the person receiving services and
329.13 complete the updated community support plan and the updated coordinated service and
329.14 support plan no more than 60 days from the reassessment visit.

329.15 (b) The commissioner shall develop mechanisms for providers and case managers to
329.16 share information with the assessor to facilitate a reassessment and support planning process
329.17 tailored to the person's current needs and preferences.

329.18 Sec. 19. Minnesota Statutes 2020, section 256B.0911, subdivision 4d, is amended to read:

329.19 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
329.20 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
329.21 are served in the most integrated setting appropriate to their needs and have the necessary
329.22 information to make informed choices about home and community-based service options.

329.23 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
329.24 facility must be screened prior to admission according to the requirements outlined in section
329.25 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
329.26 required under section 256.975, subdivision 7.

329.27 (c) Individuals under 65 years of age who are admitted to nursing facilities with only a
329.28 telephone screening must receive a face-to-face assessment from the long-term care
329.29 consultation team member of the county in which the facility is located or from the recipient's
329.30 county case manager within the timeline established by the commissioner, based on review
329.31 of data.

329.32 (d) At the face-to-face assessment, the long-term care consultation team member or
329.33 county case manager must perform the activities required under subdivision 3b.

330.1 (e) For individuals under 21 years of age, a screening interview which recommends
330.2 nursing facility admission must be face-to-face and approved by the commissioner before
330.3 the individual is admitted to the nursing facility.

330.4 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
330.5 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the
330.6 next working day, and a face-to-face assessment as described in paragraph (c) must be
330.7 conducted within the timeline established by the commissioner, based on review of data.

330.8 (g) At the face-to-face assessment, the long-term care consultation team member or the
330.9 case manager must present information about home and community-based options, including
330.10 consumer-directed options, so the individual can make informed choices. If the individual
330.11 chooses home and community-based services, the long-term care consultation team member
330.12 or case manager must complete a written relocation plan within 20 working days of the
330.13 visit. The plan shall describe the services needed to move out of the facility and a time line
330.14 for the move which is designed to ensure a smooth transition to the individual's home and
330.15 community.

330.16 (h) An individual under 65 years of age residing in a nursing facility shall receive a
330.17 ~~face-to-face assessment~~ reassessment at least every 12 months to review the person's service
330.18 choices and available alternatives unless the individual indicates, in writing, that annual
330.19 visits are not desired. In this case, the individual must receive a ~~face-to-face assessment~~
330.20 reassessment at least once every 36 months for the same purposes. A remote reassessment
330.21 is permitted only if the person being reassessed, the person's legal representative, and the
330.22 lead agency case manager all agree that there is no change in the person's condition, there
330.23 is no need for a change in service, and that a remote reassessment is appropriate. The person
330.24 being reassessed, or the person's legal representative, has the right to refuse a remote
330.25 reassessment at any time. During a remote reassessment, if the certified assessor determines
330.26 in the assessor's sole judgment that a remote reassessment is inappropriate, the certified
330.27 assessor shall suspend the remote reassessment and schedule a face-to-face reassessment
330.28 to complete the reassessment. All other requirements of a face-to-face reassessment apply
330.29 to a remote reassessment.

330.30 (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
330.31 agencies directly for ~~face-to-face~~ assessments for individuals under 65 years of age who
330.32 are being considered for placement or residing in a nursing facility.

330.33 (j) Funding for preadmission screening follow-up shall be provided to the Disability
330.34 Hub for the under-60 population by the Department of Human Services to cover options

331.1 counseling salaries and expenses to provide the services described in subdivisions 7a to 7c.
331.2 The Disability Hub shall employ, or contract with other agencies to employ, within the
331.3 limits of available funding, sufficient personnel to provide preadmission screening follow-up
331.4 services and shall seek to maximize federal funding for the service as provided under section
331.5 256.01, subdivision 2, paragraph (aa).

331.6 Sec. 20. Minnesota Statutes 2020, section 256B.0924, subdivision 6, is amended to read:

331.7 Subd. 6. **Payment for targeted case management.** (a) Medical assistance and
331.8 MinnesotaCare payment for targeted case management shall be made on a monthly basis.
331.9 In order to receive payment for an eligible adult, the provider must document at least one
331.10 contact per month and not more than two consecutive months without a face-to-face contact
331.11 or a contact by interactive video that meets the requirements of section 256B.0625,
331.12 subdivision 20b, with the adult or the adult's legal representative, family, primary caregiver,
331.13 or other relevant persons identified as necessary to the development or implementation of
331.14 the goals of the personal service plan.

331.15 (b) Payment for targeted case management provided by county staff under this subdivision
331.16 shall be based on the monthly rate methodology under section 256B.094, subdivision 6,
331.17 paragraph (b), calculated as one combined average rate together with adult mental health
331.18 case management under section 256B.0625, subdivision 20, except for calendar year 2002.
331.19 In calendar year 2002, the rate for case management under this section shall be the same as
331.20 the rate for adult mental health case management in effect as of December 31, 2001. Billing
331.21 and payment must identify the recipient's primary population group to allow tracking of
331.22 revenues.

331.23 (c) Payment for targeted case management provided by county-contracted vendors shall
331.24 be based on a monthly rate negotiated by the host county. The negotiated rate must not
331.25 exceed the rate charged by the vendor for the same service to other payers. If the service is
331.26 provided by a team of contracted vendors, the county may negotiate a team rate with a
331.27 vendor who is a member of the team. The team shall determine how to distribute the rate
331.28 among its members. No reimbursement received by contracted vendors shall be returned
331.29 to the county, except to reimburse the county for advance funding provided by the county
331.30 to the vendor.

331.31 (d) If the service is provided by a team that includes contracted vendors and county staff,
331.32 the costs for county staff participation on the team shall be included in the rate for
331.33 county-provided services. In this case, the contracted vendor and the county may each
331.34 receive separate payment for services provided by each entity in the same month. In order

332.1 to prevent duplication of services, the county must document, in the recipient's file, the need
332.2 for team targeted case management and a description of the different roles of the team
332.3 members.

332.4 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
332.5 targeted case management shall be provided by the recipient's county of responsibility, as
332.6 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
332.7 used to match other federal funds.

332.8 (f) The commissioner may suspend, reduce, or terminate reimbursement to a provider
332.9 that does not meet the reporting or other requirements of this section. The county of
332.10 responsibility, as defined in sections 256G.01 to 256G.12, is responsible for any federal
332.11 disallowances. The county may share this responsibility with its contracted vendors.

332.12 (g) The commissioner shall set aside five percent of the federal funds received under
332.13 this section for use in reimbursing the state for costs of developing and implementing this
332.14 section.

332.15 (h) Payments to counties for targeted case management expenditures under this section
332.16 shall only be made from federal earnings from services provided under this section. Payments
332.17 to contracted vendors shall include both the federal earnings and the county share.

332.18 (i) Notwithstanding section 256B.041, county payments for the cost of case management
332.19 services provided by county staff shall not be made to the commissioner of management
332.20 and budget. For the purposes of targeted case management services provided by county
332.21 staff under this section, the centralized disbursement of payments to counties under section
332.22 256B.041 consists only of federal earnings from services provided under this section.

332.23 (j) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
332.24 and the recipient's institutional care is paid by medical assistance, payment for targeted case
332.25 management services under this subdivision is limited to the lesser of:

332.26 (1) the last 180 days of the recipient's residency in that facility; or

332.27 (2) the limits and conditions which apply to federal Medicaid funding for this service.

332.28 (k) Payment for targeted case management services under this subdivision shall not
332.29 duplicate payments made under other program authorities for the same purpose.

332.30 (l) Any growth in targeted case management services and cost increases under this
332.31 section shall be the responsibility of the counties.

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

333.3 Sec. 21. Minnesota Statutes 2020, section 256B.094, subdivision 6, is amended to read:

333.4 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
333.5 assistance reimbursement for services under this section shall be made on a monthly basis.
333.6 Payment is based on face-to-face, interactive video, or telephone contacts between the case
333.7 manager and the client, client's family, primary caregiver, legal representative, or other
333.8 relevant person identified as necessary to the development or implementation of the goals
333.9 of the individual service plan regarding the status of the client, the individual service plan,
333.10 or the goals for the client. These contacts must meet the minimum standards in clauses (1)
333.11 and (2):

333.12 (1) there must be a face-to-face contact, or a contact by interactive video that meets the
333.13 requirements of section 256B.0625, subdivision 20b, at least once a month except as provided
333.14 in clause (2); and

333.15 (2) for a client placed outside of the county of financial responsibility, or a client served
333.16 by tribal social services placed outside the reservation, in an excluded time facility under
333.17 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
333.18 Children, section 260.93, and the placement in either case is more than 60 miles beyond
333.19 the county or reservation boundaries, there must be at least one contact per month and not
333.20 more than two consecutive months without a face-to-face contact.

333.21 Face-to-face contacts under this paragraph may be conducted using interactive video for
333.22 up to two consecutive contacts following each in-person contact.

333.23 (b) Except as provided under paragraph (c), the payment rate is established using time
333.24 study data on activities of provider service staff and reports required under sections 245.482
333.25 and 256.01, subdivision 2, paragraph (p).

333.26 (c) Payments for tribes may be made according to section 256B.0625 or other relevant
333.27 federally approved rate setting methodology for child welfare targeted case management
333.28 provided by Indian health services and facilities operated by a tribe or tribal organization.

333.29 (d) Payment for case management provided by county or tribal social services contracted
333.30 vendors shall be based on a monthly rate negotiated by the host county or tribal social
333.31 services. The negotiated rate must not exceed the rate charged by the vendor for the same
333.32 service to other payers. If the service is provided by a team of contracted vendors, the county
333.33 or tribal social services may negotiate a team rate with a vendor who is a member of the

334.1 team. The team shall determine how to distribute the rate among its members. No
334.2 reimbursement received by contracted vendors shall be returned to the county or tribal social
334.3 services, except to reimburse the county or tribal social services for advance funding provided
334.4 by the county or tribal social services to the vendor.

334.5 (e) If the service is provided by a team that includes contracted vendors and county or
334.6 tribal social services staff, the costs for county or tribal social services staff participation in
334.7 the team shall be included in the rate for county or tribal social services provided services.
334.8 In this case, the contracted vendor and the county or tribal social services may each receive
334.9 separate payment for services provided by each entity in the same month. To prevent
334.10 duplication of services, each entity must document, in the recipient's file, the need for team
334.11 case management and a description of the roles and services of the team members.

334.12 (f) Separate payment rates may be established for different groups of providers to
334.13 maximize reimbursement as determined by the commissioner. The payment rate will be
334.14 reviewed annually and revised periodically to be consistent with the most recent time study
334.15 and other data. Payment for services will be made upon submission of a valid claim and
334.16 verification of proper documentation described in subdivision 7. Federal administrative
334.17 revenue earned through the time study, or under paragraph (c), shall be distributed according
334.18 to earnings, to counties, reservations, or groups of counties or reservations which have the
334.19 same payment rate under this subdivision, and to the group of counties or reservations which
334.20 are not certified providers under section 256F.10. The commissioner shall modify the
334.21 requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to
334.22 accomplish this.

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

334.25 Sec. 22. Minnesota Statutes 2020, section 256B.49, subdivision 14, is amended to read:

334.26 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments shall be
334.27 conducted by certified assessors according to section 256B.0911, subdivision 2b.

334.28 (b) There must be a determination that the client requires a hospital level of care or a
334.29 nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and
334.30 subsequent assessments to initiate and maintain participation in the waiver program.

334.31 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
334.32 appropriate to determine nursing facility level of care for purposes of medical assistance
334.33 payment for nursing facility services, only ~~face-to-face~~ assessments conducted according

335.1 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
335.2 determination or a nursing facility level of care determination must be accepted for purposes
335.3 of initial and ongoing access to waiver services payment.

335.4 (d) Recipients who are found eligible for home and community-based services under
335.5 this section before their 65th birthday may remain eligible for these services after their 65th
335.6 birthday if they continue to meet all other eligibility factors.

335.7 Sec. 23. Minnesota Statutes 2020, section 256J.09, subdivision 3, is amended to read:

335.8 Subd. 3. **Submitting application form.** (a) A county agency must offer, in person or
335.9 by mail, the application forms prescribed by the commissioner as soon as a person makes
335.10 a written or oral inquiry. At that time, the county agency must:

335.11 (1) inform the person that assistance begins ~~with~~ on the date ~~that the signed~~ application
335.12 is received by the county agency either as a written application; an application submitted
335.13 by telephone; or an application submitted through Internet telepresence; or on the date that
335.14 all eligibility criteria are met, whichever is later;

335.15 (2) inform a person that the person may submit the application by telephone or through
335.16 Internet telepresence;

335.17 (3) inform a person that when the person submits the application by telephone or through
335.18 Internet telepresence, the county agency must receive a signed written application within
335.19 30 days of the date that the person submitted the application by telephone or through Internet
335.20 telepresence;

335.21 (4) inform the person that any delay in submitting the application will reduce the amount
335.22 of assistance paid for the month of application;

335.23 ~~(3)~~ (5) inform a person that the person may submit the application before an interview;

335.24 ~~(4)~~ (6) explain the information that will be verified during the application process by
335.25 the county agency as provided in section 256J.32;

335.26 ~~(5)~~ (7) inform a person about the county agency's average application processing time
335.27 and explain how the application will be processed under subdivision 5;

335.28 ~~(6)~~ (8) explain how to contact the county agency if a person's application information
335.29 changes and how to withdraw the application;

335.30 ~~(7)~~ (9) inform a person that the next step in the application process is an interview and
335.31 what a person must do if the application is approved including, but not limited to, attending

336.1 orientation under section 256J.45 and complying with employment and training services
336.2 requirements in sections 256J.515 to 256J.57;

336.3 ~~(8)~~ (10) inform the person that ~~the~~ an interview must be conducted. The interview may
336.4 be conducted face-to-face in the county office or at a location mutually agreed upon, through
336.5 Internet telepresence, ~~or at a location mutually agreed upon~~ by telephone;

336.6 ~~(9) inform a person who has received MFIP or DWP in the past 12 months of the option~~
336.7 ~~to have a face-to-face, Internet telepresence, or telephone interview;~~

336.8 ~~(10)~~ (11) explain the child care and transportation services that are available under
336.9 paragraph (c) to enable caregivers to attend the interview, screening, and orientation; and

336.10 ~~(11)~~ (12) identify any language barriers and arrange for translation assistance during
336.11 appointments, including, but not limited to, screening under subdivision 3a, orientation
336.12 under section 256J.45, and assessment under section 256J.521.

336.13 (b) Upon receipt of a signed application, the county agency must stamp the date of receipt
336.14 on the face of the application. The county agency must process the application within the
336.15 time period required under subdivision 5. An applicant may withdraw the application at
336.16 any time by giving written or oral notice to the county agency. The county agency must
336.17 issue a written notice confirming the withdrawal. The notice must inform the applicant of
336.18 the county agency's understanding that the applicant has withdrawn the application and no
336.19 longer wants to pursue it. When, within ten days of the date of the agency's notice, an
336.20 applicant informs a county agency, in writing, that the applicant does not wish to withdraw
336.21 the application, the county agency must reinstate the application and finish processing the
336.22 application.

336.23 (c) Upon a participant's request, the county agency must arrange for transportation and
336.24 child care or reimburse the participant for transportation and child care expenses necessary
336.25 to enable participants to attend the screening under subdivision 3a and orientation under
336.26 section 256J.45.

336.27 Sec. 24. Minnesota Statutes 2020, section 256J.45, subdivision 1, is amended to read:

336.28 Subdivision 1. **County agency to provide orientation.** A county agency must provide
336.29 ~~a face-to-face~~ an orientation to each MFIP caregiver unless the caregiver is:

336.30 (1) a single parent, or one parent in a two-parent family, employed at least 35 hours per
336.31 week; or

337.1 (2) a second parent in a two-parent family who is employed for 20 or more hours per
337.2 week provided the first parent is employed at least 35 hours per week.

337.3 The county agency must inform caregivers who are not exempt under clause (1) or (2) that
337.4 failure to attend the orientation is considered an occurrence of noncompliance with program
337.5 requirements, and will result in the imposition of a sanction under section 256J.46. If the
337.6 client complies with the orientation requirement prior to the first day of the month in which
337.7 the grant reduction is proposed to occur, the orientation sanction shall be lifted.

337.8 Sec. 25. Minnesota Statutes 2020, section 256S.05, subdivision 2, is amended to read:

337.9 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
337.10 assessments identified in section 144.0724, subdivision 4, only ~~face-to-face~~ assessments
337.11 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
337.12 facility level of care determination at initial and subsequent assessments shall be accepted
337.13 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
337.14 service provider's access to service payments under this chapter.

337.15 Sec. 26. **STUDY OF TELEHEALTH.**

337.16 (a) The commissioner of health, in consultation with the commissioners of human services
337.17 and commerce, shall study the impact of telehealth payment methodologies and expansion
337.18 under the Minnesota Telehealth Act on the coverage and provision of health care services
337.19 under public health care programs and private health insurance. The study shall review and
337.20 make recommendations related to:

337.21 (1) the impact of telehealth payment methodologies and expansion on access to health
337.22 care services, quality of care, and value-based payments and innovation in care delivery;

337.23 (2) the short-term and long-term impacts of telehealth payment methodologies and
337.24 expansion in reducing health care disparities and providing equitable access for underserved
337.25 communities;

337.26 (3) the use of audio-only communication in supporting equitable access to health care
337.27 services, including behavioral health services for the elderly, rural communities, and
337.28 communities of color, and eliminating barriers for vulnerable and underserved populations;

337.29 (4) whether there is evidence to suggest that increased access to telehealth improves
337.30 health outcomes and, if so, for which services and populations; and

337.31 (5) the effect of payment parity on public and private health care costs, health care
337.32 premiums, and health outcomes.

338.1 (b) When conducting the study, the commissioner shall consult with stakeholders and
338.2 communities impacted by telehealth payment and expansion. The commissioner,
338.3 notwithstanding Minnesota Statutes, section 62U.04, subdivision 11, may use data available
338.4 under that section to conduct the study. The commissioner shall report findings to the chairs
338.5 and ranking minority members of the legislative committees with jurisdiction over health
338.6 care policy and finance and commerce, by February 15, 2023.

338.7 Sec. 27. **EFFECTIVE DATE.**

338.8 The amendments in this article to, or establishing, the following provisions of Minnesota
338.9 Statutes are effective January 1, 2022: 245G.01, subdivision 26; 245G.06, subdivision 1;
338.10 256B.0596; and 256B.0625, subdivisions 3h and 13h.

338.11 Sec. 28. **EXPIRATION DATE.**

338.12 (a) The amendments in this article to, or establishing, the following provisions of
338.13 Minnesota Statutes expire July 1, 2023: 245G.01, subdivision 13; 245G.01, subdivision 26;
338.14 245G.06, subdivision 1; 254A.19, subdivision 5; 254B.05, subdivision 5; 256B.0596; and
338.15 256B.0625, subdivisions 3b, 3h, 13h, and 46.

338.16 (b) Notwithstanding paragraph (a), the definition of "originating site" in Minnesota
338.17 Statutes, section 256B.0625, subdivision 3b, paragraph (d), clause (3), shall not expire.

338.18 Sec. 29. **REVISOR INSTRUCTION.**

338.19 The revisor of statutes shall substitute the term "telemedicine" with "telehealth" whenever
338.20 the term appears in Minnesota Statutes and substitute Minnesota Statutes, section 62A.673,
338.21 whenever references to Minnesota Statutes, sections 62A.67, 62A.671, and 62A.672, appear
338.22 in Minnesota Statutes.

338.23 Sec. 30. **REPEALER.**

338.24 (a) Minnesota Statutes 2020, sections 62A.67; 62A.671; and 62A.672, are repealed.

338.25 (b) Minnesota Statutes 2020, sections 256B.0596; and 256B.0924, subdivision 4a, are
338.26 repealed upon federal approval. The commissioner of human services shall notify the revisor
338.27 of statutes when federal approval is obtained.

338.28 **ARTICLE 8**

338.29 **APPROPRIATIONS**

338.30 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

340.1 Regulations, title 45, section 263.1. In order
340.2 to meet these basic TANF/MOE requirements,
340.3 the commissioner may report as TANF/MOE
340.4 expenditures only nonfederal money expended
340.5 for allowable activities listed in the following
340.6 clauses:

340.7 (1) MFIP cash, diversionary work program,
340.8 and food assistance benefits under Minnesota
340.9 Statutes, chapter 256J;

340.10 (2) the child care assistance programs under
340.11 Minnesota Statutes, sections 119B.03 and
340.12 119B.05, and county child care administrative
340.13 costs under Minnesota Statutes, section
340.14 119B.15;

340.15 (3) state and county MFIP administrative costs
340.16 under Minnesota Statutes, chapters 256J and
340.17 256K;

340.18 (4) state, county, and tribal MFIP employment
340.19 services under Minnesota Statutes, chapters
340.20 256J and 256K;

340.21 (5) expenditures made on behalf of legal
340.22 noncitizen MFIP recipients who qualify for
340.23 the MinnesotaCare program under Minnesota
340.24 Statutes, chapter 256L;

340.25 (6) qualifying working family credit
340.26 expenditures under Minnesota Statutes, section
340.27 290.0671;

340.28 (7) qualifying Minnesota education credit
340.29 expenditures under Minnesota Statutes, section
340.30 290.0674; and

340.31 (8) qualifying Head Start expenditures under
340.32 Minnesota Statutes, section 119A.50.

341.1 **(b) Nonfederal Expenditures; Reporting.**
341.2 For the activities listed in paragraph (a),
341.3 clauses (2) to (8), the commissioner may
341.4 report only expenditures that are excluded
341.5 from the definition of assistance under Code
341.6 of Federal Regulations, title 45, section
341.7 260.31.

341.8 **(c) Certain Expenditures Required. The**
341.9 commissioner shall ensure that the MOE used
341.10 by the commissioner of management and
341.11 budget for the February and November
341.12 forecasts required under Minnesota Statutes,
341.13 section 16A.103, contains expenditures under
341.14 paragraph (a), clause (1), equal to at least 16
341.15 percent of the total required under Code of
341.16 Federal Regulations, title 45, section 263.1.

341.17 **(d) Limitation; Exceptions. The**
341.18 commissioner must not claim an amount of
341.19 TANF/MOE in excess of the 75 percent
341.20 standard in Code of Federal Regulations, title
341.21 45, section 263.1(a)(2), except:

341.22 (1) to the extent necessary to meet the 80
341.23 percent standard under Code of Federal
341.24 Regulations, title 45, section 263.1(a)(1), if it
341.25 is determined by the commissioner that the
341.26 state will not meet the TANF work
341.27 participation target rate for the current year;

341.28 (2) to provide any additional amounts under
341.29 Code of Federal Regulations, title 45, section
341.30 264.5, that relate to replacement of TANF
341.31 funds due to the operation of TANF penalties;
341.32 and

341.33 (3) to provide any additional amounts that may
341.34 contribute to avoiding or reducing TANF work

342.1 participation penalties through the operation
342.2 of the excess MOE provisions of Code of
342.3 Federal Regulations, title 45, section 261.43
342.4 (a)(2).

342.5 **(e) Supplemental Expenditures.** For the
342.6 purposes of paragraph (d), the commissioner
342.7 may supplement the MOE claim with working
342.8 family credit expenditures or other qualified
342.9 expenditures to the extent such expenditures
342.10 are otherwise available after considering the
342.11 expenditures allowed in this subdivision.

342.12 **(f) Reduction of Appropriations; Exception.**
342.13 The requirement in Minnesota Statutes, section
342.14 256.011, subdivision 3, that federal grants or
342.15 aids secured or obtained under that subdivision
342.16 be used to reduce any direct appropriations
342.17 provided by law, does not apply if the grants
342.18 or aids are federal TANF funds.

342.19 **(g) IT Appropriations Generally.** This
342.20 appropriation includes funds for information
342.21 technology projects, services, and support.
342.22 Notwithstanding Minnesota Statutes, section
342.23 16E.0466, funding for information technology
342.24 project costs shall be incorporated into the
342.25 service level agreement and paid to the Office
342.26 of MN.IT Services by the Department of
342.27 Human Services under the rates and
342.28 mechanism specified in that agreement.

342.29 **(h) Receipts for Systems Project.**
342.30 Appropriations and federal receipts for
342.31 information systems projects for MAXIS,
342.32 PRISM, MMIS, ISDS, METS, and SSIS must
342.33 be deposited in the state systems account
342.34 authorized in Minnesota Statutes, section
342.35 256.014. Money appropriated for computer

343.1 projects approved by the commissioner of the
343.2 Office of MN.IT Services, funded by the
343.3 legislature, and approved by the commissioner
343.4 of management and budget may be transferred
343.5 from one project to another and from
343.6 development to operations as the
343.7 commissioner of human services considers
343.8 necessary. Any unexpended balance in the
343.9 appropriation for these projects does not
343.10 cancel and is available for ongoing
343.11 development and operations.

343.12 **(i) Federal SNAP Education and Training**
343.13 **Grants.** Federal funds available during fiscal
343.14 years 2022 and 2023 for Supplemental
343.15 Nutrition Assistance Program Education and
343.16 Training and SNAP Quality Control
343.17 Performance Bonus grants are appropriated
343.18 to the commissioner of human services for the
343.19 purposes allowable under the terms of the
343.20 federal award. This paragraph is effective the
343.21 day following final enactment.

343.22 **Subd. 3. Information Technology**

343.23 **(a) IT Appropriations Generally.** This
343.24 appropriation includes funds for information
343.25 technology projects, services, and support.
343.26 Notwithstanding Minnesota Statutes, section
343.27 16E.0466, funding for information technology
343.28 project costs shall be incorporated into the
343.29 service level agreement and paid to the Office
343.30 of MN.IT Services by the Department of
343.31 Human Services under the rates and
343.32 mechanism specified in that agreement.

343.33 **(b) Receipts for Systems Project.**
343.34 Appropriations and federal receipts for
343.35 information systems projects for MAXIS,

344.1 PRISM, MMIS, ISDS, METS, and SSIS must
 344.2 be deposited in the state systems account
 344.3 authorized in Minnesota Statutes, section
 344.4 256.014. Money appropriated for computer
 344.5 projects approved by the commissioner of the
 344.6 Office of MN.IT Services, funded by the
 344.7 legislature, and approved by the commissioner
 344.8 of management and budget may be transferred
 344.9 from one project to another and from
 344.10 development to operations as the
 344.11 commissioner of human services considers
 344.12 necessary. Any unexpended balance in the
 344.13 appropriation for these projects does not
 344.14 cancel and is available for ongoing
 344.15 development and operations.

344.16 **Subd. 4. Central Office; Operations**

344.17	<u>Appropriations by Fund</u>	
344.18	<u>General</u>	<u>174,080,000</u> <u>167,456,000</u>
344.19	<u>State Government</u>	
344.20	<u>Special Revenue</u>	<u>4,174,000</u> <u>4,174,000</u>
344.21	<u>Health Care Access</u>	<u>16,966,000</u> <u>16,966,000</u>
344.22	<u>Federal TANF</u>	<u>100,000</u> <u>100,000</u>

344.23 **(a) Administrative Recovery; Set-Aside. The**
 344.24 commissioner may invoice local entities
 344.25 through the SWIFT accounting system as an
 344.26 alternative means to recover the actual cost of
 344.27 administering the following provisions:
 344.28 (1) Minnesota Statutes, section 125A.744,
 344.29 subdivision 3;
 344.30 (2) Minnesota Statutes, section 245.495,
 344.31 paragraph (b);
 344.32 (3) Minnesota Statutes, section 256B.0625,
 344.33 subdivision 20, paragraph (k);

- 345.1 (4) Minnesota Statutes, section 256B.0924,
345.2 subdivision 6, paragraph (g);
- 345.3 (5) Minnesota Statutes, section 256B.0945,
345.4 subdivision 4, paragraph (d); and
- 345.5 (6) Minnesota Statutes, section 256F.10,
345.6 subdivision 6, paragraph (b).
- 345.7 **(b) Background Studies.** (1) \$2,074,000 in
345.8 fiscal year 2022 is from the general fund to
345.9 provide a credit to providers who paid for
345.10 emergency background studies in NETStudy
345.11 2.0.
- 345.12 (2) \$2,061,000 in fiscal year 2022 is from the
345.13 general fund to cover the costs of reprocessing
345.14 emergency studies conducted under
345.15 interagency agreements with other agencies.
- 345.16 **(c) Personal Care Assistance Compensation**
345.17 **for Services Provided by a Parent or**
345.18 **Spouse.** \$349,000 in fiscal year 2022 is from
345.19 the general fund for compensation for personal
345.20 care assistance services provided by a parent
345.21 or spouse under Laws 2020, Fifth Special
345.22 Session chapter 3, article 10, section 3, as
345.23 amended.
- 345.24 **(d) Family Foster Setting Background**
345.25 **Studies.** \$338,000 in fiscal year 2022 and
345.26 \$349,000 in fiscal year 2023 are from the
345.27 general fund for costs related to implementing
345.28 and administering licensed family foster
345.29 setting background study requirements.
- 345.30 **(e) Cultural and Ethnic Communities**
345.31 **Leadership Council.** \$18,000 in fiscal year
345.32 2022 and \$62,000 in fiscal year 2023 are from
345.33 the general fund for the Cultural and Ethnic
345.34 Communities Leadership Council.

346.1 (f) Base Level Adjustment. The general fund
 346.2 base is \$162,024,000 in fiscal year 2024 and
 346.3 \$162,255,000 in fiscal year 2025.

346.4 Subd. 5. Central Office; Children and Families

346.5	<u>Appropriations by Fund</u>		
346.6	<u>General</u>	<u>18,382,000</u>	<u>18,407,000</u>
346.7	<u>Federal TANF</u>	<u>2,582,000</u>	<u>2,582,000</u>

346.8 (a) Financial Institution Data Match and
 346.9 Payment of Fees. The commissioner is
 346.10 authorized to allocate up to \$310,000 each
 346.11 year in fiscal year 2022 and fiscal year 2023
 346.12 from the systems special revenue account to
 346.13 make payments to financial institutions in
 346.14 exchange for performing data matches
 346.15 between account information held by financial
 346.16 institutions and the public authority's database
 346.17 of child support obligors as authorized by
 346.18 Minnesota Statutes, section 13B.06,
 346.19 subdivision 7.

346.20 (b) Base Level Adjustment. The general fund
 346.21 base is \$18,692,000 in fiscal year 2024 and
 346.22 \$18,692,000 in fiscal year 2025.

346.23 Subd. 6. Central Office; Health Care

346.24	<u>Appropriations by Fund</u>		
346.25	<u>General</u>	<u>26,005,000</u>	<u>23,992,000</u>
346.26	<u>Health Care Access</u>	<u>28,168,000</u>	<u>28,168,000</u>

346.27 (a) Case Management Benefit Study for
 346.28 American Indians. \$200,000 in fiscal year
 346.29 2022 is from the general fund for a contract
 346.30 to conduct fiscal analysis and development of
 346.31 standards for a targeted case management
 346.32 benefit for American Indians. The
 346.33 commissioner of human services must consult
 346.34 the Minnesota Indian Affairs Council in the

347.1 development of any request for proposal and
 347.2 in the evaluation of responses. This is a
 347.3 onetime appropriation. Any unencumbered
 347.4 balance remaining from the first year does not
 347.5 cancel and is available for the second year of
 347.6 the biennium.

347.7 **(b) Integrated Care for High-Risk Pregnant**
 347.8 **Women Grant Program. \$106,000 in fiscal**
 347.9 **year 2022 and \$122,000 in fiscal year 2023**
 347.10 **are from the general fund for administration**
 347.11 **of the integrated care for high-risk pregnant**
 347.12 **women grant program under Minnesota**
 347.13 **Statutes, section 256B.79.**

347.14 **(c) Studies on Health Care Delivery.**
 347.15 **\$700,000 in fiscal year 2022 and \$300,000 in**
 347.16 **fiscal year 2023 are from the general fund for**
 347.17 **the commissioner of human services to**
 347.18 **develop a legislative proposal for a public**
 347.19 **option program and to compare and report to**
 347.20 **the legislature on delivery and payment system**
 347.21 **models to deliver services to MinnesotaCare**
 347.22 **enrollees and certain medical assistance**
 347.23 **enrollees.**

347.24 **(d) Base Level Adjustment. The general fund**
 347.25 **base is \$24,036,000 in fiscal year 2024 and**
 347.26 **\$24,004,000 in fiscal year 2025.**

347.27 **Subd. 7. Central Office; Continuing Care for**
 347.28 **Older Adults**

347.29	<u>Appropriations by Fund</u>		
347.30	<u>General</u>	<u>18,873,000</u>	<u>18,900,000</u>
347.31	<u>State Government</u>		
347.32	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

347.33 **(a) Assisted Living Survey. \$2,593,000 in**
 347.34 **fiscal year 2022 and \$2,593,000 in fiscal year**
 347.35 **2023 are from the general fund for**

348.1 development and administration of a resident
 348.2 experience survey and family survey for all
 348.3 assisted living facilities according to
 348.4 Minnesota Statutes, section 256B.439,
 348.5 subdivision 3c. These appropriations are
 348.6 available in either year of the biennium.

348.7 **(b) Base Level Adjustment.** The general fund
 348.8 base is \$18,830,000 in fiscal year 2024 and
 348.9 \$18,900,000 in fiscal year 2025.

348.10 **Subd. 8. Central Office; Community Supports**

348.11	<u>Appropriations by Fund</u>		
348.12	<u>General</u>	<u>35,294,000</u>	<u>35,846,000</u>
348.13	<u>Lottery Prize</u>	<u>163,000</u>	<u>163,000</u>
348.14	<u>Opioid Epidemic</u>		
348.15	<u>Response</u>	<u>60,000</u>	<u>60,000</u>

348.16 **(a) Study of Self Directed Tiered Wage**
 348.17 **Structure.** \$25,000 in fiscal year 2022 is from
 348.18 the general fund for a study of the feasibility
 348.19 of a tiered wage structure for individual
 348.20 providers. This is a onetime appropriation.
 348.21 This appropriation is available only if the labor
 348.22 agreement between the state of Minnesota and
 348.23 the Service Employees International Union
 348.24 Healthcare Minnesota under Minnesota
 348.25 Statutes, section 179A.54, is approved under
 348.26 Minnesota Statutes, section 3.855.

348.27 **(b) Substance Use Disorder Treatment**
 348.28 **Paperwork Reduction.** \$234,000 in fiscal
 348.29 year 2022 and \$201,000 in fiscal year 2023
 348.30 are from the general fund for a contract with
 348.31 a vendor to develop, assess, and recommend
 348.32 systems improvements to minimize regulatory
 348.33 paperwork and improve systems for licensed
 348.34 substance use disorder programs. This is a
 348.35 onetime appropriation.

349.1 **(c) Case Management and Substance Use**
 349.2 **Disorder Treatment Rate Methodology**
 349.3 **Analysis.** \$500,000 in fiscal year 2022 and
 349.4 \$200,000 in fiscal year 2023 are from the
 349.5 general fund for the fiscal analysis needed to
 349.6 establish federally compliant payment
 349.7 methodologies for all medical
 349.8 assistance-funded case management services,
 349.9 including substance use disorder treatment
 349.10 rates. This is a onetime appropriation.

349.11 **(d) Substance Use Disorder Community of**
 349.12 **Practice.** \$250,000 in fiscal year 2022 and
 349.13 \$250,000 in fiscal year 2023 are from the
 349.14 general fund for the commissioner of human
 349.15 services to establish and administer the
 349.16 substance use disorder community of practice,
 349.17 including providing compensation for
 349.18 community of practice participants.

349.19 **(e) Sober Housing Program**
 349.20 **Recommendations Development.** \$90,000
 349.21 in fiscal year 2022 is from the general fund
 349.22 for developing recommendations related to
 349.23 sober housing programs and completing and
 349.24 submitting a report on the recommendations
 349.25 to the legislature.

349.26 **(f) Base Level Adjustment.** The general fund
 349.27 base is \$34,634,000 in fiscal year 2024 and
 349.28 \$34,666,000 in fiscal year 2025. The opiate
 349.29 epidemic response fund base is \$60,000 in
 349.30 fiscal year 2024 and \$0 in fiscal year 2025.

349.31 **Subd. 9. Forecasted Programs; MFIP/DWP**

349.32	<u>Appropriations by Fund</u>	
349.33	<u>General</u>	<u>92,588,000</u>
		<u>91,668,000</u>
349.34	<u>Federal TANF</u>	<u>104,285,000</u>
		<u>104,410,000</u>

350.1	<u>Subd. 10. Forecasted Programs; MFIP Child</u>		
350.2	<u>Care Assistance.</u>	<u>146,000</u>	<u>569,000</u>
350.3	<u>Subd. 11. Forecasted Programs; General</u>		
350.4	<u>Assistance.</u>	<u>53,574,000</u>	<u>52,835,000</u>
350.5	<u>(a) General Assistance Standard. The</u>		
350.6	<u>commissioner shall set the monthly standard</u>		
350.7	<u>of assistance for general assistance units</u>		
350.8	<u>consisting of an adult recipient who is</u>		
350.9	<u>childless and unmarried or living apart from</u>		
350.10	<u>parents or a legal guardian at \$203. The</u>		
350.11	<u>commissioner may reduce this amount</u>		
350.12	<u>according to Laws 1997, chapter 85, article 3,</u>		
350.13	<u>section 54.</u>		
350.14	<u>(b) Emergency General Assistance Limit.</u>		
350.15	<u>The amount appropriated for emergency</u>		
350.16	<u>general assistance is limited to no more than</u>		
350.17	<u>\$6,729,812 in fiscal year 2022 and \$6,729,812</u>		
350.18	<u>in fiscal year 2023. Funds to counties shall be</u>		
350.19	<u>allocated by the commissioner using the</u>		
350.20	<u>allocation method under Minnesota Statutes,</u>		
350.21	<u>section 256D.06.</u>		
350.22	<u>Subd. 12. Forecasted Programs; Minnesota</u>		
350.23	<u>Supplemental Aid</u>	<u>51,779,000</u>	<u>52,486,000</u>
350.24	<u>Subd. 13. Forecasted Programs; Housing</u>		
350.25	<u>Support</u>	<u>184,005,000</u>	<u>191,966,000</u>
350.26	<u>Subd. 14. Forecasted Programs; Northstar Care</u>		
350.27	<u>for Children</u>	<u>110,583,000</u>	<u>121,246,000</u>
350.28	<u>Subd. 15. Forecasted Programs; MinnesotaCare</u>	<u>207,437,000</u>	<u>184,822,000</u>
350.29	<u>Generally. This appropriation is from the</u>		
350.30	<u>health care access fund.</u>		
350.31	<u>Subd. 16. Forecasted Programs; Medical</u>		
350.32	<u>Assistance</u>		
350.33	<u>Appropriations by Fund</u>		
350.34	<u>General</u>	<u>6,058,378,000</u>	<u>6,557,536,000</u>
350.35	<u>Health Care Access</u>	<u>611,178,000</u>	<u>612,099,000</u>

351.1 **Behavioral Health Services.** \$1,000,000 in
 351.2 fiscal year 2022 and \$1,000,000 in fiscal year
 351.3 2023 are for behavioral health services
 351.4 provided by hospitals identified under
 351.5 Minnesota Statutes, section 256.969,
 351.6 subdivision 2b, paragraph (a), clause (4). The
 351.7 increase in payments shall be made by
 351.8 increasing the adjustment under Minnesota
 351.9 Statutes, section 256.969, subdivision 2b,
 351.10 paragraph (e), clause (2).

351.11 **Subd. 17. Forecasted Programs; Alternative**
 351.12 **Care**

45,669,000

45,656,000

351.13 **Alternative Care Transfer.** Any money
 351.14 allocated to the alternative care program that
 351.15 is not spent for the purposes indicated does
 351.16 not cancel but must be transferred to the
 351.17 medical assistance account.

351.18 **Subd. 18. Forecasted Programs; Behavioral**
 351.19 **Health Fund**

132,377,000

116,706,000

351.20 **(a) Grants to Tribal Governments.**
 351.21 \$28,873,377 in fiscal year 2022 is from the
 351.22 general fund to satisfy the value of
 351.23 overpayments owed by the Leech Lake Band
 351.24 of Ojibwe and White Earth Band of Chippewa
 351.25 to repay overpayments for medication-assisted
 351.26 treatment services between fiscal year 2014
 351.27 and fiscal year 2019. The grant to the Leech
 351.28 Lake Band of Ojibwe shall be \$14,666,122
 351.29 and the grant to the White Earth Band of
 351.30 Chippewa shall be \$14,207,215. This is a
 351.31 onetime appropriation.

351.32 **(b) Institutions for Mental Disease**
 351.33 **Payments.** \$8,328,000 in fiscal year 2022 is
 351.34 from the general fund for the commissioner
 351.35 of human services to reimburse counties for

352.1 the amount identified by the commissioner for
 352.2 the statewide county share of costs for which
 352.3 federal funds were claimed, but were not
 352.4 eligible for federal funding for substance use
 352.5 disorder services provided in institutions for
 352.6 mental disease, for claims paid between
 352.7 January 1, 2014, and June 30, 2019. The
 352.8 commissioner of human services shall allocate
 352.9 this appropriation between counties in the
 352.10 amount identified by the department that is
 352.11 owed by each county. Prior to a county
 352.12 receiving reimbursement, the county must pay
 352.13 in full any unpaid consolidated chemical
 352.14 dependency treatment fund invoiced county
 352.15 share. This is a onetime appropriation.

352.16 **Subd. 19. Grant Programs; Support Services**
 352.17 **Grants**

352.18	<u>Appropriations by Fund</u>		
352.19	<u>General</u>	<u>8,715,000</u>	<u>8,715,000</u>
352.20	<u>Federal TANF</u>	<u>96,312,000</u>	<u>96,311,000</u>

352.21	<u>Subd. 20. Grant Programs; BSF Child Care</u>		
352.22	<u>Grants.</u>	<u>(17,000)</u>	<u>(23,000)</u>

352.23	<u>Subd. 21. Grant Programs; Child Support</u>		
352.24	<u>Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>

352.25 **Subd. 22. Grant Programs; Children's Services**
 352.26 **Grants**

352.27	<u>Appropriations by Fund</u>		
352.28	<u>General</u>	<u>52,133,000</u>	<u>51,848,000</u>
352.29	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>

352.30 **(a) Title IV-E Adoption Assistance.** The
 352.31 commissioner shall allocate funds from the
 352.32 Title IV-E reimbursement to the state from
 352.33 the Fostering Connections to Success and
 352.34 Increasing Adoptions Act for adoptive, foster,
 352.35 and kinship families as required in Minnesota
 352.36 Statutes, section 256N.261.

353.1 **(b) Indian Child Welfare Training.**
 353.2 \$1,012,000 in fiscal year 2022 and \$993,000
 353.3 in fiscal year 2023 are from the general fund
 353.4 for the establishment and operation of the
 353.5 Tribal Training and Certification Partnership
 353.6 at the University of Minnesota-Duluth to
 353.7 provide training, establish federal Indian Child
 353.8 Welfare Act and Minnesota Family
 353.9 Preservation Act training requirements for
 353.10 county child welfare workers, and develop
 353.11 Indigenous child welfare training for American
 353.12 Indian Tribes. The base for this appropriation
 353.13 is \$1,053,000 in fiscal year 2024 and
 353.14 \$1,053,000 in fiscal year 2025.

353.15 **(c) Parent Support for Better Outcomes**
 353.16 **Grants.** \$150,000 in fiscal year 2022 and
 353.17 \$150,000 in fiscal year 2023 are from the
 353.18 general fund for grants to Minnesota One-Stop
 353.19 for Communities to provide mentoring,
 353.20 guidance, and support services to parents
 353.21 navigating the child welfare system in
 353.22 Minnesota, in order to promote the
 353.23 development of safe, stable, and healthy
 353.24 families. Grant money may be used for parent
 353.25 mentoring, peer-to-peer support groups,
 353.26 housing support services, training, staffing,
 353.27 and administrative costs.

353.28	<u>Subd. 23. Grant Programs; Children and</u>		
353.29	<u>Community Service Grants</u>	<u>60,251,000</u>	<u>60,856,000</u>

353.30	<u>Subd. 24. Grant Programs; Children and</u>		
353.31	<u>Economic Support Grants</u>	<u>34,240,000</u>	<u>34,240,000</u>

353.32 **(a) Minnesota Food Assistance Program.**
 353.33 Unexpended funds for the Minnesota food
 353.34 assistance program for fiscal year 2022 do not
 353.35 cancel but are available for this purpose in
 353.36 fiscal year 2023.

354.1 (b) Emergency Shelters. \$2,500,000 in fiscal
 354.2 year 2022 and \$2,500,000 in fiscal year 2023
 354.3 are for short-term housing facilities to increase
 354.4 the supply and improve the condition of
 354.5 shelters for individuals and families without
 354.6 a permanent residence. The commissioner
 354.7 shall ensure that a portion of the funds are
 354.8 expended to provide for short-term housing
 354.9 facilities for tribes and shall ensure equitable
 354.10 geographic distribution of funds. This
 354.11 appropriation is available until June 30, 2026.

354.12 (c) Emergency Services Grants. \$9,000,000
 354.13 in fiscal year 2022 and \$9,000,000 in fiscal
 354.14 year 2023 are to provide emergency services
 354.15 grants under Minnesota Statutes, section
 354.16 256E.36.

354.17 **Subd. 25. Grant Programs; Health Care Grants**

354.18	<u>Appropriations by Fund</u>		
354.19	<u>General</u>	<u>4,811,000</u>	<u>4,811,000</u>
354.20	<u>Health Care Access</u>	<u>3,465,000</u>	<u>3,465,000</u>

354.21 **Integrated Care for High Risk Pregnancies**
 354.22 **Initiative. \$1,100,000 in fiscal year 2022 and**
 354.23 **\$1,100,000 in fiscal year 2023 are from the**
 354.24 **general fund for the commissioner of human**
 354.25 **services to enter into a contract with the**
 354.26 **Integrated Care for High Risk Pregnancies**
 354.27 **(ICHRP) initiative to provide support to the**
 354.28 **integrated care for high-risk pregnant women**
 354.29 **grant program under Minnesota Statutes,**
 354.30 **section 256B.79.**

354.31	<u>Subd. 26. Grant Programs; Other Long-Term</u>		
354.32	<u>Care Grants</u>	<u>1,925,000</u>	<u>1,925,000</u>
354.33	<u>Subd. 27. Grant Programs; Aging and Adult</u>		
354.34	<u>Services Grants</u>	<u>32,495,000</u>	<u>32,495,000</u>

355.1	<u>Subd. 28. Grant Programs; Deaf and</u>		
355.2	<u>Hard-of-Hearing Grants</u>	<u>2,886,000</u>	<u>2,886,000</u>
355.3	<u>Subd. 29. Grant Programs; Disabilities Grants</u>	<u>20,251,000</u>	<u>18,863,000</u>
355.4	<u>Training Stipends for Direct Support</u>		
355.5	<u>Services Providers. \$1,000,000 in fiscal year</u>		
355.6	<u>2022 is from the general fund for stipends for</u>		
355.7	<u>individual providers of direct support services</u>		
355.8	<u>as defined in Minnesota Statutes, section</u>		
355.9	<u>256B.0711, subdivision 1. These stipends are</u>		
355.10	<u>available to individual providers who have</u>		
355.11	<u>completed designated voluntary trainings</u>		
355.12	<u>made available through the State-Provider</u>		
355.13	<u>Cooperation Committee formed by the State</u>		
355.14	<u>of Minnesota and the Service Employees</u>		
355.15	<u>International Union Healthcare Minnesota.</u>		
355.16	<u>Any unspent appropriation in fiscal year 2022</u>		
355.17	<u>is available in fiscal year 2023. This is a</u>		
355.18	<u>onetime appropriation. This appropriation is</u>		
355.19	<u>available only if the labor agreement between</u>		
355.20	<u>the state of Minnesota and the Service</u>		
355.21	<u>Employees International Union Healthcare</u>		
355.22	<u>Minnesota under Minnesota Statutes, section</u>		
355.23	<u>179A.54, is approved under Minnesota</u>		
355.24	<u>Statutes, section 3.855.</u>		
355.25	<u>Subd. 30. Grant Programs; Housing Support</u>		
355.26	<u>Grants</u>	<u>11,364,000</u>	<u>11,364,000</u>
355.27	<u>Long-Term Homeless Supportive Services.</u>		
355.28	<u>\$1,000,000 in fiscal year 2022 and \$1,000,000</u>		
355.29	<u>in fiscal year 2023 are for long-term homeless</u>		
355.30	<u>supportive services under Minnesota Statutes,</u>		
355.31	<u>section 256K.26.</u>		
355.32	<u>Subd. 31. Grant Programs; Adult Mental Health</u>		
355.33	<u>Grants</u>		

356.1	<u>Appropriations by Fund</u>		
356.2	<u>General</u>	<u>84,073,000</u>	<u>84,074,000</u>
356.3	<u>Opiate Epidemic</u>		
356.4	<u>Response</u>	<u>2,000,000</u>	<u>2,000,000</u>
356.5	<u>(a) Culturally and Linguistically</u>		
356.6	<u>Appropriate Services Implementation</u>		
356.7	<u>Grants.</u> \$750,000 in fiscal year 2022 and		
356.8	\$750,000 in fiscal year 2023 are from the		
356.9	<u>general fund for grants to substance use</u>		
356.10	<u>disorder treatment providers to implement</u>		
356.11	<u>culturally and linguistically appropriate</u>		
356.12	<u>services standards, according to the</u>		
356.13	<u>implementation and transition plan developed</u>		
356.14	<u>by the commissioner. This is a onetime</u>		
356.15	<u>appropriation.</u>		
356.16	<u>(b) Base Level Adjustment.</u> The general fund		
356.17	<u>base is \$82,324,000 in fiscal year 2024 and</u>		
356.18	<u>\$82,324,000 in fiscal year 2025. The opiate</u>		
356.19	<u>epidemic response fund base is \$2,000,000 in</u>		
356.20	<u>fiscal year 2024 and \$0 in fiscal year 2025.</u>		
356.21	<u>Subd. 32. Grant Programs; Child Mental Health</u>		
356.22	<u>Grants</u>	<u>28,703,000</u>	<u>28,703,000</u>
356.23	<u>(a) Children's Residential Facilities.</u>		
356.24	<u>\$3,000,000 in fiscal year 2022 and \$3,000,000</u>		
356.25	<u>in fiscal year 2023 are to reimburse counties</u>		
356.26	<u>for a portion of the costs of treatment in</u>		
356.27	<u>children's residential facilities. The</u>		
356.28	<u>commissioner shall distribute the appropriation</u>		
356.29	<u>on an annual basis to counties proportionally</u>		
356.30	<u>based on a methodology developed by the</u>		
356.31	<u>commissioner. Of this appropriation, \$100,000</u>		
356.32	<u>in fiscal year 2022 and \$100,000 in fiscal year</u>		
356.33	<u>2023 are available to the commissioner for</u>		
356.34	<u>administrative expenses.</u>		

357.1 (b) Base Level Adjustment. The general fund
 357.2 base is \$28,726,000 in fiscal year 2024 and
 357.3 \$28,726,000 in fiscal year 2025.

357.4 Subd. 33. Grant Programs; Chemical
 357.5 Dependency Treatment Support Grants

357.6	<u>Appropriations by Fund</u>		
357.7 <u>General</u>	<u>2,846,000</u>		<u>2,845,000</u>
357.8 <u>Lottery Prize</u>	<u>1,733,000</u>		<u>1,733,000</u>
357.9 <u>Opiate Epidemic</u>			
357.10 <u>Response</u>	<u>500,000</u>		<u>500,000</u>

357.11 (a) Problem Gambling. \$225,000 in fiscal
 357.12 year 2022 and \$225,000 in fiscal year 2023
 357.13 are from the lottery prize fund for a grant to
 357.14 the state affiliate recognized by the National
 357.15 Council on Problem Gambling. The affiliate
 357.16 must provide services to increase public
 357.17 awareness of problem gambling, education,
 357.18 and training for individuals and organizations
 357.19 providing effective treatment services to
 357.20 problem gamblers and their families, and
 357.21 research related to problem gambling.

357.22 (b) Recovery Community Organization
 357.23 Grants. \$573,000 in fiscal year 2022 and
 357.24 \$571,000 in fiscal year 2023 are from the
 357.25 general fund for grants to recovery community
 357.26 organizations, as defined in Minnesota
 357.27 Statutes, section 254B.01, subdivision 8, to
 357.28 provide for costs and community-based peer
 357.29 recovery support services that are not
 357.30 otherwise eligible for reimbursement under
 357.31 Minnesota Statutes, section 254B.05, as part
 357.32 of the continuum of care for substance use
 357.33 disorders.

357.34 (c) Base Level Adjustment. The general fund
 357.35 base is \$2,636,000 in fiscal year 2024 and

358.1 \$2,636,000 in fiscal year 2025. The opiate
 358.2 epidemic response fund base is \$500,000 in
 358.3 fiscal year 2024 and \$0 in fiscal year 2025.

358.4 **Subd. 34. Direct Care and Treatment; Generally**

358.5 **Transfer Authority.** Money appropriated to
 358.6 budget activities under this subdivision and
 358.7 subdivisions 35 to 39, may be transferred
 358.8 between budget activities and between years
 358.9 of the biennium with the approval of the
 358.10 commissioner of management and budget.

358.11 **Subd. 35. Direct Care and Treatment; Mental**
 358.12 **Health and Substance Abuse**

139,946,000

144,103,000

358.13 **(a) Transfer Authority.** Money appropriated
 358.14 to support the continued operations of the
 358.15 Community Addiction Recovery Enterprise
 358.16 (C.A.R.E.) program may be transferred to the
 358.17 enterprise fund for C.A.R.E.

358.18 **(b) Operating Adjustment.** \$2,307,000 in
 358.19 fiscal year 2022 and \$2,453,000 in fiscal year
 358.20 2023 are for the Community Addiction
 358.21 Recovery Enterprise program. The
 358.22 commissioner may transfer \$2,307,000 in
 358.23 fiscal year 2022 and \$2,453,000 in fiscal year
 358.24 2023 to the enterprise fund for Community
 358.25 Addiction Recovery Enterprise.

358.26 **Subd. 36. Direct Care and Treatment;**
 358.27 **Community-Based Services**

18,771,000

19,752,000

358.28 **(a) Transfer Authority.** Money appropriated
 358.29 to support the continued operations of the
 358.30 Minnesota State Operated Community
 358.31 Services (MSOCS) program may be
 358.32 transferred to the enterprise fund for MSOCS.

358.33 **(b) Operating Adjustment.** \$1,519,000 in
 358.34 fiscal year 2022 and \$2,541,000 in fiscal year

359.1 2023 are for the Minnesota State Operated
 359.2 Community Services program. The
 359.3 commissioner may transfer \$1,519,000 in
 359.4 fiscal year 2022 and \$2,541,000 in fiscal year
 359.5 2023 to the enterprise fund for Minnesota State
 359.6 Operated Community Services.

359.7	<u>Subd. 37. Direct Care and Treatment; Forensic</u>		
359.8	<u>Services</u>	<u>119,854,000</u>	<u>122,206,000</u>

359.9	<u>Subd. 38. Direct Care and Treatment; Sex</u>		
359.10	<u>Offender Program</u>	<u>97,570,000</u>	<u>99,917,000</u>

359.11 **Transfer Authority.** Money appropriated for
 359.12 the Minnesota sex offender program may be
 359.13 transferred between fiscal years of the
 359.14 biennium with the approval of the
 359.15 commissioner of management and budget.

359.16	<u>Subd. 39. Direct Care and Treatment;</u>		
359.17	<u>Operations</u>	<u>63,504,000</u>	<u>65,910,000</u>

359.18	<u>Subd. 40. Technical Activities</u>		
		<u>79,204,000</u>	<u>78,260,000</u>

359.19 (a) **Generally.** This appropriation is from the
 359.20 federal TANF fund.

359.21 (b) **Base Level Adjustment.** The TANF fund
 359.22 base is \$71,493,000 in fiscal year 2024 and
 359.23 \$71,493,000 in fiscal year 2025.

359.24 Sec. 3. **COMMISSIONER OF HEALTH**

359.25	<u>Subdivision 1. Total Appropriation</u>	<u>\$</u>	<u>258,989,000</u>	<u>\$</u>	<u>251,881,000</u>
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359.26 Appropriations by Fund

		<u>2022</u>	<u>2023</u>
359.27			
359.28	<u>General</u>	<u>155,953,000</u>	<u>150,554,000</u>
359.29	<u>State Government</u>		
359.30	<u>Special Revenue</u>	<u>54,465,000</u>	<u>53,356,000</u>
359.31	<u>Health Care Access</u>	<u>36,858,000</u>	<u>36,258,000</u>
359.32	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

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

360.4 **Subd. 2. Health Improvement**

360.5	<u>Appropriations by Fund</u>		
360.6	<u>General</u>	<u>113,697,000</u>	<u>112,692,000</u>
360.7	<u>State Government</u>		
360.8	<u>Special Revenue</u>	<u>9,103,000</u>	<u>7,777,000</u>
360.9	<u>Health Care Access</u>	<u>36,858,000</u>	<u>36,258,000</u>
360.10	<u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

360.11 (a) TANF Appropriations. (1) \$3,579,000 in
 360.12 fiscal year 2022 and \$3,579,000 in fiscal year
 360.13 2023 are from the TANF fund for home
 360.14 visiting and nutritional services listed under
 360.15 Minnesota Statutes, section 145.882,
 360.16 subdivision 7, clauses (6) and (7). Funds must
 360.17 be distributed to community health boards
 360.18 according to Minnesota Statutes, section
 360.19 145A.131, subdivision 1;

360.20 (2) \$2,000,000 in fiscal year 2022 and
 360.21 \$2,000,000 in fiscal year 2023 are from the
 360.22 TANF fund for decreasing racial and ethnic
 360.23 disparities in infant mortality rates under
 360.24 Minnesota Statutes, section 145.928,
 360.25 subdivision 7;

360.26 (3) \$4,978,000 in fiscal year 2022 and
 360.27 \$4,978,000 in fiscal year 2023 are from the
 360.28 TANF fund for the family home visiting grant
 360.29 program according to Minnesota Statutes,
 360.30 section 145A.17. \$4,000,000 of the funding
 360.31 in each fiscal year must be distributed to
 360.32 community health boards according to
 360.33 Minnesota Statutes, section 145A.131,
 360.34 subdivision 1. \$978,000 of the funding in each
 360.35 fiscal year must be distributed to tribal

361.1 governments according to Minnesota Statutes,
361.2 section 145A.14, subdivision 2a;
361.3 (4) \$1,156,000 in fiscal year 2022 and
361.4 \$1,156,000 in fiscal year 2023 are from the
361.5 TANF fund for family planning grants under
361.6 Minnesota Statutes, section 145.925; and
361.7 (5) the commissioner may use up to 6.23
361.8 percent of the funds appropriated from the
361.9 TANF fund each fiscal year to conduct the
361.10 ongoing evaluations required under Minnesota
361.11 Statutes, section 145A.17, subdivision 7, and
361.12 training and technical assistance as required
361.13 under Minnesota Statutes, section 145A.17,
361.14 subdivisions 4 and 5.

361.15 **(b) TANF Carryforward.** Any unexpended
361.16 balance of the TANF appropriation in the first
361.17 year of the biennium does not cancel but is
361.18 available for the second year.

361.19 **(c) Maternal Morbidity and Death Studies.**
361.20 \$198,000 in fiscal year 2022 and \$198,000 in
361.21 fiscal year 2023 are from the general fund to
361.22 be used to conduct maternal morbidity and
361.23 death studies under Minnesota Statutes,
361.24 sections 145.901 and 145.9013.

361.25 **(d) Comprehensive Advanced Life Support**
361.26 **Educational Program.** \$100,000 in fiscal
361.27 year 2022 and \$100,000 in fiscal year 2023
361.28 are from the general fund for the
361.29 comprehensive advanced life support
361.30 educational program under Minnesota Statutes,
361.31 section 144.6062. This is a onetime
361.32 appropriation.

361.33 **(e) Local Public Health Grants.** \$2,978,000
361.34 in fiscal year 2022 and \$2,978,000 in fiscal

362.1 year 2023 are from the general fund for local
362.2 public health grants under Minnesota Statutes,
362.3 section 145A.131. The base for this
362.4 appropriation is \$2,500,000 in fiscal year 2024
362.5 and \$2,500,000 in fiscal year 2025.

362.6 **(f) Public Health Infrastructure and Health**
362.7 **Equity and Outreach.** \$5,000,000 in fiscal
362.8 year 2022 and \$5,000,000 in fiscal year 2023
362.9 are from the general fund for purposes of
362.10 Minnesota Statutes, sections 144.0661 to
362.11 144.0663, and to build public health
362.12 infrastructure at the state and local levels to
362.13 address current and future public health
362.14 emergencies, conduct outreach to underserved
362.15 communities in the state experiencing health
362.16 disparities, and build systems at the state and
362.17 local levels with the goals of reducing and
362.18 eliminating health disparities in these
362.19 communities.

362.20 **(g) Mental Health Cultural Community**
362.21 **Continuing Education.** \$500,000 in fiscal
362.22 year 2022 and \$500,000 in fiscal year 2023
362.23 are from the general fund for the mental health
362.24 cultural community continuing education grant
362.25 program.

362.26 **(h) Health Professional Education Loan**
362.27 **Forgiveness Program.** \$3,000,000 in fiscal
362.28 year 2022 and \$3,000,000 in fiscal year 2023
362.29 are from the general fund for loan forgiveness
362.30 under the health professional education loan
362.31 forgiveness program under Minnesota Statutes,
362.32 section 144.1501, for individuals who: (1) are
362.33 eligible alcohol and drug counselors or eligible
362.34 mental health professionals, as defined in
362.35 Minnesota Statutes, section 144.1501,

363.1 subdivision 1; and (2) are Black, Indigenous,
363.2 or people of color, or members of an
363.3 underrepresented community as defined in
363.4 Minnesota Statutes, section 148E.010,
363.5 subdivision 20. Loan forgiveness shall be
363.6 provided according to this paragraph
363.7 notwithstanding the priorities and distribution
363.8 requirements for loan forgiveness in
363.9 Minnesota Statutes, section 144.1501.

363.10 **(i) Birth Records; Homeless Youth. \$72,000**
363.11 **in fiscal year 2022 and \$32,000 in fiscal year**
363.12 **2023 are from the general fund for**
363.13 **administration and issuance of certified birth**
363.14 **records and statements of no vital record found**
363.15 **to homeless youth under Minnesota Statutes,**
363.16 **section 144.2255.**

363.17 **(j) Trauma-Informed Gun Violence**
363.18 **Reduction Pilot Program. \$100,000 in fiscal**
363.19 **year 2022 is from the general fund for the**
363.20 **trauma-informed gun violence reduction pilot**
363.21 **program.**

363.22 **(k) Home Visiting for Pregnant Women and**
363.23 **Families with Young Children. \$2,500,000**
363.24 **in fiscal year 2022 and \$2,500,000 in fiscal**
363.25 **year 2023 are from the general fund for grants**
363.26 **for home visiting services under Minnesota**
363.27 **Statutes, section 145.87.**

363.28 **(l) Supporting Healthy Development of**
363.29 **Babies During Pregnancy and Postpartum.**
363.30 **\$279,000 in fiscal year 2022 and \$279,000 in**
363.31 **fiscal year 2023 are from the general fund for**
363.32 **a grant to the Amherst H. Wilder Foundation**
363.33 **for the African American Babies Coalition**
363.34 **initiative for community-driven training and**
363.35 **education on best practices to support healthy**

364.1 development of babies during pregnancy and
364.2 postpartum. Grant funds must be used to build
364.3 capacity in, train, educate, or improve
364.4 practices among individuals, from youth to
364.5 elders, serving families with members who
364.6 are Black, Indigenous, or people of color,
364.7 during pregnancy and postpartum. Of this
364.8 appropriation, \$19,000 in fiscal year 2022 and
364.9 \$19,000 in fiscal year 2023 are for the
364.10 commissioner to use for administration. This
364.11 is a onetime appropriation. Any unexpended
364.12 balance in the first year of the biennium does
364.13 not cancel and is available in the second year
364.14 of the biennium.

364.15 **(m) Dignity in Pregnancy and Childbirth.**
364.16 \$1,695,000 in fiscal year 2022 and \$908,000
364.17 in fiscal year 2023 are from the general fund
364.18 for purposes of Minnesota Statutes, section
364.19 144.1461. Of this appropriation, \$845,000 in
364.20 fiscal year 2022 is for a grant to the University
364.21 of Minnesota School of Public Health's Center
364.22 for Antiracism Research for Health Equity, to
364.23 develop a model curriculum on anti-racism
364.24 and implicit bias for use by hospitals with
364.25 obstetric care and birth centers to provide
364.26 continuing education to staff caring for
364.27 pregnant or postpartum women. The model
364.28 curriculum must be evidence-based and must
364.29 meet the criteria in Minnesota Statutes, section
364.30 144.1461, subdivision 2, paragraph (a). The
364.31 base for this appropriation is \$907,000 in fiscal
364.32 year 2024 and \$860,000 in fiscal year 2025.

364.33 **(n) Recommendations to Expand Access to**
364.34 **Data from the All-Payer Claims Database.**
364.35 \$55,000 in fiscal year 2022 is from the general

365.1 fund for the commissioner to develop
 365.2 recommendations to expand access to data
 365.3 from the all-payer claims database under
 365.4 Minnesota Statutes, section 62U.04, to
 365.5 additional outside entities for public health or
 365.6 research purposes.

365.7 **(o) Base Level Adjustments.** The general
 365.8 fund base is \$110,895,000 in fiscal year 2024
 365.9 and \$111,787,000 in fiscal year 2025. The
 365.10 state government special revenue fund base is
 365.11 \$7,777,000 in fiscal year 2024 and \$7,777,000
 365.12 in fiscal year 2025. The health care access
 365.13 fund base is \$36,858,000 in fiscal year 2024
 365.14 and \$36,258,000 in fiscal year 2025.

365.15 **Subd. 3. Health Protection**

365.16	<u>Appropriations by Fund</u>		
365.17	<u>General</u>	<u>30,686,000</u>	<u>26,283,000</u>
365.18	<u>State Government</u>		
365.19	<u>Special Revenue</u>	<u>45,362,000</u>	<u>45,579,000</u>

365.20 **(a) Lead Risk Assessments and Lead**
 365.21 **Orders.** \$1,530,000 in fiscal year 2022 and
 365.22 \$1,314,000 in fiscal year 2023 are from the
 365.23 general fund for implementation of the
 365.24 requirements for conducting lead risk
 365.25 assessments under Minnesota Statutes, section
 365.26 144.9504, subdivision 2, and for issuance of
 365.27 lead orders under Minnesota Statutes, section
 365.28 144.9504, subdivision 5.

365.29 **(b) Hospital Closure or Curtailment of**
 365.30 **Operations.** \$10,000 in fiscal year 2022 and
 365.31 \$1,000 in fiscal year 2023 are from the general
 365.32 fund for purposes of Minnesota Statutes,
 365.33 section 144.555, subdivisions 1a, 1b, and 2.

365.34 **(c) Transfer; Public Health Response**
 365.35 **Contingency Account.** The commissioner

366.1 shall transfer \$500,000 in fiscal year 2022
 366.2 from the general fund to the public health
 366.3 response contingency account established in
 366.4 Minnesota Statutes, section 144.4199. This is
 366.5 a onetime transfer.

366.6 **(d) Skin Lightening Products Public**
 366.7 **Awareness and Education Grant Program.**
 366.8 \$100,000 in fiscal year 2022 and \$100,000 in
 366.9 fiscal year 2023 are from the general fund for
 366.10 a skin lightening products public awareness
 366.11 and education grant program. This is a onetime
 366.12 appropriation.

366.13 **(e) Base Level Adjustments.** The general
 366.14 fund base is \$26,183,000 in fiscal year 2024
 366.15 and \$26,183,000 in fiscal year 2025. The state
 366.16 government special revenue fund base is
 366.17 \$45,579,000 in fiscal year 2024 and
 366.18 \$45,579,000 in fiscal year 2025.

366.19 <u>Subd. 4. Health Operations</u>	<u>11,570,000</u>	<u>11,579,000</u>
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366.20 Sec. 4. **HEALTH-RELATED BOARDS**

366.21 <u>Subdivision 1. Total Appropriation</u>	<u>\$ 27,535,000</u>	<u>\$ 26,960,000</u>
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366.22 Appropriations by Fund

366.23 <u>State Government</u>		
366.24 <u>Special Revenue</u>	<u>27,459,000</u>	<u>26,884,000</u>
366.25 <u>Health Care Access</u>	<u>76,000</u>	<u>76,000</u>

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

366.31 <u>Subd. 2. Board of Behavioral Health and</u>		
366.32 <u>Therapy</u>	<u>877,000</u>	<u>875,000</u>

366.33 <u>Subd. 3. Board of Chiropractic Examiners</u>	<u>666,000</u>	<u>666,000</u>
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366.34 <u>Subd. 4. Board of Dentistry</u>	<u>4,228,000</u>	<u>3,753,000</u>
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- 367.1 **(a) Administrative Services Unit - Operating**
367.2 **Costs.** Of this appropriation, \$2,738,000 in
367.3 fiscal year 2022 and \$2,263,000 in fiscal year
367.4 2023 are for operating costs of the
367.5 administrative services unit. The
367.6 administrative services unit may receive and
367.7 expend reimbursements for services it
367.8 performs for other agencies.
- 367.9 **(b) Administrative Services Unit - Volunteer**
367.10 **Health Care Provider Program.** Of this
367.11 appropriation, \$150,000 in fiscal year 2022
367.12 and \$150,000 in fiscal year 2023 are to pay
367.13 for medical professional liability coverage
367.14 required under Minnesota Statutes, section
367.15 214.40.
- 367.16 **(c) Administrative Services Unit -**
367.17 **Retirement Costs.** Of this appropriation,
367.18 \$475,000 in fiscal year 2022 is a onetime
367.19 appropriation to the administrative services
367.20 unit to pay for the retirement costs of
367.21 health-related board employees. This funding
367.22 may be transferred to the health board
367.23 incurring retirement costs. Any board that has
367.24 an unexpended balance for an amount
367.25 transferred under this paragraph shall transfer
367.26 the unexpended amount to the administrative
367.27 services unit. These funds are available either
367.28 year of the biennium.
- 367.29 **(d) Administrative Services Unit - Contested**
367.30 **Cases and Other Legal Proceedings.** Of this
367.31 appropriation, \$200,000 in fiscal year 2022
367.32 and \$200,000 in fiscal year 2023 are for costs
367.33 of contested case hearings and other
367.34 unanticipated costs of legal proceedings
367.35 involving health-related boards funded under

368.1 this section. Upon certification by a
 368.2 health-related board to the administrative
 368.3 services unit that costs will be incurred and
 368.4 that there is insufficient money available to
 368.5 pay for the costs out of money currently
 368.6 available to that board, the administrative
 368.7 services unit is authorized to transfer money
 368.8 from this appropriation to the board for
 368.9 payment of those costs with the approval of
 368.10 the commissioner of management and budget.
 368.11 The commissioner of management and budget
 368.12 must require any board that has an unexpended
 368.13 balance for an amount transferred under this
 368.14 paragraph to transfer the unexpended amount
 368.15 to the administrative services unit to be
 368.16 deposited in the state government special
 368.17 revenue fund.

368.18	<u>Subd. 5. Board of Dietetics and Nutrition</u>		
368.19	<u>Practice</u>	<u>164,000</u>	<u>164,000</u>

368.20	<u>Subd. 6. Board of Executives for Long Term</u>		
368.21	<u>Services and Supports</u>	<u>693,000</u>	<u>635,000</u>

368.22	<u>Subd. 7. Board of Marriage and Family Therapy</u>		
		<u>413,000</u>	<u>410,000</u>

368.23	<u>Subd. 8. Board of Medical Practice</u>		
		<u>5,912,000</u>	<u>5,868,000</u>

368.24 **Health Professional Services Program. This**
 368.25 appropriation includes \$1,002,000 in fiscal
 368.26 year 2022 and \$1,002,000 in fiscal year 2023
 368.27 for the health professional services program.

368.28	<u>Subd. 9. Board of Nursing</u>		
		<u>5,345,000</u>	<u>5,355,000</u>

368.29	<u>Subd. 10. Board of Occupational Therapy</u>		
368.30	<u>Practice</u>	<u>456,000</u>	<u>456,000</u>

368.31	<u>Subd. 11. Board of Optometry</u>		
		<u>238,000</u>	<u>238,000</u>

368.32	<u>Subd. 12. Board of Pharmacy</u>		
		<u>4,479,000</u>	<u>4,479,000</u>

369.1	<u>Appropriations by Fund</u>		
369.2	<u>State Government</u>		
369.3	<u>Special Revenue</u>	<u>4,403,000</u>	<u>4,403,000</u>
369.4	<u>Health Care Access</u>	<u>76,000</u>	<u>76,000</u>
369.5	<u>Base Level Adjustment.</u> <u>The health care</u>		
369.6	<u>access fund base is \$76,000 in fiscal year</u>		
369.7	<u>2024, \$38,000 in fiscal year 2025, and \$0 in</u>		
369.8	<u>fiscal year 2026.</u>		
369.9	<u>Subd. 13. Board of Physical Therapy</u>	<u>564,000</u>	<u>564,000</u>
369.10	<u>Subd. 14. Board of Podiatric Medicine</u>	<u>214,000</u>	<u>214,000</u>
369.11	<u>Subd. 15. Board of Psychology</u>	<u>1,362,000</u>	<u>1,360,000</u>
369.12	<u>Subd. 16. Board of Social Work</u>	<u>1,561,000</u>	<u>1,560,000</u>
369.13	<u>Subd. 17. Board of Veterinary Medicine</u>	<u>363,000</u>	<u>363,000</u>
369.14	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
369.15	<u>REGULATORY BOARD</u>	<u>\$ 4,453,000</u>	<u>\$ 3,829,000</u>
369.16	<u>(a) Cooper/Sams Volunteer Ambulance</u>		
369.17	<u>Program.</u> <u>\$950,000 in fiscal year 2022 and</u>		
369.18	<u>\$950,000 in fiscal year 2023 are for the</u>		
369.19	<u>Cooper/Sams volunteer ambulance program</u>		
369.20	<u>under Minnesota Statutes, section 144E.40.</u>		
369.21	<u>(1) Of this amount, \$861,000 in fiscal year</u>		
369.22	<u>2022 and \$861,000 in fiscal year 2023 are for</u>		
369.23	<u>the ambulance service personnel longevity</u>		
369.24	<u>award and incentive program under Minnesota</u>		
369.25	<u>Statutes, section 144E.40.</u>		
369.26	<u>(2) Of this amount, \$89,000 in fiscal year 2022</u>		
369.27	<u>and \$89,000 in fiscal year 2023 are for the</u>		
369.28	<u>operations of the ambulance service personnel</u>		
369.29	<u>longevity award and incentive program under</u>		
369.30	<u>Minnesota Statutes, section 144E.40.</u>		
369.31	<u>(b) EMSRB Operations.</u> <u>\$1,880,000 in fiscal</u>		
369.32	<u>year 2022 and \$1,880,000 in fiscal year 2023</u>		
369.33	<u>are for board operations.</u>		

370.1 (c) **Regional Grants.** \$585,000 in fiscal year
 370.2 2022 and \$585,000 in fiscal year 2023 are for
 370.3 regional emergency medical services
 370.4 programs, to be distributed equally to the eight
 370.5 emergency medical service regions under
 370.6 Minnesota Statutes, section 144E.52.

370.7 (d) **Ambulance Training Grant.** \$361,000
 370.8 in fiscal year 2022 and \$361,000 in fiscal year
 370.9 2023 are for training grants under Minnesota
 370.10 Statutes, section 144E.35.

370.11 (e) **Grants to Regional Emergency Medical**
 370.12 **Services Programs.** \$650,000 in fiscal year
 370.13 2022 is for grants to regional emergency
 370.14 medical services programs, to be distributed
 370.15 among the eight emergency medical services
 370.16 regions according to Minnesota Statutes,
 370.17 section 144E.50.

370.18 Sec. 6. <u>COUNCIL ON DISABILITY</u>	<u>\$</u>	<u>1,022,000</u>	<u>\$</u>	<u>1,038,000</u>
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370.19 Sec. 7. <u>OMBUDSMAN FOR MENTAL</u> 370.20 <u>HEALTH AND DEVELOPMENTAL</u> 370.21 <u>DISABILITIES</u>	<u>\$</u>	<u>2,487,000</u>	<u>\$</u>	<u>2,536,000</u>
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370.22 **Department of Psychiatry Monitoring.**
 370.23 \$100,000 in fiscal year 2022 and \$100,000 in
 370.24 fiscal year 2023 are for monitoring the
 370.25 Department of Psychiatry at the University of
 370.26 Minnesota.

370.27 Sec. 8. <u>OMBUDSPERSONS FOR FAMILIES</u>	<u>\$</u>	<u>733,000</u>	<u>\$</u>	<u>744,000</u>
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370.28 Sec. 9. <u>ATTORNEY GENERAL</u>	<u>\$</u>	<u>200,000</u>	<u>\$</u>	<u>200,000</u>
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370.29 **Excessive Drug Price Increases.** This
 370.30 appropriation is for costs of expert witnesses
 370.31 and investigations under Minnesota Statutes,
 370.32 section 62J.844. This is a onetime
 370.33 appropriation.

371.1 Sec. 10. Laws 2019, First Special Session chapter 9, article 14, section 3, as amended by
 371.2 Laws 2019, First Special Session chapter 12, section 6, is amended to read:

371.3 **Sec. 3. COMMISSIONER OF HEALTH**

371.4				<u>236,188,000</u>
371.5	Subdivision 1. Total Appropriation		\$ 231,829,000	\$ <u>233,584,000</u>

371.6 Appropriations by Fund

371.7		2020	2021
371.8			126,276,000
371.9	General	124,381,000	<u>125,881,000</u>
371.10	State Government		61,367,000
371.11	Special Revenue	58,450,000	<u>59,158,000</u>
371.12	Health Care Access	37,285,000	36,832,000
371.13	Federal TANF	11,713,000	11,713,000

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

371.17 **Subd. 2. Health Improvement**

371.18 Appropriations by Fund

371.19			96,117,000
371.20	General	94,980,000	<u>95,722,000</u>
371.21	State Government		7,558,000
371.22	Special Revenue	7,614,000	<u>6,924,000</u>
371.23	Health Care Access	37,285,000	36,832,000
371.24	Federal TANF	11,713,000	11,713,000

371.25 **(a) TANF Appropriations.** (1) \$3,579,000 in
 371.26 fiscal year 2020 and \$3,579,000 in fiscal year
 371.27 2021 are from the TANF fund for home
 371.28 visiting and nutritional services under
 371.29 Minnesota Statutes, section 145.882,
 371.30 subdivision 7, clauses (6) and (7). Funds must
 371.31 be distributed to community health boards
 371.32 according to Minnesota Statutes, section
 371.33 145A.131, subdivision 1;

371.34 (2) \$2,000,000 in fiscal year 2020 and
 371.35 \$2,000,000 in fiscal year 2021 are from the
 371.36 TANF fund for decreasing racial and ethnic

372.1 disparities in infant mortality rates under
372.2 Minnesota Statutes, section 145.928,
372.3 subdivision 7;

372.4 (3) \$4,978,000 in fiscal year 2020 and
372.5 \$4,978,000 in fiscal year 2021 are from the
372.6 TANF fund for the family home visiting grant
372.7 program under Minnesota Statutes, section
372.8 145A.17. \$4,000,000 of the funding in each
372.9 fiscal year must be distributed to community
372.10 health boards according to Minnesota Statutes,
372.11 section 145A.131, subdivision 1. \$978,000 of
372.12 the funding in each fiscal year must be
372.13 distributed to tribal governments according to
372.14 Minnesota Statutes, section 145A.14,
372.15 subdivision 2a;

372.16 (4) \$1,156,000 in fiscal year 2020 and
372.17 \$1,156,000 in fiscal year 2021 are from the
372.18 TANF fund for family planning grants under
372.19 Minnesota Statutes, section 145.925; and

372.20 (5) The commissioner may use up to 6.23
372.21 percent of the amounts appropriated from the
372.22 TANF fund each year to conduct the ongoing
372.23 evaluations required under Minnesota Statutes,
372.24 section 145A.17, subdivision 7, and training
372.25 and technical assistance as required under
372.26 Minnesota Statutes, section 145A.17,
372.27 subdivisions 4 and 5.

372.28 **(b) TANF Carryforward.** Any unexpended
372.29 balance of the TANF appropriation in the first
372.30 year of the biennium does not cancel but is
372.31 available for the second year.

372.32 **(c) Comprehensive Suicide Prevention.**
372.33 \$2,730,000 in fiscal year 2020 and \$2,730,000
372.34 in fiscal year 2021 are from the general fund

373.1 for a comprehensive, community-based suicide
373.2 prevention strategy. The funds are allocated
373.3 as follows:

373.4 (1) \$955,000 in fiscal year 2020 and \$955,000
373.5 in fiscal year 2021 are for community-based
373.6 suicide prevention grants authorized in
373.7 Minnesota Statutes, section 145.56,
373.8 subdivision 2. Specific emphasis must be
373.9 placed on those communities with the greatest
373.10 disparities. The base for this appropriation is
373.11 \$1,291,000 in fiscal year 2022 and \$1,291,000
373.12 in fiscal year 2023;

373.13 (2) \$683,000 in fiscal year 2020 and \$683,000
373.14 in fiscal year 2021 are to support
373.15 evidence-based training for educators and
373.16 school staff and purchase suicide prevention
373.17 curriculum for student use statewide, as
373.18 authorized in Minnesota Statutes, section
373.19 145.56, subdivision 2. The base for this
373.20 appropriation is \$913,000 in fiscal year 2022
373.21 and \$913,000 in fiscal year 2023;

373.22 (3) \$137,000 in fiscal year 2020 and \$137,000
373.23 in fiscal year 2021 are to implement the Zero
373.24 Suicide framework with up to 20 behavioral
373.25 and health care organizations each year to treat
373.26 individuals at risk for suicide and support
373.27 those individuals across systems of care upon
373.28 discharge. The base for this appropriation is
373.29 \$205,000 in fiscal year 2022 and \$205,000 in
373.30 fiscal year 2023;

373.31 (4) \$955,000 in fiscal year 2020 and \$955,000
373.32 in fiscal year 2021 are to develop and fund a
373.33 Minnesota-based network of National Suicide
373.34 Prevention Lifeline, providing statewide
373.35 coverage. The base for this appropriation is

374.1 \$1,321,000 in fiscal year 2022 and \$1,321,000
374.2 in fiscal year 2023; and

374.3 (5) the commissioner may retain up to 18.23
374.4 percent of the appropriation under this
374.5 paragraph to administer the comprehensive
374.6 suicide prevention strategy.

374.7 **(d) Statewide Tobacco Cessation.** \$1,598,000
374.8 in fiscal year 2020 and \$2,748,000 in fiscal
374.9 year 2021 are from the general fund for
374.10 statewide tobacco cessation services under
374.11 Minnesota Statutes, section 144.397. The base
374.12 for this appropriation is \$2,878,000 in fiscal
374.13 year 2022 and \$2,878,000 in fiscal year 2023.

374.14 **(e) Health Care Access Survey.** \$225,000 in
374.15 fiscal year 2020 and \$225,000 in fiscal year
374.16 2021 are from the health care access fund to
374.17 continue and improve the Minnesota Health
374.18 Care Access Survey. These appropriations
374.19 may be used in either year of the biennium.

374.20 **(f) Community Solutions for Healthy Child**
374.21 **Development Grant Program.** \$1,000,000
374.22 in fiscal year 2020 and \$1,000,000 in fiscal
374.23 year 2021 are for the community solutions for
374.24 healthy child development grant program to
374.25 promote health and racial equity for young
374.26 children and their families under article 11,
374.27 section 107. The commissioner may use up to
374.28 23.5 percent of the total appropriation for
374.29 administration. The base for this appropriation
374.30 is \$1,000,000 in fiscal year 2022, \$1,000,000
374.31 in fiscal year 2023, and \$0 in fiscal year 2024.

374.32 **(g) Domestic Violence and Sexual Assault**
374.33 **Prevention Program.** \$375,000 in fiscal year
374.34 2020 and \$375,000 in fiscal year 2021 are

375.1 from the general fund for the domestic
 375.2 violence and sexual assault prevention
 375.3 program under article 11, section 108. This is
 375.4 a onetime appropriation.

375.5 **(h) Skin Lightening Products Public**
 375.6 **Awareness Grant Program.** \$100,000 in
 375.7 fiscal year 2020 and \$100,000 in fiscal year
 375.8 2021 are from the general fund for a skin
 375.9 lightening products public awareness and
 375.10 education grant program. This is a onetime
 375.11 appropriation.

375.12 **(i) Cannabinoid Products Workgroup.**
 375.13 \$8,000 in fiscal year 2020 is from the state
 375.14 government special revenue fund for the
 375.15 cannabinoid products workgroup. This is a
 375.16 onetime appropriation.

375.17 **(j) Base Level Adjustments.** The general fund
 375.18 base is \$96,742,000 in fiscal year 2022 and
 375.19 \$96,742,000 in fiscal year 2023. The health
 375.20 care access fund base is \$37,432,000 in fiscal
 375.21 year 2022 and \$36,832,000 in fiscal year 2023.

375.22 **Subd. 3. Health Protection**

375.23 Appropriations by Fund

375.24	General	18,803,000	19,774,000
375.25	State Government		53,809,000
375.26	Special Revenue	50,836,000	<u>52,234,000</u>

375.27 **(a) Public Health Laboratory Equipment.**
 375.28 \$840,000 in fiscal year 2020 and \$655,000 in
 375.29 fiscal year 2021 are from the general fund for
 375.30 equipment for the public health laboratory.
 375.31 This is a onetime appropriation and is
 375.32 available until June 30, 2023.

375.33 **(b) Base Level Adjustment.** The general fund
 375.34 base is \$19,119,000 in fiscal year 2022 and

376.1 \$19,119,000 in fiscal year 2023. The state
 376.2 government special revenue fund base is
 376.3 \$53,782,000 in fiscal year 2022 and
 376.4 \$53,782,000 in fiscal year 2023.

376.5 Subd. 4. **Health Operations** 10,598,000 10,385,000

376.6 **Base Level Adjustment.** The general fund
 376.7 base is \$10,912,000 in fiscal year 2022 and
 376.8 \$10,912,000 in fiscal year 2023.

376.9 **EFFECTIVE DATE.** This section is effective the day following final enactment and
 376.10 the reductions in subdivisions 1 to 3 are onetime reductions.

376.11 Sec. 11. **APPROPRIATION; MINNESOTA FAMILY INVESTMENT PROGRAM**
 376.12 **SUPPLEMENTAL PAYMENT.**

376.13 \$24,235,000 in fiscal year 2021 is appropriated from the TANF fund to the commissioner
 376.14 of human services to provide a onetime cash benefit of up to \$750 for each household
 376.15 enrolled in the Minnesota family investment program or diversionary work program under
 376.16 Minnesota Statutes, chapter 256J, at the time that the cash benefit is distributed. The
 376.17 commissioner shall distribute these funds through existing systems and in a manner that
 376.18 minimizes the burden to families. This is a onetime appropriation.

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

376.20 Sec. 12. **APPROPRIATION; REFINANCING OF EMERGENCY CHILD CARE**
 376.21 **GRANTS; CANCELLATION.**

376.22 \$26,622,626 in fiscal year 2021 is appropriated from the coronavirus relief federal fund
 376.23 to the commissioner of human services for fiscal year 2020 to replace a portion of the general
 376.24 fund appropriation in Laws 2020, chapter 71, article 1, section 2, subdivision 9. The general
 376.25 fund appropriation that is replaced by coronavirus relief funds under this section is canceled
 376.26 to the general fund. This is a onetime appropriation.

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

377.1 Sec. 13. **CANCELLATION; TRANSFER FROM STATE GOVERNMENT SPECIAL**
377.2 **REVENUE FUND TO GENERAL FUND.**

377.3 The \$77,000 transfer each year from the state government special revenue fund to the
377.4 general fund under Laws 2008, chapter 364, section 17, paragraph (b), is canceled. This
377.5 section does not expire.

377.6 **EFFECTIVE DATE.** This section is effective June 30, 2021.

377.7 Sec. 14. **FEDERAL FUNDS FOR VACCINE ACTIVITIES; APPROPRIATION.**

377.8 Federal funds made available to the commissioner of health for vaccine activities are
377.9 appropriated to the commissioner for that purpose and shall be used to support work under
377.10 Minnesota Statutes, sections 144.0661 to 144.0663.

377.11 Sec. 15. **FEDERAL FUNDS REPLACEMENT; APPROPRIATION.**

377.12 Notwithstanding any law to the contrary, the commissioner of management and budget
377.13 must determine whether the expenditures authorized under this act are eligible uses of federal
377.14 funding received under the Coronavirus State Fiscal Recovery Fund or any other federal
377.15 funds received by the state under the American Rescue Plan Act, Public Law 117-2. If the
377.16 commissioner of management and budget determines an expenditure is eligible for funding
377.17 under Public Law 117-2, the amount of the eligible expenditure is appropriated from the
377.18 account where those amounts have been deposited and the corresponding general fund
377.19 amounts appropriated under this act are canceled to the general fund.

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

377.21 Sec. 16. **TRANSFERS; HUMAN SERVICES.**

377.22 Subdivision 1. **Grants.** The commissioner of human services, with the approval of the
377.23 commissioner of management and budget, may transfer unencumbered appropriation balances
377.24 for the biennium ending June 30, 2023, within fiscal years among the MFIP, general
377.25 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
377.26 Statutes, section 119B.05, Minnesota supplemental aid program, group residential housing
377.27 program, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
377.28 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
377.29 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
377.30 and ranking minority members of the senate Health and Human Services Finance Division
377.31 and the house of representatives Health Finance and Policy Committee and Human Services
377.32 Finance and Policy Committee quarterly about transfers made under this subdivision.

378.1 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money
378.2 may be transferred within the Department of Human Services as the commissioners consider
378.3 necessary, with the advance approval of the commissioner of management and budget. The
378.4 commissioner shall inform the chairs and ranking minority members of the senate Health
378.5 and Human Services Finance Division and the house of representatives Health Finance and
378.6 Policy Committee and Human Services Finance and Policy Committee quarterly about
378.7 transfers made under this subdivision.

378.8 Sec. 17. **TRANSFERS; HEALTH.**

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

378.14 Sec. 18. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

378.15 The commissioners of health and human services shall not use indirect cost allocations
378.16 to pay for the operational costs of any program for which they are responsible.

378.17 Sec. 19. **APPROPRIATION ENACTED MORE THAN ONCE.**

378.18 If an appropriation in this act is enacted more than once in the 2021 legislative session,
378.19 the appropriation must be given effect only once.

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

378.21 Sec. 20. **EXPIRATION OF UNCODIFIED LANGUAGE.**

378.22 All uncodified language contained in this article expires on June 30, 2023, unless a
378.23 different expiration date is explicit.

378.24 Sec. 21. **REPEALER.**

378.25 Minnesota Statutes 2020, section 16A.724, subdivision 2, is repealed effective June 30,
378.26 2025.

378.27 Sec. 22. **EFFECTIVE DATE.**

378.28 This article is effective July 1, 2021, unless a different effective date is specified.

16A.724 HEALTH CARE ACCESS FUND.

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in fiscal year 2016 shall not exceed \$48,000,000, the amount in fiscal year 2017 shall not exceed \$122,000,000, and the amount in any fiscal biennium thereafter shall not exceed \$244,000,000. The purpose of this transfer is to meet the rate increase required under section 256B.04, subdivision 25.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

62A.67 SHORT TITLE.

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

62A.671 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmission does not constitute telemedicine consultations or services. A communication between a licensed health care provider and a patient that consists solely of an e-mail or facsimile transmission does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

62A.672 COVERAGE OF TELEMEDICINE SERVICES.

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

62J.63 CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT.

Subd. 3. **Report.** The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health website and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement.

144.0721 ASSESSMENTS OF CARE AND SERVICES TO NURSING HOME RESIDENTS.

Subdivision 1. **Appropriateness and quality.** Until the date of implementation of the revised case mix system based on the minimum data set, the commissioner of health shall assess the appropriateness and quality of care and services furnished to private paying residents in nursing homes and boarding care homes that are certified for participation in the medical assistance program under United States Code, title 42, sections 1396-1396p. These assessments shall be conducted until the date of implementation of the revised case mix system with the exception of provisions requiring recommendations for changes in the level of care provided to the private paying residents.

144.0722 RESIDENT REIMBURSEMENT CLASSIFICATIONS.

Subdivision 1. **Resident reimbursement classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under section 144.0721, or under rules established by the commissioner of human services under chapter 256R. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **Notice of resident reimbursement classification.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity

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to request a reconsideration of the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident. The nursing home or boarding care home is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the notices from the department.

Subd. 2a. **Semiannual assessment by nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0059, subpart 2, item B, the individual dependencies items 21 to 24 and 28 are required to be completed in accordance with the Facility Manual for Completing Case Mix Requests for Classification, July 1987, issued by the Minnesota Department of Health.

Subd. 3. **Request for reconsideration.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the receipt of the notice of resident classification. For reconsideration requests submitted by or on behalf of the resident, the time period for submission of the request begins as of the date the resident or the resident's representative receives the classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 3a. **Access to information.** Upon written request, the nursing home or boarding care home must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home or boarding care home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a \$100 fine the first day of noncompliance, and an increase in the \$100 fine by \$50 increments for each day the noncompliance continues. For the purposes of this section, "representative" includes the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the nursing home ombudsman's office whose assistance has been requested, or any other individual designated by the resident.

Subd. 3b. **Facility's request for reconsideration.** In addition to the information required in subdivision 3, a reconsideration request from a nursing home or boarding care home must contain the following information: the date the resident reimbursement classification notices were received by the facility; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the department and the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide this information with the reconsideration request, the request must be denied, and the facility may not make further reconsideration requests on that specific reimbursement classification.

Subd. 4. **Reconsideration.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be

notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Subd. 5. **Audit authority.** The Department of Health may audit assessments of nursing home and boarding care home residents. These audits may be in addition to the assessments completed by the department under section 144.0721. The audits may be conducted at the facility, and the department may conduct the audits on an unannounced basis.

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

144.693 MEDICAL MALPRACTICE CLAIMS; REPORTS.

Subdivision 1. **Insurers' reports to commissioner.** On or before September 1, 1976, and on or before March 1 and September 1 of each year thereafter, each insurer providing professional liability insurance to one or more hospitals, outpatient surgery centers, or health maintenance organizations, shall submit to the state commissioner of health a report listing by facility or organization all claims which have been closed by or filed with the insurer during the period ending December 31 of the previous year or June 30 of the current year. The report shall contain, but not be limited to, the following information:

(1) the total number of claims made against each facility or organization which were filed or closed during the reporting period;

(2) the date each new claim was filed with the insurer;

(3) the allegations contained in each claim filed during the reporting period;

(4) the disposition and closing date of each claim closed during the reporting period;

(5) the dollar amount of the award or settlement for each claim closed during the reporting period; and

(6) any other information the commissioner of health may, by rule, require.

Any hospital, outpatient surgery center, or health maintenance organization which is self insured shall be considered to be an insurer for the purposes of this section and shall comply with the reporting provisions of this section.

A report from an insurer submitted pursuant to this section is private data, as defined in section 13.02, subdivision 12, accessible to the facility or organization which is the subject of the data, and to its authorized agents. Any data relating to patient records which is reported to the state commissioner of health pursuant to this section shall be reported in the form of summary data, as defined in section 13.02, subdivision 19.

Subd. 2. **Report to legislature.** The state commissioner of health shall collect and review the data reported pursuant to subdivision 1. On December 1, 1976, and on January 2 of each year thereafter, the state commissioner of health shall report to the legislature the findings related to the incidence and size of malpractice claims against hospitals, outpatient surgery centers, and health maintenance organizations, and shall make any appropriate recommendations to reduce the incidence and size of the claims. Data published by the state commissioner of health pursuant to this subdivision with respect to malpractice claims information shall be summary data within the meaning of section 13.02, subdivision 19.

Subd. 3. **Access to insurers' records.** The state commissioner of health shall have access to the records of any insurer relating to malpractice claims made against hospitals, outpatient surgery centers, and health maintenance organizations in years prior to 1976 if the commissioner determines the records are necessary to fulfill the duties of the commissioner under Laws 1976, chapter 325.

245C.10 BACKGROUND STUDY; FEES.

Subd. 2. **Supplemental nursing services agencies.** The commissioner shall recover the cost of the background studies initiated by supplemental nursing services agencies registered under section 144A.71, subdivision 1, through a fee of no more than \$20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

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Subd. 2a. **Occupations regulated by commissioner of health.** The commissioner shall set fees to recover the cost of combined background studies and criminal background checks initiated by applicants, licensees, and certified practitioners regulated under sections 148.511 to 148.5198 and chapter 153A. The fees collected under this subdivision shall be deposited in the special revenue fund and are appropriated to the commissioner for the purpose of conducting background studies and criminal background checks.

Subd. 3. **Personal care provider organizations.** The commissioner shall recover the cost of background studies initiated by a personal care provider organization under sections 256B.0651 to 256B.0654 and 256B.0659 through a fee of no more than \$20 per study charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 4. **Temporary personnel agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03, subdivision 4, through a fee of no more than \$20 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for the purposes of adult foster care and family adult day services licensing, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 6. **Unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities.** The commissioner shall recover the cost of background studies initiated by unlicensed home and community-based waiver providers of service to seniors and individuals with disabilities under section 256B.4912 through a fee of no more than \$20 per study.

Subd. 7. **Private agencies.** The commissioner shall recover the cost of conducting background studies under section 245C.33 for studies initiated by private agencies for the purpose of adoption through a fee of no more than \$70 per study charged to the private agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 7, for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03, subdivision 1, for all programs that are licensed by the commissioner, except child foster care when the applicant or license holder resides in the home where child foster care services are provided, family child care, child care centers, certified license-exempt child care centers, and legal nonlicensed child care authorized under chapter 119B, through a fee of no more than \$20 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 9a. **Child care programs.** The commissioner shall recover the cost of a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care providers authorized under chapter 119B through a fee of no more than \$40 per study charged to the license holder. A fee of no more than \$20 per study shall be charged for studies conducted under section 245C.05, subdivision 5a, paragraph (a). The fees collected under this subdivision are appropriated to the commissioner to conduct background studies.

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services provider providing service functions under section 256B.85, subdivision 13, through a fee of no more than \$20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 11. **Providers of housing support.** The commissioner shall recover the cost of background studies initiated by providers of housing support under section 256I.04 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 12. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall recover the cost of background studies initiated by county social services agencies and local welfare agencies for individuals who are required to have a background study under section 626.559, subdivision 1b, through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 13. **Providers of special transportation service.** The commissioner shall recover the cost of background studies initiated by providers of special transportation service under section 174.30 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Subd. 14. **Children's residential facilities.** The commissioner shall recover the cost of background studies initiated by a licensed children's residential facility through a fee of no more than \$51 per study. Fees collected under this subdivision are appropriated to the commissioner for purposes of conducting background studies.

Subd. 16. **Providers of housing support services.** The commissioner shall recover the cost of background studies initiated by providers of housing support services under section 256B.051 through a fee of no more than \$20 per study. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

256B.0596 MENTAL HEALTH CASE MANAGEMENT.

Counties shall contract with eligible providers willing to provide mental health case management services under section 256B.0625, subdivision 20. In order to be eligible, in addition to general provider requirements under this chapter, the provider must:

- (1) be willing to provide the mental health case management services; and
- (2) have a minimum of at least one contact with the client per week. This section is not intended to limit the ability of a county to provide its own mental health case management services.

256B.0625 COVERED SERVICES.

Subd. 18c. **Nonemergency Medical Transportation Advisory Committee.** (a) The Nonemergency Medical Transportation Advisory Committee shall advise the commissioner on the administration of nonemergency medical transportation covered under medical assistance. The advisory committee shall meet at least quarterly the first year following January 1, 2015, and at least biannually thereafter and may meet more frequently as required by the commissioner. The advisory committee shall annually elect a chair from among its members, who shall work with the commissioner or the commissioner's designee to establish the agenda for each meeting. The commissioner, or the commissioner's designee, shall attend all advisory committee meetings.

(b) The Nonemergency Medical Transportation Advisory Committee shall advise and make recommendations to the commissioner on:

- (1) updates to the nonemergency medical transportation policy manual;
- (2) other aspects of the nonemergency medical transportation system, as requested by the commissioner; and
- (3) other aspects of the nonemergency medical transportation system, as requested by:
 - (i) a committee member, who may request an item to be placed on the agenda for a future meeting. The request may be considered by the committee and voted upon. If the motion carries, the meeting agenda item may be developed for presentation to the committee; and
 - (ii) a member of the public, who may approach the committee by letter or e-mail requesting that an item be placed on a future meeting agenda. The request may be considered by the committee and voted upon. If the motion carries, the agenda item may be developed for presentation to the committee.

(c) The Nonemergency Medical Transportation Advisory Committee shall coordinate its activities with the Minnesota Council on Transportation Access established under section 174.285. The chair

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of the advisory committee, or the chair's designee, shall attend all meetings of the Minnesota Council on Transportation Access.

(d) The Nonemergency Medical Transportation Advisory Committee shall expire December 1, 2019.

Subd. 18d. **Advisory committee members.** (a) The Nonemergency Medical Transportation Advisory Committee consists of:

(1) four voting members who represent counties, utilizing the rural urban commuting area classification system. As defined in subdivision 17, these members shall be designated as follows:

- (i) two counties within the 11-county metropolitan area;
- (ii) one county representing the rural area of the state; and
- (iii) one county representing the super rural area of the state.

The Association of Minnesota Counties shall appoint one county within the 11-county metropolitan area and one county representing the super rural area of the state. The Minnesota Inter-County Association shall appoint one county within the 11-county metropolitan area and one county representing the rural area of the state;

(2) three voting members who represent medical assistance recipients, including persons with physical and developmental disabilities, persons with mental illness, seniors, children, and low-income individuals;

(3) five voting members who represent providers that deliver nonemergency medical transportation services to medical assistance enrollees, one of whom is a taxicab owner or operator;

(4) two voting members of the house of representatives, one from the majority party and one from the minority party, appointed by the speaker of the house, and two voting members from the senate, one from the majority party and one from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration;

(5) one voting member who represents demonstration providers as defined in section 256B.69, subdivision 2;

(6) one voting member who represents an organization that contracts with state or local governments to coordinate transportation services for medical assistance enrollees;

(7) one voting member who represents the Minnesota State Council on Disability;

(8) the commissioner of transportation or the commissioner's designee, who shall serve as a voting member;

(9) one voting member appointed by the Minnesota Ambulance Association; and

(10) one voting member appointed by the Minnesota Hospital Association.

(b) Members of the advisory committee shall not be employed by the Department of Human Services. Members of the advisory committee shall receive no compensation.

Subd. 18e. **Single administrative structure and delivery system.** The commissioner, in coordination with the commissioner of transportation, shall implement a single administrative structure and delivery system for nonemergency medical transportation, beginning the latter of the date the single administrative assessment tool required in this subdivision is available for use, as determined by the commissioner or by July 1, 2016.

In coordination with the Department of Transportation, the commissioner shall develop and authorize a web-based single administrative structure and assessment tool, which must operate 24 hours a day, seven days a week, to facilitate the enrollee assessment process for nonemergency medical transportation services. The web-based tool shall facilitate the transportation eligibility determination process initiated by clients and client advocates; shall include an accessible automated intake and assessment process and real-time identification of level of service eligibility; and shall authorize an appropriate and auditable mode of transportation authorization. The tool shall provide a single framework for reconciling trip information with claiming and collecting complaints regarding inappropriate level of need determinations, inappropriate transportation modes utilized, and interference with accessing nonemergency medical transportation. The web-based single administrative structure shall operate on a trial basis for one year from implementation and, if approved by the commissioner, shall be permanent thereafter. The commissioner shall seek input

from the Nonemergency Medical Transportation Advisory Committee to ensure the software is effective and user-friendly and make recommendations regarding funding of the single administrative system.

Subd. 18h. **Managed care.** (a) The following subdivisions apply to managed care plans and county-based purchasing plans:

- (1) subdivision 17, paragraphs (a), (b), (i), and (n);
- (2) subdivision 18; and
- (3) subdivision 18a.

(b) A nonemergency medical transportation provider must comply with the operating standards for special transportation service specified in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

256B.0924 TARGETED CASE MANAGEMENT SERVICES.

Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal approval, contact made for targeted case management by interactive video shall be eligible for payment under subdivision 6 if:

- (1) the person receiving targeted case management services is residing in:
 - (i) a hospital;
 - (ii) a nursing facility; or
 - (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging establishment or lodging establishment that provides supportive services or health supervision services according to section 157.17 that is staffed 24 hours a day, seven days a week;
 - (2) interactive video is in the best interests of the person and is deemed appropriate by the person receiving targeted case management or the person's legal guardian, the case management provider, and the provider operating the setting where the person is residing;
 - (3) the use of interactive video is approved as part of the person's written personal service or case plan; and
 - (4) interactive video is used for up to, but not more than, 50 percent of the minimum required face-to-face contact.
- (b) The person receiving targeted case management or the person's legal guardian has the right to choose and consent to the use of interactive video under this subdivision and has the right to refuse the use of interactive video at any time.
- (c) The commissioner shall establish criteria that a targeted case management provider must attest to in order to demonstrate the safety or efficacy of delivering the service via interactive video. The attestation may include that the case management provider has:
- (1) written policies and procedures specific to interactive video services that are regularly reviewed and updated;
 - (2) policies and procedures that adequately address client safety before, during, and after the interactive video services are rendered;
 - (3) established protocols addressing how and when to discontinue interactive video services; and
 - (4) established a quality assurance process related to interactive video services.
- (d) As a condition of payment, the targeted case management provider must document the following for each occurrence of targeted case management provided by interactive video:
- (1) the time the service began and the time the service ended, including an a.m. and p.m. designation;
 - (2) the basis for determining that interactive video is an appropriate and effective means for delivering the service to the person receiving case management services;

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(3) the mode of transmission of the interactive video services and records evidencing that a particular mode of transmission was utilized;

(4) the location of the originating site and the distant site; and

(5) compliance with the criteria attested to by the targeted case management provider as provided in paragraph (c).

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially disabling condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1693 to 9505.1748.

Subp. 2. **Duties of provider.** The provider shall sign a provider agreement stating that the provider will provide screening services according to standards in parts 9505.1693 to 9505.1748 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

9505.1693 SCOPE AND PURPOSE.

Parts 9505.1693 to 9505.1748 govern the early and periodic screening, diagnosis, and treatment (EPSDT) program.

Parts 9505.1693 to 9505.1748 must be read in conjunction with section 1905(a)(4)(B) of the Social Security Act, as amended through December 31, 1981, and the Code of Federal Regulations, title 42, part 441, subpart B, as amended through October 1, 1987, and section 6403 of the Omnibus Budget Reconciliation Act of 1989. The purpose of the EPSDT program is to identify potentially disabling conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage parents and their children to use health care services when necessary.

9505.1696 DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9505.1693 to 9505.1748, the following terms have the meanings given them.

Subp. 2. **Child.** "Child" means a person who is eligible for early and periodic screening, diagnosis, and treatment under part 9505.1699.

Subp. 3. **Community health clinic.** "Community health clinic" means a clinic that provides services by or under the supervision of a physician and that:

- A. is incorporated as a nonprofit corporation under Minnesota Statutes, chapter 317A;
- B. is exempt from federal income tax under Internal Revenue Code of 1986, section 501(c)(3), as amended through December 31, 1987;
- C. is established to provide health services to low-income population groups; and
- D. has written clinic policies describing the services provided by the clinic and concerning (1) the medical management of health problems, including problems that require referral to physicians, (2) emergency health services, and (3) the maintenance and review of health records by the physician.

Subp. 4. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 5. **Diagnosis.** "Diagnosis" means the identification and determination of the nature or cause of a disease or abnormality through the use of a health history; physical, developmental, and psychological examination; and laboratory tests.

Subp. 6. **Early and periodic screening clinic or EPS clinic.** "Early and periodic screening clinic" or "EPS clinic" means an individual or facility that is approved by the Minnesota Department of Health under parts 4615.0900 to 4615.2000.

Subp. 7. **Early and periodic screening, diagnosis, and treatment program or EPSDT program.** "Early and periodic screening, diagnosis, and treatment program" or "EPSDT program" means the program that provides screening, diagnosis, and treatment

under parts 9505.1693 to 9505.1748; Code of Federal Regulations, title 42, section 441.55, as amended through October 1, 1986; and Minnesota Statutes, section 256B.02, subdivision 8, paragraph (12).

Subp. 8. **EPSDT clinic.** "EPSDT clinic" means a facility supervised by a physician that provides screening according to parts 9505.1693 to 9505.1748 or an EPS clinic.

Subp. 9. **EPSDT provider agreement.** "EPSDT provider agreement" means the agreement required by part 9505.1703, subpart 2.

Subp. 11. **Follow-up.** "Follow-up" means efforts by a local agency to ensure that a screening requested for a child is provided to that child and that diagnosis and treatment indicated as necessary by a screening are also provided to that child.

Subp. 12. **Head Start agency.** "Head Start agency" refers to the child development program administered by the United States Department of Health and Human Services, Office of Administration for Children, Youth and Families.

Subp. 13. **Local agency.** "Local agency" means the county welfare board, multicounty welfare board, or human service agency established in Minnesota Statutes, section 256B.02, subdivision 6, and Minnesota Statutes, chapter 393.

Subp. 14. **Medical assistance.** "Medical assistance" means the program authorized by title XIX of the Social Security Act and Minnesota Statutes, chapters 256 and 256B.

Subp. 15. **Outreach.** "Outreach" means efforts by the department or a local agency to inform eligible persons about early and periodic screening, diagnosis, and treatment or to encourage persons to use the EPSDT program.

Subp. 16. **Parent.** "Parent" refers to the genetic or adoptive parent of a child.

Subp. 17. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of the person's profession under Minnesota Statutes, chapter 147.

Subp. 18. **Prepaid health plan.** "Prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C, and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients of medical assistance entitlements.

Subp. 19. **Public health nursing service.** "Public health nursing service" means the nursing program provided by a community health board under Minnesota Statutes, section 145A.04, subdivisions 1 and 1a.

Subp. 20. **Screening.** "Screening" means the use of quick, simple procedures to separate apparently well children from those who need further examination for possible physical, developmental, or psychological problems.

Subp. 21. **Skilled professional medical personnel and supporting staff.** "Skilled professional medical personnel" and "supporting staff" means persons as defined by Code of Federal Regulations, title 42, section 432.2, as amended through October 1, 1987.

Subp. 22. **Treatment.** "Treatment" means the prevention, correction, or amelioration of a disease or abnormality identified by screening or diagnosis.

9505.1699 ELIGIBILITY TO BE SCREENED.

A person under age 21 who is eligible for medical assistance is eligible for the EPSDT program.

9505.1701 CHOICE OF PROVIDER.

Subpart 1. **Choice of screening provider.** Except as provided by subpart 3, a child or parent of a child who requests screening may choose any screening provider who has signed an EPSDT provider agreement and a medical assistance provider agreement.

Subp. 2. **Choice of diagnosis and treatment provider.** Except as provided by subpart 3, a child or parent of a child may choose any diagnosis and treatment provider as provided by part 9505.0190.

Subp. 3. **Exception to subparts 1 and 2.** A child who is enrolled in a prepaid health plan must receive screening, diagnosis, and treatment from that plan.

9505.1703 ELIGIBILITY TO PROVIDE SCREENING.

Subpart 1. **Providers.** An EPSDT clinic or a community health clinic shall be approved for medical assistance reimbursement for EPSDT services if it complies with the requirements of parts 9505.1693 to 9505.1748. A Head Start agency shall be approved as provided by subpart 2.

Subp. 2. **EPSDT provider agreement.** To be eligible to provide screening and receive reimbursement under the EPSDT program, an individual or facility must sign an EPSDT provider agreement provided by the department and a medical assistance provider agreement under part 9505.0195 or be a prepaid health plan.

Subp. 3. **Terms of EPSDT provider agreement.** The EPSDT provider agreement required by subpart 2 must state that the provider must:

- A. screen children according to parts 9505.1693 to 9505.1748;
- B. report all findings of the screenings on EPSDT screening forms; and
- C. refer children for diagnosis and treatment if a referral is indicated by the screening.

The EPSDT provider agreement also must state that the department will provide training according to part 9505.1712 and will train and consult with the provider on billing and reporting procedures.

9505.1706 REIMBURSEMENT.

Subpart 1. **Maximum payment rates.** Payment rates shall be as provided by part 9505.0445, item M.

Subp. 2. **Eligibility for reimbursement; Head Start agency.** A Head Start agency may complete all the screening components under part 9505.1718, subparts 2 to 14 or those components that have not been completed by another provider within the six months before completion of the screening components by the Head Start agency. A Head Start agency that completes the previously incomplete screening components must document on the EPSDT screening form that the other screening components of part 9505.1718, subparts 2 to 14, have been completed by another provider.

The department shall reimburse a Head Start agency for those screening components of part 9505.1718, subparts 2 to 14, that the Head Start agency has provided. The amount of reimbursement must be the same as a Head Start agency's usual and customary cost for each screening component or the maximum fee determined under subpart 1, whichever is lower.

Subp. 3. **Prepaid health plan.** A prepaid health plan is not eligible for a separate payment for screening. The early and periodic screening, diagnosis, and treatment screening must be a service included within the prepaid capitation rate specified in its contract with the department.

9505.1712 TRAINING.

The department must train the staff of an EPSDT clinic that is supervised by a physician on how to comply with the procedures required by part 9505.1718 if the EPSDT clinic requests the training.

9505.1715 COMPLIANCE WITH SURVEILLANCE AND UTILIZATION REVIEW.

A screening provider must comply with the surveillance and utilization review requirements of parts 9505.2160 to 9505.2245.

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

Subpart 1. **Requirement.** An early and periodic screening, diagnosis, and treatment screening must meet the requirements of subparts 2 to 15 except as provided by part 9505.1706, subpart 2.

Subp. 2. **Health and developmental history.** A history of a child's health and development must be obtained from the child, parent of the child, or an adult who is familiar with the child's health history. The history must include information on sexual development, lead and tuberculosis exposure, nutrition intake, chemical abuse, and social, emotional, and mental health status.

Subp. 3. **Assessment of physical growth.** The child's height or length and the child's weight must be measured and the results plotted on a growth grid based on data from the National Center for Health Statistics (NCHS). The head circumference of a child up to 36 months of age or a child whose growth in head circumference appears to deviate from the expected circumference for that child must be measured and plotted on an NCHS-based growth grid.

Subp. 4. **Physical examination.** The following must be checked according to accepted medical procedures: pulse; respiration; blood pressure; head; eyes; ears; nose; mouth; pharynx; neck; chest; heart; lungs; abdomen; spine; genitals; extremities; joints; muscle tone; skin; and neurological condition.

Subp. 5. **Vision.** A child must be checked for a family history of maternal and neonatal infection and ocular abnormalities. A child must be observed for pupillary reflex; the presence of nystagmus; and muscle balance, which includes an examination for esotropia, exotropia, phorias, and extraocular movements. The external parts of a child's eyes must be examined including the lids, conjunctiva, cornea, iris, and pupils. A child or parent of the child must be asked whether he or she has concerns about the child's vision.

Subp. 6. **Vision of a child age three or older.** In addition to the requirements of subpart 5, the visual acuity of a child age three years or older must be checked by use of the Screening Test for Young Children and Retardates (STYCAR) or the Snellen Alphabet Chart.

Subp. 7. **Hearing.** A child must be checked for a family history of hearing disability or loss, delay of language acquisition or history of such delay, the ability to determine the direction of a sound, and a history of repeated otitis media during early life. A child or parent of the child must be asked whether he or she has any concerns regarding the child's hearing.

Subp. 8. **Hearing of a child age three or older.** In addition to the requirements of subpart 7, a child age three or older must receive a pure tone audiometric test or referral for the test if the examination under subpart 7 indicates the test is needed.

Subp. 9. **Development.** A child must be screened for the following according to the screening provider's standard procedures: fine and gross motor development, speech and language development, social development, cognitive development, and self-help skills. Standardized tests that are used in screening must be culturally sensitive and have norms for the age range tested, written procedures for administration and for scoring and interpretation that are statistically reliable and valid. The provider must use a combination of the child's health and developmental history and standardized test or clinical judgment to determine the child's developmental status or need for further assessment.

Subp. 10. **Sexual development.** A child must be evaluated to determine whether the child's sexual development is consistent with the child's chronological age. A female must receive a breast examination and pelvic examination when indicated. A male must receive

a testicular examination when indicated. If it is in the best interest of a child, counseling on normal sexual development, information on birth control and sexually transmitted diseases, and prescriptions and tests must be offered to a child. If it is in the best interest of a child, a screening provider may refer the child to other resources for counseling or a pelvic examination.

Subp. 11. **Nutrition.** When the assessment of a child's physical growth performed according to subpart 3 indicates a nutritional risk condition, the child must be referred for further assessment, receive nutritional counseling, or be referred to a nutrition program such as the Special Supplemental Food Program for Women, Infants, and Children; food stamps or food support; Expanded Food and Nutrition Education Program; or Head Start.

Subp. 12. **Immunizations.** The immunization status of a child must be compared to the "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition. Immunizations that the comparison shows are needed must be offered to the child and given to the child if the child or parent of the child accepts the offer. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is incorporated by reference and is available at the State Law Library, Judicial Center, 25 Rev. Dr. Martin Luther King Jr. Blvd., Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 13. **Laboratory tests.** Laboratory tests must be done according to items A to F.

A. A Mantoux test must be administered yearly to a child whose health history indicates ongoing exposure to tuberculosis, unless the child has previously tested positive. A child who tests positive must be referred for diagnosis and treatment.

B. A child aged one to five years must initially be screened for lead through the use of either an erythrocyte protoporphyrin (EP) test or a direct blood lead screening test until December 31, 1992. Beginning January 1, 1993, a child age one to five must initially be screened using a direct blood lead screening test. Either capillary or venous blood may be used as the specimen for the direct blood lead test. Blood tests must be performed at a minimum of once at 12 months of age and once at 24 months of age or whenever the history indicates that there are risk factors for lead poisoning. When the result of the EP or capillary blood test is greater than the maximum allowable level set by the Centers for Disease Control of the United States Public Health Service, the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than the maximum allowable level set by the Centers for Disease Control must be referred for diagnosis and treatment.

C. The urine of a child must be tested for the presence of glucose, ketones, protein, and other abnormalities. A female at or near the age of four and a female at or near the age of ten must be tested for bacteriuria.

D. Either a microhematocrit determination or a hemoglobin concentration test for anemia must be done.

E. A test for sickle cell or other hemoglobinopathy, or abnormal blood conditions must be offered to a child who is at risk of such abnormalities and who has not yet been tested. These tests must be provided if accepted or requested by the child or parent of the child. If the tests identify a hemoglobin abnormality or other abnormal blood condition, the child must be referred for genetic counseling.

F. Other laboratory tests such as those for cervical cancer, sexually transmitted diseases, pregnancy, and parasites must be performed when indicated by a child's medical or family history.

Subp. 14. **Oral examination.** An oral examination of a child's mouth must be performed to detect deterioration of hard tissue, and inflammation or swelling of soft tissue.

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Counseling about the systemic use of fluoride must be given to a child when fluoride is not available through the community water supply or school programs.

Subp. 14a. **Health education and health counseling.** Health education and health counseling concerning the child's health must be offered to the child who is being screened and to the child's parent or representative. The health education and health counseling are for the purposes of assisting the child or the parent or representative of the child to understand the expected growth and development of the child and of informing the child or the parent or representative of the child about the benefits of healthy lifestyles and about practices to promote accident and disease prevention.

Subp. 15. **Schedule of age related screening standards.** An early and periodic screening, diagnosis, and treatment screening for a child at a specific age must include, at a minimum, the screening requirements of subparts 2 to 14 as provided by the following schedule:

Schedule of age related screening standards

A. Infancy:

Standards	Ages						
	By 1 month	2 months	4 months	6 months	9 months	12 months	
Health History	X	X	X	X	X	X	
Assessment of Physical Growth:							
Height	X	X	X	X	X	X	
Weight	X	X	X	X	X	X	
Head Circumference	X	X	X	X	X	X	
Physical Examination	X	X	X	X	X	X	
Vision	X	X	X	X	X	X	
Hearing	X	X	X	X	X	X	
Development	X	X	X	X	X	X	
Health Education/Counseling	X	X	X	X	X	X	
Sexual Development	X	X	X	X	X	X	
Nutrition	X	X	X	X	X	X	
Immunizations/Review		X	X	X	X	X	
Laboratory Tests:							
Tuberculin				if history indicates			
Lead Absorption				if history indicates			X
Urinalysis	←	←	←	X	←	←	
Hematocrit or Hemoglobin	←	←	←	←	X	X	
Sickle Cell				at parent's or child's request			
Other Laboratory Tests				as indicated			

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Oral Examination X X X X X X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

B. Early Childhood:

Standards	Ages				
	15 months	18 months	24 months	3 years	4 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Head Circumference	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure				X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin				if history indicates	
Lead Absorption				X	if history indicates
Urinalysis	←	←	X	←	←
Bacteriuria (females)					X
Hematocrit or Hemoglobin	←	←	←	←	←
Sickle Cell				at parent's or child's request	
Other Laboratory Tests				as indicated	
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

C. Late childhood:

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Weight	X	X	X	X
Physical Examination	X	X	X	X
Vision	X	X	X	X
Hearing	X	X	X	X
Blood Pressure	X	X	X	X
Development	X	X	X	X
Health Education/Counseling	X	X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations/Review	X	X	X	X
Laboratory Tests:				
Tuberculin				if history indicates
Lead Absorption				if history indicates
Urinalysis	←		X	
Bacteriuria (females)	←		←	
Hemoglobin or Hematocrit	←		X	
Sickle Cell				at parent's or child's request
Other Laboratory Tests				as indicated
Oral Examination	X		X	

X = Procedure to be completed.

← = Procedure to be completed if not done at the previous visit, or on the first visit.

Subp. 15a. **Additional screenings.** A child may have a partial or complete screening between the ages specified in the schedule under subpart 15 if the screening is medically necessary or a concern develops about the child's health or development.

9505.1724 PROVISION OF DIAGNOSIS AND TREATMENT.

Diagnosis and treatment identified as needed under part 9505.1718 shall be eligible for medical assistance payment subject to the provisions of parts 9505.0170 to 9505.0475.

9505.1727 INFORMING.

A local agency must inform each child or parent of a child about the EPSDT program no later than 60 days after the date the child is determined to be eligible for medical assistance. The information about the EPSDT program must be given orally and in writing, indicate the purpose and benefits of the EPSDT program, indicate that the EPSDT program is without cost to the child or parent of the child while the child is eligible for medical assistance, state the types of medical and dental services available under the EPSDT program, and state that the transportation and appointment scheduling assistance required under part 9505.1730 is available.

The department must send a written notice to a child or parent of a child who has been screened informing the child or parent that the child should be screened again. This notice

must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years after age four.

Each year, on the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to a child or parent of a child who has never been screened informing the child or parent that the child is eligible to be screened.

9505.1730 ASSISTANCE WITH OBTAINING A SCREENING.

Within ten working days of receiving a request for screening from a child or parent of a child, a local agency must give or mail to the child or parent of the child:

- A. a written list of EPSDT clinics in the area in which the child lives; and
- B. a written offer of help in making a screening appointment and in transporting the child to the site of the screening.

If the child or parent of the child requests help, the local agency must provide it.

Transportation under this item must be provided according to part 9505.0140, subpart 1.

9505.1733 ASSISTANCE WITH OBTAINING DIAGNOSIS AND TREATMENT.

An EPSDT clinic must notify a child or parent of a child who is referred for diagnosis and treatment that the local agency will provide names and addresses of diagnosis and treatment providers and will help with appointment scheduling and transportation to the diagnosis and treatment provider. The notice must be on a form provided by the department and must be given to the child or parent of the child on the day the child is screened.

If a child or parent of a child asks a local agency for assistance with obtaining diagnosis and treatment, the local agency must provide that assistance within ten working days of the date of the request.

9505.1736 SPECIAL NOTIFICATION REQUIREMENT.

A local agency must effectively inform an individual who is blind or deaf, or who cannot read or understand the English language, about the EPSDT program.

9505.1739 CHILDREN IN FOSTER CARE.

Subpart 1. **Dependent or neglected state wards.** The local agency must provide early and periodic screening, diagnosis, and treatment services for a child in foster care who is a dependent or neglected state ward under parts 9560.0410 to 9560.0470, and who is eligible for medical assistance unless the early and periodic screening, diagnosis, and treatment services are not in the best interest of the child.

Subp. 2. **Other children in foster care.** The local agency must discuss the EPSDT program with a parent of a child in foster care who is under the legal custody or protective supervision of the local agency or whose parent has entered into a voluntary placement agreement with the local agency. The local agency must help the parent decide whether to accept early and periodic screening, diagnosis, and treatment services for the child. If a parent cannot be consulted, the local agency must decide whether to accept early and periodic screening, diagnosis, and treatment services for the child and must document the reasons for the decision.

Subp. 3. **Assistance with appointment scheduling and transportation.** The local agency must help a child in foster care with appointment scheduling and transportation for screening, diagnosis, and treatment as provided by parts 9505.1730 to 9505.1733.

Subp. 4. **Notification.** The department must send a written notice to the local agency stating that a child in foster care who has been screened should be screened again. This

notice must be sent at the following ages of the child: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter.

Each year, by the anniversary of the date the child was determined eligible for medical assistance entitlements, the department must send a written notice to the local agency that a child in foster care who has never been screened is eligible to be screened.

If a written notice under this subpart pertains to a child who is a dependent or neglected state ward, the local agency must proceed according to subpart 1. The local agency must proceed according to subpart 2 if the written notice pertains to a child who is not a dependent or neglected state ward.

9505.1742 DOCUMENTATION.

The local agency must document compliance with parts 9505.1693 to 9505.1748 on forms provided by the department.

9505.1745 INTERAGENCY COORDINATION.

The local agency must coordinate the EPSDT program with other programs that provide health services to children as provided by Code of Federal Regulations, title 42, section 441.61(c), as amended through October 1, 1986. Examples of such agencies are a public health nursing service, a Head Start agency, and a school district.

9505.1748 CONTRACTS FOR ADMINISTRATIVE SERVICES.

Subpart 1. **Authority.** A local agency may contract with a county public health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district for early and periodic screening, diagnosis, and treatment administrative services. Early and periodic screening, diagnosis, and treatment administrative services include outreach; notification; appointment scheduling and transportation; follow-up; and documentation. For purposes of this subpart, "community action agency" means an entity defined in Minnesota Statutes, section 256E.31, subdivision 1, and "school district" means a school district as defined in Minnesota Statutes, section 120A.05, subdivisions 5, 10, and 14.

Subp. 2. **Federal financial participation.** The percent of federal financial participation for salaries, fringe benefits, and travel of skilled professional medical personnel and their supporting staff shall be paid as provided by Code of Federal Regulations, title 42, section 433.15(b)(5), as amended through October 1, 1986.

Subp. 3. **State reimbursement.** State reimbursement for contracts for EPSDT administrative services under this part shall be as provided by Minnesota Statutes, section 256B.19, subdivision 1, except for the provisions under subdivision 1 that pertain to a prepaid health plan.

Subp. 4. **Approval.** A contract for administrative services must be approved by the local agency and submitted to the department for approval by November 1 of the year before the beginning of the calendar year in which the contract will be effective. A contract must contain items A to L to be approved by the department for reimbursement:

- A. names of the contracting parties;
- B. purpose of the contract;
- C. beginning and ending dates of the contract;
- D. amount of the contract, budget breakdown, and a clause that stipulates that the department's procedures for certifying expenditures will be followed by the local agency;
- E. the method by which the contract may be amended or terminated;
- F. a clause that stipulates that the contract will be renegotiated if federal or state program regulations or federal financial reimbursement regulations change;

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G. a clause that stipulates that the contracting parties will provide program and fiscal records and maintain all nonpublic data required by the contract according to the Minnesota Government Data Practices Act and will cooperate with state and federal program reviews;

H. a description of the services contracted for and the agency that will perform them;

I. methods by which the local agency will monitor and evaluate the contract;

J. signatures of the representatives of the contracting parties with the authority to obligate the parties by contract and dates of those signatures;

K. a clause that stipulates that the services provided under contract must be performed by or under the supervision of skilled medical personnel; and

L. a clause that stipulates that the contracting parties will comply with state and federal requirements for the receipt of medical assistance funds.