..... moves to amend S.F. No. 3656, the second engrossment, the Article 22 Health Care delete everything amendment (A18-0940), in conference committee, as follows:

Page 373, delete Article 22 and insert:

"ARTICLE 22

HEALTH CARE

Section 1. Minnesota Statutes 2016, section 3.3005, subdivision 8, is amended to read:

Subd. 8. **Request contents.** A request to spend federal funds submitted under this section must include the name of the federal grant, the federal agency from which the funds are available, a federal identification number, a brief description of the purpose of the grant, the amounts expected by fiscal year, an indication if any state match is required, an indication if there is a maintenance of effort requirement, and the number of full-time equivalent positions needed to implement the grant. For new grants, the request must provide a narrative description of the short- and long-term commitments required, including whether continuation of any full-time equivalent positions will be a condition of receiving the federal award.

Sec. 2. Minnesota Statutes 2017 Supplement, section 13.69, subdivision 1, is amended to read:

Subdivision 1. **Classifications.** (a) The following government data of the Department of Public Safety are private data:

(1) medical data on driving instructors, licensed drivers, and applicants for parking certificates and special license plates issued to physically disabled persons;

(2) other data on holders of a disability certificate under section 169.345, except that (i) data that are not medical data may be released to law enforcement agencies, and (ii) data necessary for enforcement of sections 169.345 and 169.346 may be released to parking

enforcement employees or parking enforcement agents of statutory or home rule charter cities and towns;

(3) Social Security numbers in driver's license and motor vehicle registration records, except that Social Security numbers must be provided to the Department of Revenue for purposes of tax administration, the Department of Labor and Industry for purposes of workers' compensation administration and enforcement, the judicial branch for purposes of debt collection, and the Department of Natural Resources for purposes of license application administration, and except that the last four digits of the Social Security number must be provided to the Department of Human Services for purposes of recovery of Minnesota health care program benefits paid; and

(4) data on persons listed as standby or temporary custodians under section 171.07, subdivision 11, except that the data must be released to:

(i) law enforcement agencies for the purpose of verifying that an individual is a designated caregiver; or

(ii) law enforcement agencies who state that the license holder is unable to communicate at that time and that the information is necessary for notifying the designated caregiver of the need to care for a child of the license holder.

The department may release the Social Security number only as provided in clause (3) and must not sell or otherwise provide individual Social Security numbers or lists of Social Security numbers for any other purpose.

(b) The following government data of the Department of Public Safety are confidential data: data concerning an individual's driving ability when that data is received from a member of the individual's family.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 3. **[62J.90] MINNESOTA HEALTH POLICY COMMISSION.**

Subdivision 1. **Definition.** For purposes of this section, "commission" means the Minnesota Health Policy Commission.

Subd. 2. **Commission membership.** The commission shall consist of 16 voting members, appointed by the Legislative Coordinating Commission as provided in subdivision 9, as follows:

(1) one member with demonstrated expertise in health care finance;

(2) one member with demonstrated expertise in health economics;

(3) one member with demonstrated expertise in actuarial science;

(4) one member with demonstrated expertise in health plan management and finance;

(5) one member with demonstrated expertise in health care system management;

(6) one member with demonstrated expertise as a purchaser, or a representative of a purchaser, of employer-sponsored health care services or employer-sponsored health insurance;

(7) one member with demonstrated expertise in the development and utilization of innovative medical technologies;

(8) one member with demonstrated expertise as a health care consumer advocate;

(9) one member who is a primary care physician;

(10) one member with demonstrated knowledge and expertise in patient privacy issues;

(11) one member who provides long-term care services through medical assistance;

(12) one member with direct experience as an enrollee, or parent or caregiver of an enrollee, in MinnesotaCare or medical assistance;

(13) two members of the senate, including one member appointed by the majority leader and one member from the minority party appointed by the minority leader; and

(14) two members of the house of representatives, including one member appointed by the speaker of the house and one member from the minority party appointed by the minority leader.

Subd. 3. **Duties.** (a) The commission shall:

(1) compare Minnesota's private market health care costs and public health care program spending to that of the other states;

(2) compare Minnesota's private market health care costs and public health care program spending in any given year to its costs and spending in previous years;

(3) identify factors that influence and contribute to Minnesota's ranking for private market health care costs and public health care program spending, including the year over year and trend line change in total costs and spending in the state;

(4) continually monitor efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the health insurance market, including the private health care market, large self-insured employers, and the state's public health care programs in order to identify opportunities for state action to achieve:

(i) improved patient experience of care, including quality and satisfaction;

(ii) improved health of all populations; and

(iii) reduced per capita cost of health care;

(5) make recommendations for legislative policy, the health care market, or any other reforms to:

(i) lower the rate of growth in private market health care costs and public health care program spending in the state;

(ii) positively impact the state's ranking in the areas listed in this subdivision; and

(iii) improve the quality and value of care for all Minnesotans; and

(6) conduct any additional reviews requested by the legislature.

(b) In making recommendations to the legislature, the commission shall consider:

(i) how the recommendations might positively impact the cost-shifting interplay between public payer reimbursement rates and health insurance premiums; and

(ii) how public health care programs, where appropriate, may be utilized as a means to help prepare enrollees for an eventual transition to the private health care market.

Subd. 4. **Report.** The commission shall submit recommendations for changes in health care policy and financing by June 15 each year to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care. The report shall include any draft legislation to implement the commission's recommendations.

Subd. 5. **Staff.** The commission shall hire a director who may employ or contract for professional and technical assistance as the commission determines necessary to perform its duties. The commission may also contract with private entities with expertise in health economics, health finance, and actuarial science to secure additional information, data, research, or modeling that may be necessary for the commission to carry out its duties.

Subd. 6. **Access to information.** (a) The commission may request that a state department or agency provide the commission with any publicly available information in a usable format as requested by the commission, at no cost to the commission.

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

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

(d) By July 1, 2020, and annually thereafter, the commission shall provide the legislative committees with jurisdiction over data practices with a report describing the de-identified information and data obtained by the commission from state departments and agencies in the preceding year. The report must describe the information obtained, including the scope of the information obtained, the purpose for which it was obtained, the classification of any data obtained, the length of time the information shall be used, and security measures for protecting the information in accordance with chapter 13. The report must include a notification to the public that although the information obtained by the commission is de-identified, de-identified data retains some risk of identification, and that a data use agreement must limit the use of the data and prohibit attempts to reidentify the data. The commission shall also maintain the reports on the commission's Web site.

Subd. 7. **Terms; vacancies; compensation.** (a) Public members of the commission shall serve four-year terms. The public members may not serve for more than two consecutive terms.

(b) The legislative members shall serve on the commission as long as the member or the appointing authority holds office.

(c) The removal of members and filling of vacancies on the commission are as provided in section 15.059.

(d) Public members may receive compensation and expenses as provided in section 15.059, subdivision 3.

Subd. 8. **Chairs; officers.** The commission shall elect a chair annually. The commission may elect other officers necessary for the performance of its duties.

Subd. 9. **Selection of members; advisory council.** The Legislative Coordinating Commission shall take applications from members of the public who are qualified and interested to serve in one of the listed positions. The applications must be reviewed by a health policy commission advisory council comprised of four members as follows: the state economist, legislative auditor, state demographer, and the president of the Federal Reserve Bank of Minneapolis or a designee of the president. The advisory council shall recommend two applicants for each of the specified positions by September 30 in the calendar year

preceding the end of the members' terms. The Legislative Coordinating Commission shall appoint one of the two recommended applicants to the commission.

Subd. 10. **Meetings.** The commission shall meet at least four times each year. Commission meetings are subject to chapter 13D.

Subd. 11. **Conflict of interest.** A member of the commission may not participate in or vote on a decision of the commission relating to an organization in which the member has either a direct or indirect financial interest.

Subd. 12. **Expiration.** The commission shall expire on June 15, 2024.

Sec. 4. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to read:

Subd. 17a. **Transfers for routine administrative operations.** (a) Unless specifically authorized by law, the commissioner may only transfer money from the general fund to any other fund for routine administrative operations and may not transfer money from the general fund to any other fund without approval from the commissioner of management and budget. If the commissioner of management and budget determines that a transfer proposed by the commissioner is necessary for routine administrative operations of the Department of Human Services, the commissioner may approve the transfer. If the commissioner of management and budget determines that the transfer proposed by the commissioner is not necessary for routine administrative operations of the Department of Human Services, the commissioner may not approve the transfer unless the requirements of paragraph (b) are met.

(b) If the commissioner of management and budget determines that a transfer under paragraph (a) is not necessary for routine administrative operations of the Department of Human Services, the commissioner may request approval of the transfer from the Legislative Advisory Commission under section 3.30. To request approval of a transfer from the Legislative Advisory Commission, the commissioner must submit a request that includes the amount of the transfer, the budget activity and fund from which money would be transferred and the budget activity and fund to which money would be transferred, an explanation of the administrative necessity of the transfer, and a statement from the commissioner of management and budget explaining why the transfer is not necessary for routine administrative operations of the Department of Human Services. The Legislative Advisory Commission shall review the proposed transfer and make a recommendation within 20 days of the request from the commissioner. If the Legislative Advisory Commission makes a positive recommendation or no recommendation, the commissioner may approve the transfer. If the Legislative Advisory Commission makes a negative recommendation or

a request for more information, the commissioner may not approve the transfer. A recommendation of the Legislative Advisory Commission must be made by a majority of the commission and must be made at a meeting of the commission unless a written recommendation is signed by a majority of the commission members required to vote on the question. If the commission makes a negative recommendation or a request for more information, the commission may subsequently withdraw or change its recommendation.

Sec. 5. **[256.0113] ELIGIBILITY VERIFICATION.**

Subdivision 1. **Verification required; vendor contract.** (a) The commissioner shall ensure that medical assistance, MinnesotaCare, child care assistance programs, and Supplemental Nutrition Assistance Program (SNAP) eligibility determinations through the MNsure information technology system and through other agency eligibility determination systems include the computerized verification of income, residency, identity, and when applicable, assets and compliance with SNAP work requirements.

(b) The commissioner shall contract with a vendor to verify the eligibility of all persons enrolled in medical assistance, MinnesotaCare, a child care assistance program, and SNAP during a specified audit period. This contract shall be exempt from sections 16C.08, subdivision 2, clause (1); 16C.09, paragraph (a), clause (1); 43A.047, paragraph (a), and any other law to the contrary.

(c) The contract must require the vendor to comply with enrollee data privacy requirements and to use encryption to safeguard enrollee identity. The contract must also provide penalties for vendor noncompliance.

(d) The contract must include a revenue sharing agreement, under which vendor compensation is limited to a portion of any savings to the state resulting from the vendor's implementation of eligibility verification initiatives under this section.

(e) The commissioner shall use existing resources to fund any agency administrative and technology-related costs incurred as a result of implementing this section.

(f) All state savings resulting from implementation of the vendor contract under this section, minus any payments to the vendor made under the terms of the revenue sharing agreement, shall be deposited into the health care access fund.

Subd. 2. **Verification process; vendor duties.** (a) The verification process implemented by the vendor must include but is not limited to data matches of the name, date of birth, address, and Social Security number of each medical assistance, MinnesotaCare, child care assistance program, and SNAP enrollee against relevant information in federal and state

data sources, including the federal data hub established under the Affordable Care Act. In designing the verification process, the vendor, to the extent feasible, shall incorporate procedures that are compatible and coordinated with, and build upon or improve, existing procedures used by the MNsure information technology system and other agency eligibility determination systems.

(b) The vendor, upon preliminary determination that an enrollee is eligible or ineligible, shall notify the commissioner. Within 20 business days of notification, the commissioner shall accept the preliminary determination or reject the preliminary determination with a stated reason. The commissioner shall retain final authority over eligibility determinations. The vendor shall keep a record of all preliminary determinations of ineligibility submitted to the commissioner.

(c) The vendor shall recommend to the commissioner an eligibility verification process that allows ongoing verification of enrollee eligibility under the MNsure information technology system and other agency eligibility determination systems.

(d) The commissioner and the vendor, following the conclusion of the initial contract period, shall jointly submit an eligibility verification audit report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The report shall include but is not limited to information in the form of unidentified summary data on preliminary determinations of eligibility or ineligibility communicated by the vendor, the actions taken on those preliminary determinations by the commissioner, and the commissioner's reasons for rejecting preliminary determinations by the vendor. The report must also include the recommendations for ongoing verification of enrollee eligibility required under paragraph (c).

(e) An eligibility verification vendor contract shall be awarded for an initial one-year period, beginning January 1, 2019. The commissioner shall renew the contract for up to three additional one-year periods and require additional eligibility verification audits, if the commissioner or the legislative auditor determines that the MNsure information technology system and other agency eligibility determination systems cannot effectively verify the eligibility of medical assistance, MinnesotaCare, child care assistance program, and SNAP enrollees.

Sec. 6. Minnesota Statutes 2017 Supplement, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population

adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

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

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

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

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

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

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

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

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

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

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

(6) a hospital that has a medical assistance utilization rate in the base year that is at least three standard deviations above the statewide mean utilization rate shall receive a factor of 0.3711.

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

(f) Effective for discharges on January 1, 2019, through June 30, 2019, an additional payment adjustment shall be established by the commissioner under this subdivision for hospitals that provide high levels of administering high-cost drugs to enrollees in the fee-for-service medical assistance program. The commissioner shall consider factors such as fee-for-service medical assistance utilization rates and payments made for drugs purchased through the 340B drug purchasing program and administered to fee-for-service enrollees. If any part of this adjustment exceeds a hospital's hospital-specific disproportionate share hospital limit, the commissioner shall make a payment to the hospital that equals the nonfederal share of the amount that exceeds the limit. The total nonfederal share of the amount of the payment adjustment under this paragraph shall not exceed $1,500,000.

Sec. 7. Minnesota Statutes 2016, section 256B.04, subdivision 14, is amended to read:

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

(1) eyeglasses;

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

(3) hearing aids and supplies; and

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

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

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

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

(b) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation ~~for special transportation services~~ under the provisions of chapter 16C for special transportation services or incontinence products and related supplies.

Sec. 8. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure

to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state. The commissioner may exempt a rehabilitation agency from termination or denial that would otherwise be required under this paragraph, if the agency:

(1) is unable to retain Medicare certification and enrollment solely due to a lack of billing to the Medicare program;

(2) meets all other applicable Medicare certification requirements based on a review completed by the commissioner of health; and

(3) serves primarily a pediatric population.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the

obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

(h) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 9. Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week, except as provided in paragraph (f). Telemedicine services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) For purposes of this subdivision, unless otherwise covered under this chapter, "telemedicine" is defined as 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, or a licensed health care provider and a patient that consists solely of a telephone conversation, 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.

(e) For purposes of this section, "licensed health care provider" means a licensed health care provider under section 62A.671, subdivision 6, ~~and~~ a community paramedic as defined under section 144E.001, subdivision 5f, or a mental health practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26, working under the general supervision of a mental health professional; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The limit on coverage of three telemedicine services per enrollee per calendar week does not apply if:

(1) the telemedicine services provided by the licensed health care provider are for the treatment and control of tuberculosis; and

(2) the services are provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health.

Sec. 10. Minnesota Statutes 2016, section 256B.0625, subdivision 13, is amended to read:

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

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug becomes an active ingredient of the

drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

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

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

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

(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. ~~Over-the-counter medications must be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).~~

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and

Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

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

Sec. 11. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) Effective January 1, 2019, or upon federal approval, whichever is later, the basis for determining the amount of payment shall be the lower of the ~~actual acquisition costs~~ ingredient cost of the drugs ~~or the maximum allowable cost by the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price is defined as the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes those prices the pharmacy charges to customers enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee shall be ~~$3.65~~ $10.48 for ~~legend prescription drugs~~ prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8, paragraph (k), clause (2), except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be ~~$8~~ $10.48 per bag~~, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter~~. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $10.48 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package.

The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65~~, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition~~ for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The National Average Drug Acquisition Cost (NADAC) shall be used to determine the ingredient cost of a drug. For drugs for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at wholesale acquisition cost minus two percent. The commissioner shall establish the ingredient cost of a drug acquired through the federal 340B Drug Pricing Program ~~shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent~~ at a 340B Drug Pricing Program maximum allowable cost. The 340B Drug Pricing Program maximum allowable cost shall be comparable to, but no higher than, the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to~~, but~~ the actual acquisition cost of the drug product and no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a

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

(c) ~~An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse.~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

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

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, ~~2014~~ 2019, or upon federal approval, whichever is later, the

commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by ~~20~~ 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

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

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

Sec. 12. Minnesota Statutes 2016, section 256B.0625, subdivision 13f, is amended to read:

Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and recommend drugs which require prior authorization. The Formulary Committee shall establish general criteria to be used for the prior authorization of brand-name drugs for which generically equivalent drugs are available, but the committee is not required to review each brand-name drug for which a generically equivalent drug is available.

(b) Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The Formulary Committee may recommend drugs for prior authorization directly to the commissioner. The commissioner may also request that the Formulary Committee review a drug for prior authorization. Before the commissioner may require prior authorization for a drug:

(1) the commissioner must provide information to the Formulary Committee on the impact that placing the drug on prior authorization may have on the quality of patient care and on program costs, information regarding whether the drug is subject to clinical abuse or misuse, and relevant data from the state Medicaid program if such data is available;

(2) the Formulary Committee must review the drug, taking into account medical and clinical data and the information provided by the commissioner; and

(3) the Formulary Committee must hold a public forum and receive public comment for an additional 15 days.

The commissioner must provide a 15-day notice period before implementing the prior authorization.

(c) Except as provided in subdivision 13j, prior authorization shall not be required or utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness if:

(1) there is no generically equivalent drug available; and

(2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

(3) the drug is part of the recipient's current course of treatment.

This paragraph applies to any multistate preferred drug list or supplemental drug rebate program established or administered by the commissioner. Prior authorization shall automatically be granted for 60 days for brand name drugs prescribed for treatment of mental illness within 60 days of when a generically equivalent drug becomes available, provided that the brand name drug was part of the recipient's course of treatment at the time the generically equivalent drug became available.

~~(d) Prior authorization shall not be required or utilized for any antihemophilic factor drug prescribed for the treatment of hemophilia and blood disorders where there is no generically equivalent drug available if the prior authorization is used in conjunction with any supplemental drug rebate program or multistate preferred drug list established or administered by the commissioner.~~

~~(e)~~ (d) The commissioner may require prior authorization for brand name drugs whenever a generically equivalent product is available, even if the prescriber specifically indicates "dispense as written-brand necessary" on the prescription as required by section 151.21, subdivision 2.

~~(f)~~ (e) Notwithstanding this subdivision, the commissioner may automatically require prior authorization, for a period not to exceed 180 days, for any drug that is approved by the United States Food and Drug Administration on or after July 1, 2005. The 180-day period begins no later than the first day that a drug is available for shipment to pharmacies within the state. The Formulary Committee shall recommend to the commissioner general criteria to be used for the prior authorization of the drugs, but the committee is not required to review each individual drug. In order to continue prior authorizations for a drug after the 180-day period has expired, the commissioner must follow the provisions of this subdivision.

Sec. 13. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17d. **Transportation services oversight.** The commissioner shall contract with a vendor or dedicate staff for oversight of providers of nonemergency medical transportation services pursuant to the commissioner's authority in section 256B.04 and Minnesota Rules, parts 9505.2160 to 9505.2245.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 14. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17e. **Transportation provider termination.** (a) A terminated nonemergency medical transportation provider, including all named individuals on the current enrollment disclosure form and known or discovered affiliates of the nonemergency medical transportation provider, is not eligible to enroll as a nonemergency medical transportation provider for five years following the termination.

(b) After the five-year period in paragraph (a), if a provider seeks to reenroll as a nonemergency medical transportation provider, the nonemergency medical transportation provider must be placed on a one-year probation period. During a provider's probation period, the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 15. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 17f. **Transportation provider training.** The commissioner shall make available to providers of nonemergency medical transportation and all drivers training materials and online training opportunities regarding documentation requirements, documentation procedures, and penalties for failing to meet documentation requirements.

Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

(b) A provider is not required to perform as part of an EPSDT screening any of the recommendations that were added on or after January 1, 2017, to the child and teen checkup program periodicity schedule, in order to receive the full payment amount for a complete EPSDT screening. This paragraph expires January 1, 2021.

(c) The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services of any new recommendations added to an EPSDT screening after January 1, 2018, that the provider is required to perform as part of an EPSDT screening to receive the full payment amount.

Sec. 17. **[256B.758] REIMBURSEMENT FOR DOULA SERVICES.**

Effective for services provided on or after July 1, 2018, payments for doula services provided by a certified doula shall be $47 per prenatal or postpartum visit, up to a total of six visits; and $488 for attending and providing doula services at a birth.

Sec. 18. **COVERED OUTPATIENT DRUG RULE.**

The commissioner of human services shall collaborate with the Minnesota Hospital Association, the Minnesota Pharmacists Association, the Minnesota College of Pharmacy, and other affected stakeholders to assess the impact of implementing the federal 2017 Covered Outpatient Drug Rule and develop a proposal to minimize negative impacts to medical assistance enrollees and providers. The commissioner shall report the proposal to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2019.

Sec. 19. **PAIN MANAGEMENT.**

(a) The Health Services Policy Committee established under Minnesota Statutes, section 256B.0625, subdivision 3c, shall evaluate and make recommendations on the integration of nonpharmacologic pain management that are clinically viable and sustainable; reduce or eliminate chronic pain conditions; improve functional status; and prevent addiction and reduce dependence on opiates or other pain medications. The recommendations must be based on best practices for the effective treatment of musculoskeletal pain provided by health practitioners identified in paragraph (b), and covered under medical assistance. Each health practitioner represented under paragraph (b) shall present the minimum best integrated practice recommendations, policies, and scientific evidence for nonpharmacologic treatment options for eliminating pain and improving functional status within their full professional scope. Recommendations for integration of services may include guidance regarding screening for co-occurring behavioral health diagnoses; protocols for communication between all providers treating a unique individual, including protocols for follow-up; and universal mechanisms to assess improvements in functional status.

(b) In evaluating and making recommendations, the Health Services Policy Committee shall consult and collaborate with the following health practitioners: acupuncture practitioners licensed under Minnesota Statutes, chapter 147B; chiropractors licensed under Minnesota Statutes, sections 148.01 to 148.10; physical therapists licensed under Minnesota Statutes, sections 148.68 to 148.78; medical and osteopathic physicians licensed under Minnesota Statutes, chapter 147, and advanced practice registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, with experience in providing primary care collaboratively within a multidisciplinary team of health care practitioners who employ nonpharmacologic pain therapies; and psychologists licensed under Minnesota Statutes, section 148.907.

(c) The commissioner shall submit a progress report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2019, and shall report final recommendations by August 1, 2019. The final report may also contain recommendations for developing and implementing a pilot program to assess the clinical viability, sustainability, and effectiveness of integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain and improving functional status.

Sec. 20. **RECONCILIATION OF MINNESOTACARE PREMIUMS.**

The commissioner of human services shall reconcile all MinnesotaCare premiums paid or due for health coverage provided during the period January 1, 2014, through December 31, 2017, by July 1, 2018. Based on this reconciliation, the commissioner shall notify each MinnesotaCare enrollee or former enrollee of any amount owed as premiums, refund to the enrollee or former enrollee any premium overpayment, and enter into a payment arrangement with the enrollee or former enrollee as necessary.

Sec. 21. **CONTRACT TO RECOVER THIRD-PARTY LIABILITY.**

The commissioner shall contract with a vendor to implement a third-party liability recovery program for medical assistance and MinnesotaCare. Under the terms of the contract, the vendor shall be reimbursed using a percentage of the money recovered through the third-party liability recovery program. All money recovered that remains after reimbursement of the vendor is available for operation of the medical assistance and MinnesotaCare programs. The use of this money must be authorized in law by the legislature.

EFFECTIVE DATE. This section is effective July 1, 2018.

Sec. 22. **MINNESOTA HEALTH POLICY COMMISSION; FIRST APPOINTMENTS; FIRST MEETING.**

The Health Policy Commission Advisory Council shall make its recommendations under Minnesota Statutes, section 62J.90, subdivision 9, for candidates to serve on the Minnesota Health Policy Commission to the Legislative Coordinating Commission by September 30, 2018. The Legislative Coordinating Commission shall make the first appointments of public members to the Minnesota Health Policy Commission under Minnesota Statutes, section 62J.90, by January 15, 2019. The Legislative Coordinating Commission shall designate five members to serve terms that are coterminous with the governor and six members to serve terms that end on the first Monday in January one year after the terms of the other members conclude. The director of the Legislative Coordinating Commission shall convene the first meeting of the Minnesota Health Policy Commission by June 15, 2019, and shall act as the chair until the commission elects a chair at its first meeting.

Sec. 23. **REPEALER.**

Minnesota Statutes 2017 Supplement, section 256B.0625, subdivision 31c, is repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly