

177.1 **ARTICLE 3**

177.2 **HEALTH CARE FINANCE**

177.3 Section 1. **[62J.86] DEFINITIONS.**

177.4 Subdivision 1. **Definitions.** For the purposes of sections 62J.86 to 62J.92, the following

177.5 terms have the meanings given.

177.6 Subd. 2. **Advisory council.** "Advisory council" means the Health Care Affordability

177.7 Advisory Council established under section 62J.88.

177.8 Subd. 3. **Board.** "Board" means the Health Care Affordability Board established under

177.9 section 62J.87.

177.10 Sec. 2. **[62J.87] HEALTH CARE AFFORDABILITY BOARD.**

177.11 Subdivision 1. **Establishment.** The Health Care Affordability Board is established and

177.12 shall be governed as a board under section 15.012, paragraph (a), to protect consumers,

177.13 state and local governments, health plan companies, providers, and other health care system

177.14 stakeholders from unaffordable health care costs. The board must be operational by January

177.15 1, 2023.

177.16 Subd. 2. **Membership.** (a) The Health Care Affordability Board consists of 13 members,

177.17 appointed as follows:

177.18 (1) five members appointed by the governor;

177.19 (2) two members appointed by the majority leader of the senate;

177.20 (3) two members appointed by the minority leader of the senate;

177.21 (4) two members appointed by the speaker of the house; and

177.22 (5) two members appointed by the minority leader of the house of representatives.

177.23 (b) All appointed members must have knowledge and demonstrated expertise in one or

177.24 more of the following areas: health care finance, health economics, health care management

177.25 or administration at a senior level, health care consumer advocacy, representing the health

177.26 care workforce as a leader in a labor organization, purchasing health care insurance as a

177.27 health benefits administrator, delivery of primary care, health plan company administration,

177.28 public or population health, and addressing health disparities and structural inequities.

177.29 (c) A member may not participate in board proceedings involving an organization,

177.30 activity, or transaction in which the member has either a direct or indirect financial interest,

177.31 other than as an individual consumer of health services.

178.1 (d) The Legislative Coordinating Commission shall coordinate appointments under this

178.2 subdivision to ensure that board members are appointed by August 1, 2022, and that board

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ARTICLE 3

HEALTH CARE

- 178.3 members as a whole meet all of the criteria related to the knowledge and expertise specified
178.4 in paragraph (b).
- 178.5 Subd. 3. **Terms.** (a) Board appointees shall serve four-year terms. A board member shall
178.6 not serve more than three consecutive terms.
- 178.7 (b) A board member may resign at any time by giving written notice to the board.
- 178.8 Subd. 4. **Chair; other officers.** (a) The governor shall designate an acting chair from
178.9 the members appointed by the governor.
- 178.10 (b) The board shall elect a chair to replace the acting chair at the first meeting of the
178.11 board by a majority of the members. The chair shall serve for two years.
- 178.12 (c) The board shall elect a vice-chair and other officers from its membership as it deems
178.13 necessary.
- 178.14 Subd. 5. **Staff; technical assistance; contracting.** (a) The board shall hire a full-time
178.15 executive director and other staff, who shall serve in the unclassified service. The executive
178.16 director must have significant knowledge and expertise in health economics and demonstrated
178.17 experience in health policy.
- 178.18 (b) The attorney general shall provide legal services to the board.
- 178.19 (c) The Department of Health shall provide technical assistance to the board in analyzing
178.20 health care trends and costs and in setting health care spending growth targets.
- 178.21 (d) The board may employ or contract for professional and technical assistance, including
178.22 actuarial assistance, as the board deems necessary to perform the board's duties.
- 178.23 Subd. 6. **Access to information.** (a) The board may request that a state agency provide
178.24 the board with any publicly available information in a usable format as requested by the
178.25 board, at no cost to the board.
- 178.26 (b) The board may request from a state agency unique or custom data sets, and the agency
178.27 may charge the board for providing the data at the same rate the agency would charge any
178.28 other public or private entity.
- 178.29 (c) Any information provided to the board by a state agency must be de-identified. For
178.30 purposes of this subdivision, "de-identification" means the process used to prevent the
178.31 identity of a person or business from being connected with the information and ensuring
178.32 all identifiable information has been removed.
- 179.1 (d) Any data submitted to the board retains its original classification under the Minnesota
179.2 Data Practices Act in chapter 13.
- 179.3 Subd. 7. **Compensation.** Board members shall not receive compensation but may receive
179.4 reimbursement for expenses as authorized under section 15.059, subdivision 3.

179.5 Subd. 8. **Meetings.** (a) Meetings of the board are subject to chapter 13D. The board shall
179.6 meet publicly at least quarterly. The board may meet in closed session when reviewing
179.7 proprietary information as specified in section 62J.71, subdivision 4.

179.8 (b) The board shall announce each public meeting at least two weeks prior to the
179.9 scheduled date of the meeting. Any materials for the meeting must be made public at least
179.10 one week prior to the scheduled date of the meeting.

179.11 (c) At each public meeting, the board shall provide the opportunity for comments from
179.12 the public, including the opportunity for written comments to be submitted to the board
179.13 prior to a decision by the board.

179.14 Sec. 3. **[62J.88] HEALTH CARE AFFORDABILITY ADVISORY COUNCIL.**

179.15 Subdivision 1. **Establishment.** The governor shall appoint a Health Care Affordability
179.16 Advisory Council of up to 15 members to provide advice to the board on health care costs
179.17 and access issues and to represent the views of patients and other stakeholders. Members
179.18 of the advisory council must be appointed based on their knowledge and demonstrated
179.19 expertise in one or more of the following areas: health care delivery, ensuring health care
179.20 access for diverse populations, public and population health, patient perspectives, health
179.21 care cost trends and drivers, clinical and health services research, innovation in health care
179.22 delivery, and health care benefits management.

179.23 Subd. 2. **Duties; reports.** (a) The council shall provide technical recommendations to
179.24 the board on:

179.25 (1) the identification of economic indicators and other metrics related to the development
179.26 and setting of health care spending growth targets;

179.27 (2) data sources for measuring health care spending; and

179.28 (3) measurement of the impact of health care spending growth targets on diverse
179.29 communities and populations, including but not limited to those communities and populations
179.30 adversely affected by health disparities.

180.1 (b) The council shall report technical recommendations and a summary of its activities
180.2 to the board at least annually, and shall submit additional reports on its activities and
180.3 recommendations to the board, as requested by the board or at the discretion of the council.

180.4 Subd. 3. **Terms.** (a) The initial appointed advisory council members shall serve staggered
180.5 terms of two, three, or four years determined by lot by the secretary of state. Following the
180.6 initial appointments, advisory council members shall serve four-year terms.

180.7 (b) Removal and vacancies of advisory council members are governed by section 15.059.

180.8 Subd. 4. **Compensation.** Advisory council members may be compensated according to
180.9 section 15.059.

180.10 Subd. 5. **Meetings.** The advisory council shall meet at least quarterly. Meetings of the
180.11 advisory council are subject to chapter 13D.

180.12 Subd. 6. **Exemption.** Notwithstanding section 15.059, the advisory council shall not
180.13 expire.

180.14 Sec. 4. **[62J.89] DUTIES OF THE BOARD.**

180.15 Subdivision 1. **General.** (a) The board shall monitor the administration and reform of
180.16 the health care delivery and payment systems in the state. The board shall:

180.17 (1) set health care spending growth targets for the state, as specified under section 62J.90;

180.18 (2) enhance the transparency of provider organizations;

180.19 (3) monitor the adoption and effectiveness of alternative payment methodologies;

180.20 (4) foster innovative health care delivery and payment models that lower health care
180.21 cost growth while improving the quality of patient care;

180.22 (5) monitor and review the impact of changes within the health care marketplace; and

180.23 (6) monitor patient access to necessary health care services.

180.24 (b) The board shall establish goals to reduce health care disparities in racial and ethnic
180.25 communities and to ensure access to quality care for persons with disabilities or with chronic
180.26 or complex health conditions.

180.27 Subd. 2. **Market trends.** The board shall monitor efforts to reform the health care
180.28 delivery and payment system in Minnesota to understand emerging trends in the commercial
180.29 health insurance market, including large self-insured employers and the state's public health
180.30 care programs, in order to identify opportunities for state action to achieve:

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

181.2 (2) improved health of all populations, including a reduction in health disparities; and

181.3 (3) a reduction in the growth of health care costs.

181.4 Subd. 3. **Recommendations for reform.** The board shall recommend legislative policy,
181.5 market, or any other reforms to:

181.6 (1) lower the rate of growth in commercial health care costs and public health care
181.7 program spending in the state;

181.8 (2) positively impact the state's rankings in the areas listed in this subdivision and
181.9 subdivision 2; and

181.10 (3) improve the quality and value of care for all Minnesotans, and for specific populations
181.11 adversely affected by health inequities.

181.12 Subd. 4. **Office of Patient Protection.** The board shall establish an Office of Patient
181.13 Protection, to be operational by January 1, 2024. The office shall assist consumers with
181.14 issues related to access and quality of health care, and advise the legislature on ways to
181.15 reduce consumer health care spending and improve consumer experiences by reducing
181.16 complexity for consumers.

181.17 Sec. 5. **[62J.90] HEALTH CARE SPENDING GROWTH TARGETS.**

181.18 Subdivision 1. **Establishment and administration.** The board shall establish and
181.19 administer the health care spending growth target program to limit health care spending
181.20 growth in the state, and shall report regularly to the legislature and the public on progress
181.21 toward these targets.

181.22 Subd. 2. **Methodology.** (a) The board shall develop a methodology to establish annual
181.23 health care spending growth targets and the economic indicators to be used in establishing
181.24 the initial and subsequent target levels.

181.25 (b) The health care spending growth target must:

181.26 (1) use a clear and operational definition of total state health care spending;

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

181.30 (3) define the health care markets and the entities to which the targets apply;

182.1 (4) take into consideration the potential for variability in targets across public and private
182.2 payers;

182.3 (5) account for the health status of patients; and

182.4 (6) incorporate specific benchmarks related to health equity.

182.5 (c) In developing, implementing, and evaluating the growth target program, the board
182.6 shall:

182.7 (1) consider the incorporation of quality of care and primary care spending goals;

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

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

182.14 (4) allow setting growth targets that encourage an individual health care entity to serve
182.15 populations with greater health care risks by incorporating:

- 182.16 (i) a risk factor adjustment reflecting the health status of the entity's patient mix; and
- 182.17 (ii) an equity adjustment accounting for the social determinants of health and other
- 182.18 factors related to health equity for the entity's patient mix;
- 182.19 (5) ensure that growth targets:
- 182.20 (i) do not constrain the Minnesota health care workforce, including the need to provide
- 182.21 competitive wages and benefits;
- 182.22 (ii) do not limit the use of collective bargaining or place a floor or ceiling on health care
- 182.23 workforce compensation; and
- 182.24 (iii) promote workforce stability and maintain high-quality health care jobs; and
- 182.25 (6) consult with the advisory council and other stakeholders.
- 182.26 Subd. 3. **Data.** The board shall identify data to be used for tracking performance in
- 182.27 meeting the growth target and identify methods of data collection necessary for efficient
- 182.28 implementation by the board. In identifying data and methods, the board shall:
- 182.29 (1) consider the availability, timeliness, quality, and usefulness of existing data, including
- 182.30 the data collected under section 62U.04;
- 183.1 (2) assess the need for additional investments in data collection, data validation, or data
- 183.2 analysis capacity to support the board in performing its duties; and
- 183.3 (3) minimize the reporting burden to the extent possible.
- 183.4 Subd. 4. **Setting growth targets; related duties.** (a) The board, by June 15, 2023, and
- 183.5 by June 15 of each succeeding calendar year through June 15, 2027, shall establish annual
- 183.6 health care spending growth targets for the next calendar year consistent with the
- 183.7 requirements of this section. The board shall set annual health care spending growth targets
- 183.8 for the five-year period from January 1, 2024, through December 31, 2028.
- 183.9 (b) The board shall periodically review all components of the health care spending
- 183.10 growth target program methodology, economic indicators, and other factors. The board may
- 183.11 revise the annual spending growth targets after a public hearing, as appropriate. If the board
- 183.12 revises a spending growth target, the board must provide public notice at least 60 days
- 183.13 before the start of the calendar year to which the revised growth target will apply.
- 183.14 (c) The board, based on an analysis of drivers of health care spending and evidence from
- 183.15 public testimony, shall evaluate strategies and new policies, including the establishment of
- 183.16 accountability mechanisms, that are able to contribute to meeting growth targets and limiting
- 183.17 health care spending growth without increasing disparities in access to health care.
- 183.18 Subd. 5. **Hearings.** At least annually, the board shall hold public hearings to present
- 183.19 findings from spending growth target monitoring. The board shall also regularly hold public
- 183.20 hearings to take testimony from stakeholders on health care spending growth, setting and

183.21 revising health care spending growth targets, the impact of spending growth and growth
183.22 targets on health care access and quality, and as needed to perform the duties assigned under
183.23 section 62J.89, subdivisions 1, 2, and 3.

183.24 **Sec. 6. [62J.91] NOTICE TO HEALTH CARE ENTITIES.**

183.25 Subdivision 1. **Notice.** (a) The board shall provide notice to all health care entities that
183.26 have been identified by the board as exceeding the spending growth target for any given
183.27 year.

183.28 (b) For purposes of this section, "health care entity" must be defined by the board during
183.29 the development of the health care spending growth methodology. When developing this
183.30 methodology, the board shall consider a definition of health care entity that includes clinics,
183.31 hospitals, ambulatory surgical centers, physician organizations, accountable care
183.32 organizations, integrated provider and plan systems, and other entities defined by the board,
183.33 provided that physician organizations with a patient panel of 15,000 or fewer, or which
184.1 represent providers who collectively receive less than \$25,000,000 in annual net patient
184.2 service revenue from health plan companies and other payers, are exempt.

184.3 Subd. 2. **Performance improvement plans.** (a) The board shall establish and implement
184.4 procedures to assist health care entities to improve efficiency and reduce cost growth by
184.5 requiring some or all health care entities provided notice under subdivision 1 to file and
184.6 implement a performance improvement plan. The board shall provide written notice of this
184.7 requirement to health care entities.

184.8 (b) Within 45 days of receiving a notice of the requirement to file a performance
184.9 improvement plan, a health care entity shall:

184.10 (1) file a performance improvement plan with the board; or

184.11 (2) file an application with the board to waive the requirement to file a performance
184.12 improvement plan or extend the timeline for filing a performance improvement plan.

184.13 (c) The health care entity may file any documentation or supporting evidence with the
184.14 board to support the health care entity's application to waive or extend the timeline to file
184.15 a performance improvement plan. The board shall require the health care entity to submit
184.16 any other relevant information it deems necessary in considering the waiver or extension
184.17 application, provided that this information must be made public at the discretion of the
184.18 board. The board may waive or delay the requirement for a health care entity to file a
184.19 performance improvement plan in response to a waiver or extension request in light of all
184.20 information received from the health care entity, based on a consideration of the following
184.21 factors:

184.22 (1) the costs, price, and utilization trends of the health care entity over time, and any
184.23 demonstrated improvement in reducing per capita medical expenses adjusted by health
184.24 status;

184.25 (2) any ongoing strategies or investments that the health care entity is implementing to
184.26 improve future long-term efficiency and reduce cost growth;

184.27 (3) whether the factors that led to increased costs for the health care entity can reasonably
184.28 be considered to be unanticipated and outside of the control of the entity. These factors may
184.29 include but are not limited to age and other health status adjusted factors and other cost
184.30 inputs such as pharmaceutical expenses and medical device expenses;

184.31 (4) the overall financial condition of the health care entity; and

184.32 (5) any other factors the board considers relevant. If the board declines to waive or
184.33 extend the requirement for the health care entity to file a performance improvement plan,
185.1 the board shall provide written notice to the health care entity that its application for a waiver
185.2 or extension was denied and the health care entity shall file a performance improvement
185.3 plan.

185.4 (d) A health care entity shall file a performance improvement plan with the board:

185.5 (1) within 45 days of receipt of an initial notice;

185.6 (2) if the health care entity has requested a waiver or extension, within 45 days of receipt
185.7 of a notice that such waiver or extension has been denied; or

185.8 (3) if the health care entity is granted an extension, on the date given on the extension.

185.9 (e) The performance improvement plan must identify the causes of the entity's cost
185.10 growth and include but not be limited to specific strategies, adjustments, and action steps
185.11 the entity proposes to implement to improve cost performance. The proposed performance
185.12 improvement plan must include specific identifiable and measurable expected outcomes
185.13 and a timetable for implementation. The timetable for a performance improvement plan
185.14 must not exceed 18 months.

185.15 (f) The board shall approve any performance improvement plan it determines is
185.16 reasonably likely to address the underlying cause of the entity's cost growth and has a
185.17 reasonable expectation for successful implementation. If the board determines that the
185.18 performance improvement plan is unacceptable or incomplete, the board may provide
185.19 consultation on the criteria that have not been met and may allow an additional time period
185.20 of up to 30 calendar days for resubmission. Upon approval of the proposed performance
185.21 improvement plan, the board shall notify the health care entity to begin immediate
185.22 implementation of the performance improvement plan. The board shall provide public notice
185.23 on its website identifying that the health care entity is implementing a performance
185.24 improvement plan. All health care entities implementing an approved performance
185.25 improvement plan shall be subject to additional reporting requirements and compliance
185.26 monitoring, as determined by the board. The board shall provide assistance to the health
185.27 care entity in the successful implementation of the performance improvement plan.

185.28 (g) All health care entities shall in good faith work to implement the performance
185.29 improvement plan. At any point during the implementation of the performance improvement

185.30 plan, the health care entity may file amendments to the performance improvement plan,
185.31 subject to approval of the board. At the conclusion of the timetable established in the
185.32 performance improvement plan, the health care entity shall report to the board regarding
185.33 the outcome of the performance improvement plan. If the board determines the performance
185.34 improvement plan was not implemented successfully, the board shall:

186.1 (1) extend the implementation timetable of the existing performance improvement plan;

186.2 (2) approve amendments to the performance improvement plan as proposed by the health
186.3 care entity;

186.4 (3) require the health care entity to submit a new performance improvement plan; or

186.5 (4) waive or delay the requirement to file any additional performance improvement
186.6 plans.

186.7 (h) Upon the successful completion of the performance improvement plan, the board
186.8 shall remove the identity of the health care entity from the board's website. The board may
186.9 assist health care entities with implementing the performance improvement plans or otherwise
186.10 ensure compliance with this subdivision.

186.11 (i) If the board determines that a health care entity has:

186.12 (1) willfully neglected to file a performance improvement plan with the board within
186.13 45 days as required;

186.14 (2) failed to file an acceptable performance improvement plan in good faith with the
186.15 board;

186.16 (3) failed to implement the performance improvement plan in good faith; or

186.17 (4) knowingly failed to provide information required by this subdivision to the board or
186.18 knowingly provided false information, the board may assess a civil penalty to the health
186.19 care entity of not more than \$50,000. The board must only impose a civil penalty as a last
186.20 resort.

186.21 **Sec. 7. [62J.92] REPORTING REQUIREMENTS.**

186.22 **Subdivision 1. General requirement.** (a) The board shall present the reports required
186.23 by this section to the chairs and ranking members of the legislative committees with primary
186.24 jurisdiction over health care finance and policy. The board shall also make these reports
186.25 available to the public on the board's website.

186.26 (b) The board may contract with a third-party vendor for technical assistance in preparing
186.27 the reports.

186.28 **Subd. 2. Progress reports.** The board shall submit written progress updates about the
186.29 development and implementation of the health care spending growth target program by
186.30 February 15, 2024, and February 15, 2025. The updates must include reporting on board

186.31 membership and activities, program design decisions, planned timelines for implementation
187.1 of the program, and the progress of implementation. The reports must include the
187.2 methodological details underlying program design decisions.

187.3 Subd. 3. **Health care spending trends.** By December 15, 2024, and every December
187.4 15 thereafter, the board shall submit a report on health care spending trends and the health
187.5 care spending growth target program that includes:

187.6 (1) spending growth in aggregate and for entities subject to health care spending growth
187.7 targets relative to established target levels;

187.8 (2) findings from analyses of drivers of health care spending growth;

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

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

187.14 (5) changes under consideration for revising the methodology to monitor or set growth
187.15 targets;

187.16 (6) recommendations for initiatives to assist health care entities in meeting health care
187.17 spending growth targets, including broader and more transparent adoption of value-based
187.18 payment arrangements; and

187.19 (7) the number of health care entities whose spending growth exceeded growth targets,
187.20 information on performance improvement plans and the extent to which the plans were
187.21 completed, and any civil penalties imposed on health care entities related to noncompliance
187.22 with performance improvement plans and related requirements.

187.23 Sec. 8. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

187.24 Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision
187.25 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's
187.26 designee shall only use the data submitted under subdivisions 4 and 5 for the following
187.27 purposes:

187.28 (1) to evaluate the performance of the health care home program as authorized under
187.29 section 62U.03, subdivision 7;

187.30 (2) to study, in collaboration with the reducing avoidable readmissions effectively
187.31 (RARE) campaign, hospital readmission trends and rates;

188.1 (3) to analyze variations in health care costs, quality, utilization, and illness burden based
188.2 on geographical areas or populations;

188.3 (4) to evaluate the state innovation model (SIM) testing grant received by the Departments
188.4 of Health and Human Services, including the analysis of health care cost, quality, and
188.5 utilization baseline and trend information for targeted populations and communities; ~~and~~

188.6 (5) to compile one or more public use files of summary data or tables that must:

188.7 (i) be available to the public for no or minimal cost by March 1, 2016, and available by
188.8 web-based electronic data download by June 30, 2019;

188.9 (ii) not identify individual patients, payers, or providers;

188.10 (iii) be updated by the commissioner, at least annually, with the most current data
188.11 available;

188.12 (iv) contain clear and conspicuous explanations of the characteristics of the data, such
188.13 as the dates of the data contained in the files, the absence of costs of care for uninsured
188.14 patients or nonresidents, and other disclaimers that provide appropriate context; and

188.15 (v) not lead to the collection of additional data elements beyond what is authorized under
188.16 this section as of June 30, 2015; and

188.17 (6) to provide technical assistance to the Health Care Affordability Board to implement
188.18 sections 62J.86 to 62J.92.

188.19 (b) The commissioner may publish the results of the authorized uses identified in
188.20 paragraph (a) so long as the data released publicly do not contain information or descriptions
188.21 in which the identity of individual hospitals, clinics, or other providers may be discerned.

188.22 (c) Nothing in this subdivision shall be construed to prohibit the commissioner from
188.23 using the data collected under subdivision 4 to complete the state-based risk adjustment
188.24 system assessment due to the legislature on October 1, 2015.

188.25 (d) The commissioner or the commissioner's designee may use the data submitted under
188.26 subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1,
188.27 2023.

188.28 (e) The commissioner shall consult with the all-payer claims database work group
188.29 established under subdivision 12 regarding the technical considerations necessary to create
188.30 the public use files of summary data described in paragraph (a), clause (5).

SENATE ARTICLE 3, SECTION 1 MOVED TO COMPARE WITH HOUSE
ARTICLE 22.

189.1 Sec. 9. Minnesota Statutes 2020, section 256.01, is amended by adding a subdivision to
189.2 read:

189.3 Subd. 43. Education on contraceptive options. The commissioner shall require hospitals
189.4 and primary care providers serving medical assistance and MinnesotaCare enrollees to

189.5 develop and implement protocols to provide these enrollees, when appropriate, with
189.6 comprehensive and scientifically accurate information on the full range of contraceptive
189.7 options in a medically ethical, culturally competent, and noncoercive manner. The
189.8 information provided must be designed to assist enrollees in identifying the contraceptive
189.9 method that best meets their needs and the needs of their families. The protocol must specify
189.10 the enrollee categories to which this requirement will be applied, the process to be used,
189.11 and the information and resources to be provided. Hospitals and providers must make this
189.12 protocol available to the commissioner upon request.

189.13 Sec. 10. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision
189.14 to read:

189.15 Subd. 31. **Long-acting reversible contraceptives.** (a) The commissioner must provide
189.16 separate reimbursement to hospitals for long-acting reversible contraceptives provided
189.17 immediately postpartum in the inpatient hospital setting. This payment must be in addition
189.18 to the diagnostic related group (DRG) reimbursement for labor and delivery.

189.19 (b) The commissioner must require managed care and county-based purchasing plans
189.20 to comply with this subdivision when providing services to medical assistance enrollees.

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

189.22 Sec. 11. Minnesota Statutes 2020, section 256B.021, subdivision 4, is amended to read:

189.23 Subd. 4. **Projects.** The commissioner shall request permission and funding to further
189.24 the following initiatives.

189.25 (a) Health care delivery demonstration projects. This project involves testing alternative
189.26 payment and service delivery models in accordance with sections 256B.0755 and 256B.0756.
189.27 These demonstrations will allow the Minnesota Department of Human Services to engage
189.28 in alternative payment arrangements with provider organizations that provide services to a
189.29 specified patient population for an agreed upon total cost of care or risk/gain sharing payment
189.30 arrangement, but are not limited to these models of care delivery or payment. Quality of
189.31 care and patient experience will be measured and incorporated into payment models alongside
189.32 the cost of care. Demonstration sites should include Minnesota health care programs
190.1 fee-for-services recipients and managed care enrollees and support a robust primary care
190.2 model and improved care coordination for recipients.

190.3 (b) Promote personal responsibility and encourage and reward healthy outcomes. This
190.4 project provides Medicaid funding to provide individual and group incentives to encourage
190.5 healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus
190.6 areas may include diabetes prevention and management, tobacco cessation, reducing weight,
190.7 lowering cholesterol, and lowering blood pressure.

190.8 (c) Encourage utilization of high quality, cost-effective care. This project creates
190.9 incentives ~~through Medicaid and MinnesotaCare enrollee cost sharing and other means to~~

190.10 encourage the utilization of high-quality, low-cost, high-value providers, as determined by
190.11 the state's provider peer grouping initiative under section 62U.04.

190.12 (d) Adults without children. This proposal includes requesting federal authority to impose
190.13 a limit on assets for adults without children in medical assistance, as defined in section
190.14 256B.055, subdivision 15, who have a household income equal to or less than 75 percent
190.15 of the federal poverty limit, and to impose a 180-day durational residency requirement in
190.16 MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children,
190.17 regardless of income.

190.18 (e) Empower and encourage work, housing, and independence. This project provides
190.19 services and supports for individuals who have an identified health or disabling condition
190.20 but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce
190.21 the need for intensive health care and long-term care services and supports, and to help
190.22 maintain or obtain employment or assist in return to work. Benefits may include:

190.23 (1) coordination with health care homes or health care coordinators;

190.24 (2) assessment for wellness, housing needs, employment, planning, and goal setting;

190.25 (3) training services;

190.26 (4) job placement services;

190.27 (5) career counseling;

190.28 (6) benefit counseling;

190.29 (7) worker supports and coaching;

190.30 (8) assessment of workplace accommodations;

190.31 (9) transitional housing services; and

191.1 (10) assistance in maintaining housing.

191.2 (f) Redesign home and community-based services. This project realigns existing funding,
191.3 services, and supports for people with disabilities and older Minnesotans to ensure community
191.4 integration and a more sustainable service system. This may involve changes that promote
191.5 a range of services to flexibly respond to the following needs:

191.6 (1) provide people less expensive alternatives to medical assistance services;

191.7 (2) offer more flexible and updated community support services under the Medicaid
191.8 state plan;

191.9 (3) provide an individual budget and increased opportunity for self-direction;

191.10 (4) strengthen family and caregiver support services;

191.11 (5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected
191.12 needs or foster development of needed services;

191.13 (6) use of home and community-based waiver programs for people whose needs cannot
191.14 be met with the expanded Medicaid state plan community support service options;

191.15 (7) target access to residential care for those with higher needs;

191.16 (8) develop capacity within the community for crisis intervention and prevention;

191.17 (9) redesign case management;

191.18 (10) offer life planning services for families to plan for the future of their child with a
191.19 disability;

191.20 (11) enhance self-advocacy and life planning for people with disabilities;

191.21 (12) improve information and assistance to inform long-term care decisions; and

191.22 (13) increase quality assurance, performance measurement, and outcome-based
191.23 reimbursement.

191.24 This project may include different levels of long-term supports that allow seniors to remain
191.25 in their homes and communities, and expand care transitions from acute care to community
191.26 care to prevent hospitalizations and nursing home placement. The levels of support for
191.27 seniors may range from basic community services for those with lower needs, access to
191.28 residential services if a person has higher needs, and targets access to nursing home care to
191.29 those with rehabilitation or high medical needs. This may involve the establishment of
191.30 medical need thresholds to accommodate the level of support needed; provision of a
191.31 long-term care consultation to persons seeking residential services, regardless of payer
192.1 source; adjustment of incentives to providers and care coordination organizations to achieve
192.2 desired outcomes; and a required coordination with medical assistance basic care benefit
192.3 and Medicare/Medigap benefit. This proposal will improve access to housing and improve
192.4 capacity to maintain individuals in their existing home; adjust screening and assessment
192.5 tools, as needed; improve transition and relocation efforts; seek federal financial participation
192.6 for alternative care and essential community supports; and provide Medigap coverage for
192.7 people having lower needs.

192.8 (g) Coordinate and streamline services for people with complex needs, including those
192.9 with multiple diagnoses of physical, mental, and developmental conditions. This project
192.10 will coordinate and streamline medical assistance benefits for people with complex needs
192.11 and multiple diagnoses. It would include changes that:

192.12 (1) develop community-based service provider capacity to serve the needs of this group;

192.13 (2) build assessment and care coordination expertise specific to people with multiple
192.14 diagnoses;

- 192.15 (3) adopt service delivery models that allow coordinated access to a range of services
192.16 for people with complex needs;
- 192.17 (4) reduce administrative complexity;
- 192.18 (5) measure the improvements in the state's ability to respond to the needs of this
192.19 population; and
- 192.20 (6) increase the cost-effectiveness for the state budget.
- 192.21 (h) Implement nursing home level of care criteria. This project involves obtaining any
192.22 necessary federal approval in order to implement the changes to the level of care criteria in
192.23 section 144.0724, subdivision 11, and implement further changes necessary to achieve
192.24 reform of the home and community-based service system.
- 192.25 (i) Improve integration of Medicare and Medicaid. This project involves reducing
192.26 fragmentation in the health care delivery system to improve care for people eligible for both
192.27 Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term
192.28 care. The proposal may include:
- 192.29 (1) requesting an exception to the new Medicare methodology for payment adjustment
192.30 for fully integrated special needs plans for dual eligible individuals;
- 192.31 (2) testing risk adjustment models that may be more favorable to capturing the needs of
192.32 frail dually eligible individuals;
- 193.1 (3) requesting an exemption from the Medicare bidding process for fully integrated
193.2 special needs plans for the dually eligible;
- 193.3 (4) modifying the Medicare bid process to recognize additional costs of health home
193.4 services; and
- 193.5 (5) requesting permission for risk-sharing and gain-sharing.
- 193.6 (j) Intensive residential treatment services. This project would involve providing intensive
193.7 residential treatment services for individuals who have serious mental illness and who have
193.8 other complex needs. This proposal would allow such individuals to remain in these settings
193.9 after mental health symptoms have stabilized, in order to maintain their mental health and
193.10 avoid more costly or unnecessary hospital or other residential care due to their other complex
193.11 conditions. The commissioner may pursue a specialized rate for projects created under this
193.12 section.
- 193.13 (k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center
193.14 (AMRTC). This project involves seeking Medicaid reimbursement for medical services
193.15 provided to patients to AMRTC, including requesting a waiver of United States Code, title
193.16 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services
193.17 provided by hospitals with more than 16 beds that are primarily focused on the treatment

193.18 of mental illness. This waiver would allow AMRTC to serve as a statewide resource to
193.19 provide diagnostics and treatment for people with the most complex conditions.

193.20 (l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in
193.21 residential facilities. This proposal would seek Medicaid reimbursement for any
193.22 Medicaid-covered service for children who are placed in residential settings that are
193.23 determined to be "institutions for mental diseases," under United States Code, title 42,
193.24 section 1396d.

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

193.26 Sec. 12. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, is
193.27 amended to read:

193.28 Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report
193.29 beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority
193.30 members of the legislative committees with jurisdiction over health and human services
193.31 policy and finance that includes the percentage for adults and children one through 20 years
193.32 of age for the most recent complete calendar year receiving at least one dental visit for both
193.33 fee-for-service and the prepaid medical assistance program. The report must include:

194.1 (1) statewide utilization for both fee-for-service and for the prepaid medical assistance
194.2 program;

194.3 (2) utilization by county;

194.4 (3) utilization by children receiving dental services through fee-for-service and through
194.5 a managed care plan or county-based purchasing plan;

194.6 (4) utilization by adults receiving dental services through fee-for-service and through a
194.7 managed care plan or county-based purchasing plan.

194.8 (b) The report must also include a description of any corrective action plans required to
194.9 be submitted under subdivision 2.

194.10 (c) The initial report due on March 15, 2022, must include the utilization metrics described
194.11 in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

194.12 (d) In the annual report due on March 15, 2023, and in each report due thereafter, the
194.13 commissioner shall include the following:

194.14 (1) the number of dentists enrolled with the commissioner as a medical assistance dental
194.15 provider and the congressional district or districts in which the dentist provides services;

194.16 (2) the number of enrolled dentists who provided fee-for-service dental services to
194.17 medical assistance or MinnesotaCare patients within the previous calendar year in the
194.18 following increments: one to nine patients, ten to 100 patients, and over 100 patients;

86.10 Sec. 2. Minnesota Statutes 2021 Supplement, section 256B.0371, subdivision 4, is amended
86.11 to read:

86.12 Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report
86.13 beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority
86.14 members of the legislative committees with jurisdiction over health and human services
86.15 policy and finance that includes the percentage for adults and children one through 20 years
86.16 of age for the most recent complete calendar year receiving at least one dental visit for both
86.17 fee-for-service and the prepaid medical assistance program. The report must include:

86.18 (1) statewide utilization for both fee-for-service and for the prepaid medical assistance
86.19 program;

86.20 (2) utilization by county;

86.21 (3) utilization by children receiving dental services through fee-for-service and through
86.22 a managed care plan or county-based purchasing plan;

86.23 (4) utilization by adults receiving dental services through fee-for-service and through a
86.24 managed care plan or county-based purchasing plan.

86.25 (b) The report must also include a description of any corrective action plans required to
86.26 be submitted under subdivision 2.

86.27 (c) The initial report due on March 15, 2022, must include the utilization metrics described
86.28 in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

86.29 (d) In the annual report due on March 15, 2023, and in each report due thereafter, the
86.30 commissioner shall include the following:

86.31 (1) the number of dentists enrolled with the commissioner as a medical assistance dental
86.32 provider and the congressional district or districts in which the dentist provides services;

87.1 (2) the number of enrolled dentists who provided fee-for-service dental services to
87.2 medical assistance or MinnesotaCare patients within the previous calendar year in the
87.3 following increments: one to nine patients, ten to 100 patients, and over 100 patients;

194.19 (3) the number of enrolled dentists who provided dental services to medical assistance
 194.20 or MinnesotaCare patients through a managed care plan or county-based purchasing plan
 194.21 within the previous calendar year in the following increments: one to nine patients, ten to
 194.22 100 patients, and over 100 patients; and

194.23 (4) the number of dentists who provided dental services to a new patient who was enrolled
 194.24 in medical assistance or MinnesotaCare within the previous calendar year.

194.25 (e) The report due on March 15, 2023, must include the metrics described in paragraph
 194.26 (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

194.27 Sec. 13. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
 194.28 to read:

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

195.3 (1) eyeglasses;

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

195.7 (3) hearing aids and supplies;

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

195.9 (i) hospital beds;

195.10 (ii) commodes;

195.11 (iii) glide-about chairs;

195.12 (iv) patient lift apparatus;

195.13 (v) wheelchairs and accessories;

195.14 (vi) oxygen administration equipment;

195.15 (vii) respiratory therapy equipment;

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

195.17 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,
 195.18 paragraph (c) or (d);

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

87.4 (3) the number of enrolled dentists who provided dental services to medical assistance
 87.5 or MinnesotaCare patients through a managed care plan or county-based purchasing plan
 87.6 within the previous calendar year in the following increments: one to nine patients, ten to
 87.7 100 patients, and over 100 patients; and

87.8 (4) the number of dentists who provided dental services to a new patient who was enrolled
 87.9 in medical assistance or MinnesotaCare within the previous calendar year.

87.10 (e) The report due on March 15, 2023, must include the metrics described in paragraph
 87.11 (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

195.22 (6) drugs.

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

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

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

196.1 Sec. 14. Minnesota Statutes 2021 Supplement, section 256B.04, subdivision 14, is amended
196.2 to read:

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

196.7 (1) eyeglasses;

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

196.11 (3) hearing aids and supplies;

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

196.13 (i) hospital beds;

196.14 (ii) commodes;

196.15 (iii) glide-about chairs;

196.16 (iv) patient lift apparatus;

196.17 (v) wheelchairs and accessories;

196.18 (vi) oxygen administration equipment;

196.19 (vii) respiratory therapy equipment;

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

196.21 (ix) allergen-reducing products as described in section 256B.0625, subdivision 67,
196.22 paragraph (c) or (d);

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

196.26 (6) drugs; and

196.27 (7) quitline services as described in section 256B.0625, subdivision 68.

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

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

197.4 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
197.5 whichever is later. The commissioner of human services shall notify the revisor of statutes
197.6 when federal approval is obtained.

197.7 Sec. 15. Minnesota Statutes 2020, section 256B.055, subdivision 17, is amended to read:

197.8 Subd. 17. **Adults who were in foster care at the age of 18.** (a) Medical assistance may
197.9 be paid for a person under 26 years of age who was in foster care under the commissioner's
197.10 responsibility on the date of attaining 18 years of age or older, and who was enrolled in
197.11 medical assistance under ~~the a~~ state plan or a waiver of ~~the a~~ plan while in foster care, in
197.12 accordance with section 2004 of the Affordable Care Act.

197.13 (b) Beginning January 1, 2023, medical assistance may be paid for a person under 26
197.14 years of age who was in foster care and enrolled in another state's Medicaid program while
197.15 in foster care, in accordance with Public Law 115-271, section 1002, the Substance
197.16 Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and
197.17 Communities Act.

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

197.19 Sec. 16. Minnesota Statutes 2020, section 256B.056, subdivision 3, is amended to read:

197.20 Subd. 3. **Asset limitations for certain individuals.** (a) To be eligible for medical
197.21 assistance, a person must not individually own more than ~~\$3,000~~ \$20,000 in assets, or if a
197.22 member of a household with two family members, husband and wife, or parent and child,
197.23 the household must not own more than ~~\$6,000~~ \$40,000 in assets, plus \$200 for each
197.24 additional legal dependent. In addition to these maximum amounts, an eligible individual
197.25 or family may accrue interest on these amounts, but they must be reduced to the maximum
197.26 at the time of an eligibility redetermination. The accumulation of the clothing and personal
197.27 needs allowance according to section 256B.35 must also be reduced to the maximum at the
197.28 time of the eligibility redetermination. The value of assets that are not considered in
197.29 determining eligibility for medical assistance is the value of those assets excluded under

- 197.30 the Supplemental Security Income program for aged, blind, and disabled persons, with the
197.31 following exceptions:
- 197.32 (1) household goods and personal effects are not considered;
- 198.1 (2) capital and operating assets of a trade or business that the local agency determines
198.2 are necessary to the person's ability to earn an income are not considered;
- 198.3 (3) motor vehicles are excluded to the same extent excluded by the Supplemental Security
198.4 Income program;
- 198.5 (4) assets designated as burial expenses are excluded to the same extent excluded by the
198.6 Supplemental Security Income program. Burial expenses funded by annuity contracts or
198.7 life insurance policies must irrevocably designate the individual's estate as contingent
198.8 beneficiary to the extent proceeds are not used for payment of selected burial expenses;
- 198.9 (5) for a person who no longer qualifies as an employed person with a disability due to
198.10 loss of earnings, assets allowed while eligible for medical assistance under section 256B.057,
198.11 subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility
198.12 as an employed person with a disability, to the extent that the person's total assets remain
198.13 within the allowed limits of section 256B.057, subdivision 9, paragraph (d);
- 198.14 (6) a designated employment incentives asset account is disregarded when determining
198.15 eligibility for medical assistance for a person age 65 years or older under section 256B.055,
198.16 subdivision 7. An employment incentives asset account must only be designated by a person
198.17 who has been enrolled in medical assistance under section 256B.057, subdivision 9, for a
198.18 24-consecutive-month period. A designated employment incentives asset account contains
198.19 qualified assets owned by the person and the person's spouse in the last month of enrollment
198.20 in medical assistance under section 256B.057, subdivision 9. Qualified assets include
198.21 retirement and pension accounts, medical expense accounts, and up to \$17,000 of the person's
198.22 other nonexcluded assets. An employment incentives asset account is no longer designated
198.23 when a person loses medical assistance eligibility for a calendar month or more before
198.24 turning age 65. A person who loses medical assistance eligibility before age 65 can establish
198.25 a new designated employment incentives asset account by establishing a new
198.26 24-consecutive-month period of enrollment under section 256B.057, subdivision 9. The
198.27 income of a spouse of a person enrolled in medical assistance under section 256B.057,
198.28 subdivision 9, during each of the 24 consecutive months before the person's 65th birthday
198.29 must be disregarded when determining eligibility for medical assistance under section
198.30 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions
198.31 in section 256B.059; ~~and~~
- 198.32 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
198.33 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
199.1 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
199.2 definition of Indian according to Code of Federal Regulations, title 42, section 447.50; and

199.3 (8) for individuals who were enrolled in medical assistance during the COVID-19 federal
199.4 public health emergency declared by the United States Secretary of Health and Human
199.5 Services and who are subject to the asset limits established by this subdivision, assets in
199.6 excess of the limits must be disregarded until 95 days after the individual's first renewal
199.7 occurring after the expiration of the COVID-19 federal public health emergency declared
199.8 by the United States Secretary of Health and Human Services.

199.9 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
199.10 15.

199.11 **EFFECTIVE DATE.** The amendment to paragraph (a) increasing the asset limits is
199.12 effective January 1, 2025, or upon federal approval, whichever is later. The amendment to
199.13 paragraph (a) adding clause (8) is effective July 1, 2022, or upon federal approval, whichever
199.14 is later. The commissioner of human services shall notify the revisor of statutes when federal
199.15 approval is obtained.

199.16 Sec. 17. Minnesota Statutes 2020, section 256B.056, subdivision 4, is amended to read:

199.17 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under section
199.18 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of the federal
199.19 poverty guidelines, and effective January 1, 2025, income up to 133 percent of the federal
199.20 poverty guidelines. Effective January 1, 2000, and each successive January, recipients of
199.21 Supplemental Security Income may have an income up to the Supplemental Security Income
199.22 standard in effect on that date.

199.23 (b) To be eligible for medical assistance under section 256B.055, subdivision 3a, a parent
199.24 or caretaker relative may have an income up to 133 percent of the federal poverty guidelines
199.25 for the household size.

199.26 (c) To be eligible for medical assistance under section 256B.055, subdivision 15, a
199.27 person may have an income up to 133 percent of federal poverty guidelines for the household
199.28 size.

199.29 (d) To be eligible for medical assistance under section 256B.055, subdivision 16, a child
199.30 age 19 to 20 may have an income up to 133 percent of the federal poverty guidelines for
199.31 the household size.

200.1 (e) To be eligible for medical assistance under section 256B.055, subdivision 3a, a child
200.2 under age 19 may have income up to 275 percent of the federal poverty guidelines for the
200.3 household size.

200.4 (f) In computing income to determine eligibility of persons under paragraphs (a) to (e)
200.5 who are not residents of long-term care facilities, the commissioner shall disregard increases
200.6 in income as required by Public Laws 94-566, section 503; 99-272; and 99-509. For persons
200.7 eligible under paragraph (a), veteran aid and attendance benefits and Veterans Administration
200.8 unusual medical expense payments are considered income to the recipient.

200.9 Sec. 18. Minnesota Statutes 2020, section 256B.056, subdivision 7, is amended to read:

200.10 Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application
200.11 and for three months prior to application if the person was eligible in those prior months.
200.12 A redetermination of eligibility must occur every 12 months.

200.13 (b) For a person eligible for an insurance affordability program as defined in section
200.14 256B.02, subdivision 19, who reports a change that makes the person eligible for medical
200.15 assistance, eligibility is available for the month the change was reported and for three months
200.16 prior to the month the change was reported, if the person was eligible in those prior months.

200.17 (c) Once determined eligible for medical assistance, a child under the age of 21 is
200.18 continuously eligible for a period of up to 12 months, unless:

200.19 (1) the child reaches age 21;

200.20 (2) the child requests voluntary termination of coverage;

200.21 (3) the child ceases to be a resident of Minnesota;

200.22 (4) the child dies; or

200.23 (5) the agency determines the child's eligibility was erroneously granted due to agency
200.24 error or enrollee fraud, abuse, or perjury.

200.25 **EFFECTIVE DATE.** This section is effective January 1, 2024, or upon federal approval,
200.26 whichever is later. The commissioner of human services shall notify the revisor of statutes
200.27 when federal approval is obtained.

87.12 Sec. 3. Minnesota Statutes 2020, section 256B.057, subdivision 9, is amended to read:

87.13 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for
87.14 a person who is employed and who:

87.15 (1) but for excess earnings or assets, meets the definition of disabled under the
87.16 Supplemental Security Income program;

87.17 (2) meets the asset limits in paragraph (d); and

87.18 (3) pays a premium and other obligations under paragraph (e).

87.19 (b) For purposes of eligibility, there is a \$65 earned income disregard. To be eligible
87.20 for medical assistance under this subdivision, a person must have more than \$65 of earned
87.21 income. Earned income must have Medicare, Social Security, and applicable state and
87.22 federal taxes withheld. The person must document earned income tax withholding. Any
87.23 spousal income or assets shall be disregarded for purposes of eligibility and premium
87.24 determinations.

- 87.25 (c) After the month of enrollment, a person enrolled in medical assistance under this
87.26 subdivision who:
- 87.27 (1) is temporarily unable to work and without receipt of earned income due to a medical
87.28 condition, as verified by a physician, advanced practice registered nurse, or physician
87.29 assistant; or
- 87.30 (2) loses employment for reasons not attributable to the enrollee, and is without receipt
87.31 of earned income may retain eligibility for up to four consecutive months after the month
87.32 of job loss. To receive a four-month extension, enrollees must verify the medical condition
88.1 or provide notification of job loss. All other eligibility requirements must be met and the
88.2 enrollee must pay all calculated premium costs for continued eligibility.
- 88.3 (d) For purposes of determining eligibility under this subdivision, a person's assets must
88.4 not exceed \$20,000, excluding:
- 88.5 (1) all assets excluded under section 256B.056;
- 88.6 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh
88.7 plans, and pension plans;
- 88.8 (3) medical expense accounts set up through the person's employer; and
- 88.9 (4) spousal assets, including spouse's share of jointly held assets.
- 88.10 (e) All enrollees must pay a premium to be eligible for medical assistance under this
88.11 subdivision, except as provided under clause (1), item (i), and clause (5).
- 88.12 (1) An enrollee must pay ~~the greater of a \$35 premium or~~ the premium calculated based
88.13 ~~on by applying the following sliding premium fee scale to the person's gross earned and~~
88.14 ~~unearned income and the applicable family size using a sliding fee scale established by the~~
88.15 ~~commissioner, which begins at one percent of income at 100 percent of the federal poverty~~
88.16 ~~guidelines and increases to 7.5 percent of income for those with incomes at or above 300~~
88.17 ~~percent of the federal poverty guidelines.:~~
- 88.18 (i) for enrollees with income less than 200 percent of federal poverty guidelines, the
88.19 premium shall be zero percent of income;
- 88.20 (ii) for enrollees with income from 200 to 250 percent of federal poverty guidelines, the
88.21 sliding premium fee scale shall begin at zero percent of income and increase to 2.5 percent;
- 88.22 (iii) for enrollees with income from 250 to 300 percent of federal poverty guidelines,
88.23 the sliding premium fee scale shall begin at 2.5 percent of income and increase to 4.5 percent;
- 88.24 (iv) for enrollees with income from 300 to 400 percent of federal poverty guidelines,
88.25 the sliding premium fee scale shall begin at 4.5 percent of income and increase to six percent;

- 88.26 (v) for enrollees with income from 400 to 500 percent of federal poverty guidelines, the
88.27 sliding premium fee scale shall begin at six percent of income and increase to 7.5 percent;
88.28 and
- 88.29 (vi) for enrollees with income greater than 500 percent of federal poverty guidelines,
88.30 the premium shall be 7.5 percent of income.
- 89.1 (2) Annual adjustments in the premium schedule based upon changes in the federal
89.2 poverty guidelines shall be effective for premiums due in July of each year.
- 89.3 (3) All enrollees who receive unearned income must pay one-half of one percent of
89.4 unearned income in addition to the premium amount, except as provided under clause (5).
- 89.5 (4) Increases in benefits under title II of the Social Security Act shall not be counted as
89.6 income for purposes of this subdivision until July 1 of each year.
- 89.7 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
89.8 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
89.9 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
89.10 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.
- 89.11 (f) A person's eligibility and premium shall be determined by the local county agency.
89.12 Premiums must be paid to the commissioner. All premiums are dedicated to the
89.13 commissioner.
- 89.14 (g) Any required premium shall be determined at application and redetermined at the
89.15 enrollee's six-month income review or when a change in income or household size is reported.
89.16 Enrollees must report any change in income or household size within ten days of when the
89.17 change occurs. A decreased premium resulting from a reported change in income or
89.18 household size shall be effective the first day of the next available billing month after the
89.19 change is reported. Except for changes occurring from annual cost-of-living increases, a
89.20 change resulting in an increased premium shall not affect the premium amount until the
89.21 next six-month review.
- 89.22 (h) Premium payment is due upon notification from the commissioner of the premium
89.23 amount required. Premiums may be paid in installments at the discretion of the commissioner.
- 89.24 (i) Nonpayment of the premium shall result in denial or termination of medical assistance
89.25 unless the person demonstrates good cause for nonpayment. "Good cause" means an excuse
89.26 for the enrollee's failure to pay the required premium when due because the circumstances
89.27 were beyond the enrollee's control or not reasonably foreseeable. The commissioner shall
89.28 determine whether good cause exists based on the weight of the supporting evidence
89.29 submitted by the enrollee to demonstrate good cause. Except when an installment agreement
89.30 is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must
89.31 pay any past due premiums as well as current premiums due prior to being reenrolled.
89.32 Nonpayment shall include payment with a returned, refused, or dishonored instrument. The

200.28 Sec. 19. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 9, is
200.29 amended to read:

200.30 Subd. 9. **Dental services.** (a) Medical assistance covers medically necessary dental
200.31 services.

201.1 (b) ~~Medical assistance dental coverage for nonpregnant adults is limited to the following~~
201.2 ~~services:~~

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

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

201.5 ~~(3) limited exams;~~

201.6 ~~(4) bitewing x-rays, limited to one per year;~~

201.7 ~~(5) periapical x-rays;~~

201.8 ~~(6) panoramic x-rays, limited to one every five years except (1) when medically necessary~~
201.9 ~~for the diagnosis and follow up of oral and maxillofacial pathology and trauma or (2) once~~
201.10 ~~every two years for patients who cannot cooperate for intraoral film due to a developmental~~
201.11 ~~disability or medical condition that does not allow for intraoral film placement;~~

201.12 ~~(7) prophylaxis, limited to one per year;~~

201.13 ~~(8) application of fluoride varnish, limited to one per year;~~

201.14 ~~(9) posterior fillings, all at the amalgam rate;~~

201.15 ~~(10) anterior fillings;~~

201.16 ~~(11) endodontics, limited to root canals on the anterior and premolars only;~~

201.17 ~~(12) removable prostheses, each dental arch limited to one every six years;~~

201.18 ~~(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;~~

201.19 ~~(14) palliative treatment and sedative fillings for relief of pain;~~

201.20 ~~(15) full-mouth debridement, limited to one every five years; and~~

89.33 commissioner may require a guaranteed form of payment as the only means to replace a
89.34 returned, refused, or dishonored instrument.

90.1 (j) For enrollees whose income does not exceed 200 percent of the federal poverty
90.2 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse the
90.3 enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph
90.4 (a).

- 201.21 ~~(16) nonsurgical treatment for periodontal disease, including scaling and root planing~~
 201.22 ~~once every two years for each quadrant, and routine periodontal maintenance procedures.~~
- 201.23 ~~(e) In addition to the services specified in paragraph (b), medical assistance covers the~~
 201.24 ~~following services for adults, if provided in an outpatient hospital setting or freestanding~~
 201.25 ~~ambulatory surgical center as part of outpatient dental surgery:~~
- 201.26 ~~(1) periodontics, limited to periodontal scaling and root planing once every two years;~~
 201.27 ~~(2) general anesthesia; and~~
- 201.28 ~~(3) full-mouth survey once every five years.~~
- 202.1 ~~(d) Medical assistance covers medically necessary dental services for children and~~
 202.2 ~~pregnant women. The following guidelines apply:~~
- 202.3 (1) posterior fillings are paid at the amalgam rate;
- 202.4 (2) application of sealants are covered once every five years per permanent molar ~~for~~
 202.5 ~~children only;~~
- 202.6 (3) application of fluoride varnish is covered once every six months; and
- 202.7 (4) orthodontia is eligible for coverage for children only.
- 202.8 ~~(e) (b) In addition to the services specified in paragraphs (b) and (c) paragraph (a),~~
 202.9 ~~medical assistance covers the following services for adults:~~
- 202.10 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 202.11 (2) behavioral management when additional staff time is required to accommodate
 202.12 behavioral challenges and sedation is not used;
- 202.13 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
 202.14 it or would otherwise require the service to be performed under general anesthesia in a
 202.15 hospital or surgical center; and
- 202.16 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
 202.17 no more than four times per year.
- 202.18 ~~(f) (c) The commissioner shall not require prior authorization for the services included~~
 202.19 ~~in paragraph (e) (b), clauses (1) to (3), and shall prohibit managed care and county-based~~
 202.20 ~~purchasing plans from requiring prior authorization for the services included in paragraph~~
 202.21 ~~(e) (b), clauses (1) to (3), when provided under sections 256B.69, 256B.692, and 256L.12.~~
- 202.22 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
 202.23 whichever is later. The commissioner of human services shall notify the revisor of statutes
 202.24 when federal approval is obtained.

202.25 Sec. 20. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 17, is
202.26 amended to read:

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

203.1 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
203.2 emergency medical care or transportation costs incurred by eligible persons in obtaining
203.3 emergency or nonemergency medical care when paid directly to an ambulance company,
203.4 nonemergency medical transportation company, or other recognized providers of
203.5 transportation services. Medical transportation must be provided by:

203.6 (1) nonemergency medical transportation providers who meet the requirements of this
203.7 subdivision;

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

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

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

203.11 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
203.12 subdivision 1, paragraph (h).

203.13 (c) Medical assistance covers nonemergency medical transportation provided by
203.14 nonemergency medical transportation providers enrolled in the Minnesota health care
203.15 programs. All nonemergency medical transportation providers must comply with the
203.16 operating standards for special transportation service as defined in sections 174.29 to 174.30
203.17 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the

90.5 Sec. 4. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 10, is
90.6 amended to read:

90.7 Subd. 10. **Laboratory, x-ray, and opioid testing services.** (a) Medical assistance covers
90.8 laboratory and x-ray services.

90.9 (b) Medical assistance covers screening and urinalysis tests for opioids without lifetime
90.10 or annual limits.

90.11 (c) Medical assistance covers laboratory tests ordered and performed by a licensed
90.12 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (3), at
90.13 no less than the rate for which the same services are covered when provided by any other
90.14 licensed practitioner.

90.15 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
90.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
90.17 when federal approval is obtained.

90.18 Sec. 5. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 17, is
90.19 amended to read:

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

90.24 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
90.25 emergency medical care or transportation costs incurred by eligible persons in obtaining
90.26 emergency or nonemergency medical care when paid directly to an ambulance company,
90.27 nonemergency medical transportation company, or other recognized providers of
90.28 transportation services. Medical transportation must be provided by:

90.29 (1) nonemergency medical transportation providers who meet the requirements of this
90.30 subdivision;

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

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

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

91.3 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
91.4 subdivision 1, paragraph (h).

91.5 (c) Medical assistance covers nonemergency medical transportation provided by
91.6 nonemergency medical transportation providers enrolled in the Minnesota health care
91.7 programs. All nonemergency medical transportation providers must comply with the
91.8 operating standards for special transportation service as defined in sections 174.29 to 174.30
91.9 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the

203.18 commissioner and reported on the claim as the individual who provided the service. All
 203.19 nonemergency medical transportation providers shall bill for nonemergency medical
 203.20 transportation services in accordance with Minnesota health care programs criteria. Publicly
 203.21 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
 203.22 requirements outlined in this paragraph.

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

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

203.26 (2) the provider has initiated background studies on the individuals specified in section
 203.27 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

204.1 (1) adhere to the policies defined by the commissioner in consultation with the
 204.2 Nonemergency Medical Transportation Advisory Committee;

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

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

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

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

204.15 (g) The commissioner may use an order by the recipient's attending physician, advanced
 204.16 practice registered nurse, or a medical or mental health professional to certify that the
 204.17 recipient requires nonemergency medical transportation services. Nonemergency medical
 204.18 transportation providers shall perform driver-assisted services for eligible individuals, when
 204.19 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
 204.20 residence or place of business, assistance with admittance of the individual to the medical

91.10 commissioner and reported on the claim as the individual who provided the service. All
 91.11 nonemergency medical transportation providers shall bill for nonemergency medical
 91.12 transportation services in accordance with Minnesota health care programs criteria. Publicly
 91.13 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
 91.14 requirements outlined in this paragraph.

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

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

91.18 (2) the provider has initiated background studies on the individuals specified in section
 91.19 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

91.25 (1) adhere to the policies defined by the commissioner in consultation with the
 91.26 Nonemergency Medical Transportation Advisory Committee;

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

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

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

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

92.7 (g) The commissioner may use an order by the recipient's attending physician, advanced
 92.8 practice registered nurse, or a medical or mental health professional to certify that the
 92.9 recipient requires nonemergency medical transportation services. Nonemergency medical
 92.10 transportation providers shall perform driver-assisted services for eligible individuals, when
 92.11 appropriate. Driver-assisted service includes passenger pickup at and return to the individual's
 92.12 residence or place of business, assistance with admittance of the individual to the medical

204.21 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
204.22 or stretchers in the vehicle.

204.23 Nonemergency medical transportation providers must take clients to the health care
204.24 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
204.25 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
204.26 authorization from the local agency.

204.27 Nonemergency medical transportation providers may not bill for separate base rates for
204.28 the continuation of a trip beyond the original destination. Nonemergency medical
204.29 transportation providers must maintain trip logs, which include pickup and drop-off times,
204.30 signed by the medical provider or client, whichever is deemed most appropriate, attesting
204.31 to mileage traveled to obtain covered medical services. Clients requesting client mileage
204.32 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
204.33 services.

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

205.6 (i) The covered modes of transportation are:

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

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

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

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

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

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

92.13 facility, and assistance in passenger securement or in securing of wheelchairs, child seats,
92.14 or stretchers in the vehicle.

92.15 Nonemergency medical transportation providers must take clients to the health care
92.16 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
92.17 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
92.18 authorization from the local agency.

92.19 Nonemergency medical transportation providers may not bill for separate base rates for
92.20 the continuation of a trip beyond the original destination. Nonemergency medical
92.21 transportation providers must maintain trip logs, which include pickup and drop-off times,
92.22 signed by the medical provider or client, whichever is deemed most appropriate, attesting
92.23 to mileage traveled to obtain covered medical services. Clients requesting client mileage
92.24 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
92.25 services.

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

92.31 (i) The covered modes of transportation are:

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

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

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

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

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

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

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

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

205.33 (k) The commissioner shall:

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

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

206.4 (3) investigate all complaints and appeals.

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

206.9 (m) Payments for nonemergency medical transportation must be paid based on the client's
 206.10 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
 206.11 medical assistance reimbursement rates for nonemergency medical transportation services
 206.12 that are payable by or on behalf of the commissioner for nonemergency medical
 206.13 transportation services are:

206.14 (1) \$0.22 per mile for client reimbursement;

206.15 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
 206.16 transport;

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

206.20 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

206.21 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

206.22 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

206.23 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
 206.24 an additional attendant if deemed medically necessary.

206.25 (n) The base rate for nonemergency medical transportation services in areas defined
 206.26 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

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

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

93.24 (k) The commissioner shall:

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

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

93.28 (3) investigate all complaints and appeals.

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

94.1 (m) Payments for nonemergency medical transportation must be paid based on the client's
 94.2 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
 94.3 medical assistance reimbursement rates for nonemergency medical transportation services
 94.4 that are payable by or on behalf of the commissioner for nonemergency medical
 94.5 transportation services are:

94.6 (1) \$0.22 per mile for client reimbursement;

94.7 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
 94.8 transport;

94.9 (3) equivalent to the standard fare for unassisted transport when provided by public
 94.10 transit, and ~~\$11~~ \$12.93 for the base rate and ~~\$1.30~~ \$1.53 per mile when provided by a
 94.11 nonemergency medical transportation provider;

94.12 (4) ~~\$13~~ \$15.28 for the base rate and ~~\$1.30~~ \$1.53 per mile for assisted transport;

94.13 (5) ~~\$18~~ \$21.15 for the base rate and ~~\$1.55~~ \$1.82 per mile for lift-equipped/ramp transport;

94.14 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

94.15 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
 94.16 an additional attendant if deemed medically necessary.

94.17 (n) The base rate for nonemergency medical transportation services in areas defined
 94.18 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in

206.27 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
206.28 services in areas defined under RUCA to be rural or super rural areas is:

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

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

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

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

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

207.12 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
207.13 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
207.14 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
207.15 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
207.16 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
207.17 or decrease must be calculated using the average of the most recently available price of all
207.18 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
207.19 Administration.

207.20 **EFFECTIVE DATE.** This section is effective July 1, 2022.

207.21 Sec. 21. Minnesota Statutes 2020, section 256B.0625, subdivision 17a, is amended to
207.22 read:

207.23 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
207.24 services. Providers shall bill ambulance services according to Medicare criteria.
207.25 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
207.26 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
207.27 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
207.28 effect on July 1, 2000, whichever is greater.

207.29 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
207.30 rates for ambulance services identified in this paragraph are increased by five percent.
207.31 Capitation payments made to managed care plans and county-based purchasing plans for
207.32 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
208.1 rate increase. The increased rate described in this paragraph applies to ambulance service
208.2 providers whose base of operations as defined in section 144E.10 is located:

94.19 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
94.20 services in areas defined under RUCA to be rural or super rural areas is:

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

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

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

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

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

95.4 (r) Effective for the first day of each calendar quarter in which the price of gasoline as
95.5 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
95.6 gallon, the commissioner shall adjust the rate paid per mile in paragraph (m) by one percent
95.7 up or down for every increase or decrease of ten cents for the price of gasoline. The increase
95.8 or decrease must be calculated using a base gasoline price of \$3.00. The percentage increase
95.9 or decrease must be calculated using the average of the most recently available price of all
95.10 grades of gasoline for Minnesota as posted publicly by the United States Energy Information
95.11 Administration.

95.12 Sec. 6. Minnesota Statutes 2020, section 256B.0625, subdivision 17a, is amended to read:

95.13 Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance
95.14 services. Providers shall bill ambulance services according to Medicare criteria.
95.15 Nonemergency ambulance services shall not be paid as emergencies. Effective for services
95.16 rendered on or after July 1, 2001, medical assistance payments for ambulance services shall
95.17 be paid at the Medicare reimbursement rate or at the medical assistance payment rate in
95.18 effect on July 1, 2000, whichever is greater.

95.19 (b) Effective for services provided on or after July 1, 2016, medical assistance payment
95.20 rates for ambulance services identified in this paragraph are increased by five percent.
95.21 Capitation payments made to managed care plans and county-based purchasing plans for
95.22 ambulance services provided on or after January 1, 2017, shall be increased to reflect this
95.23 rate increase. The increased rate described in this paragraph applies to ambulance service
95.24 providers whose base of operations as defined in section 144E.10 is located:

208.3 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
 208.4 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

208.5 (2) within a municipality with a population of less than 1,000.

208.6 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
 208.7 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
 208.8 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one
 208.9 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
 208.10 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
 208.11 increase or decrease must be calculated using the average of the most recently available
 208.12 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
 208.13 Information Administration.

208.14 **EFFECTIVE DATE.** This section is effective July 1, 2022.

208.15 Sec. 22. Minnesota Statutes 2020, section 256B.0625, subdivision 18h, is amended to
 208.16 read:

208.17 Subd. 18h. **Nonemergency medical transportation provisions related to managed**
 208.18 **care.** (a) The following nonemergency medical transportation subdivisions apply to managed
 208.19 care plans and county-based purchasing plans:

208.20 (1) subdivision 17, paragraphs (a), (b), (i), and (n);

208.21 (2) subdivision 18; and

208.22 (3) subdivision 18a.

208.23 (b) A nonemergency medical transportation provider must comply with the operating
 208.24 standards for special transportation service specified in sections 174.29 to 174.30 and
 208.25 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire
 208.26 vehicles are exempt from the requirements in this paragraph.

208.27 (c) Managed care and county-based purchasing plans must provide a fuel adjustment
 208.28 for nonemergency medical transportation payment rates when the price of gasoline exceeds
 208.29 \$3.00 per gallon.

209.1 Sec. 23. Minnesota Statutes 2020, section 256B.0625, subdivision 22, is amended to read:

209.2 Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public
 209.3 Law 99-272, section 9505, to the extent authorized by rule, except that a recipient age 21
 209.4 or under who elects to receive hospice services does not waive coverage for services that
 209.5 are related to the treatment of the condition for which a diagnosis of terminal illness has
 209.6 been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care
 209.7 services under this subdivision.

95.25 (1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside
 95.26 the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

95.27 (2) within a municipality with a population of less than 1,000.

95.28 (c) Effective for the first day of each calendar quarter in which the price of gasoline as
 95.29 posted publicly by the United States Energy Information Administration exceeds \$3.00 per
 95.30 gallon, the commissioner shall adjust the rate paid per mile in paragraphs (a) and (b) by one
 95.31 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
 95.32 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
 95.33 increase or decrease must be calculated using the average of the most recently available
 96.1 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
 96.2 Information Administration.

209.8 Sec. 24. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
209.9 to read:

209.10 Subd. 22a. **Residential hospice facility; hospice respite and end-of-life care for**
209.11 **children.** (a) Medical assistance covers hospice respite and end-of-life care if the care is
209.12 for recipients age 21 or under who elect to receive hospice care delivered in a facility that
209.13 is licensed under sections 144A.75 to 144A.755 and that is a residential hospice facility
209.14 under section 144A.75, subdivision 13, paragraph (a). Hospice care services under
209.15 subdivision 22 are not hospice respite or end-of-life care under this subdivision.

209.16 (b) The payment rates for coverage under this subdivision must be 100 percent of the
209.17 Medicare rate for continuous home care hospice services as published in the Centers for
209.18 Medicare and Medicaid Services annual final rule updating payments and policies for hospice
209.19 care. Payment for hospice respite and end-of-life care under this subdivision must be made
209.20 from state funds, though the commissioner shall seek to obtain federal financial participation
209.21 for the payments. Payment for hospice respite and end-of-life care must be paid to the
209.22 residential hospice facility and are not included in any limits or cap amount applicable to
209.23 hospice services payments to the elected hospice services provider.

209.24 (c) Certification of the residential hospice facility by the federal Medicare program must
209.25 not be a requirement of medical assistance payment for hospice respite and end-of-life care
209.26 under this subdivision.

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

209.28 Sec. 25. Minnesota Statutes 2020, section 256B.0625, subdivision 28b, is amended to
209.29 read:

209.30 Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a
209.31 certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For
209.32 purposes of this section, "doula services" means childbirth education and support services,
210.1 including emotional and physical support provided during pregnancy, labor, birth, and
210.2 postpartum. The commissioner shall enroll doula agencies and individual treating doulas
210.3 in order to provide direct reimbursement.

210.4 **EFFECTIVE DATE.** This section is effective January 1, 2024, subject to federal
210.5 approval. The commissioner of human services shall notify the revisor of statutes when
210.6 federal approval is obtained.

210.7 Sec. 26. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 30, is
210.8 amended to read:

210.9 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,
210.10 federally qualified health center services, nonprofit community health clinic services, and
210.11 public health clinic services. Rural health clinic services and federally qualified health center
210.12 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and

210.13 (C). Payment for rural health clinic and federally qualified health center services shall be
210.14 made according to applicable federal law and regulation.

210.15 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
210.16 submit an estimate of budgeted costs and visits for the initial reporting period in the form
210.17 and detail required by the commissioner. An FQHC that is already in operation shall submit
210.18 an initial report using actual costs and visits for the initial reporting period. Within 90 days
210.19 of the end of its reporting period, an FQHC shall submit, in the form and detail required by
210.20 the commissioner, a report of its operations, including allowable costs actually incurred for
210.21 the period and the actual number of visits for services furnished during the period, and other
210.22 information required by the commissioner. FQHCs that file Medicare cost reports shall
210.23 provide the commissioner with a copy of the most recent Medicare cost report filed with
210.24 the Medicare program intermediary for the reporting year which support the costs claimed
210.25 on their cost report to the state.

210.26 (c) In order to continue cost-based payment under the medical assistance program
210.27 according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation
210.28 as an essential community provider within six months of final adoption of rules by the
210.29 Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and
210.30 rural health clinics that have applied for essential community provider status within the
210.31 six-month time prescribed, medical assistance payments will continue to be made according
210.32 to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural
210.33 health clinics that either do not apply within the time specified above or who have had
210.34 essential community provider status for three years, medical assistance payments for health
211.1 services provided by these entities shall be according to the same rates and conditions
211.2 applicable to the same service provided by health care providers that are not FQHCs or rural
211.3 health clinics.

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

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

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

211.16 (g) Effective for services provided on or after January 1, 2021, all claims for payment
211.17 of clinic services provided by FQHCs and rural health clinics shall be paid by the
211.18 commissioner, according to an annual election by the FQHC or rural health clinic, under

211.19 the current prospective payment system described in paragraph (f) or the alternative payment
211.20 methodology described in paragraph (l).

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

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

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

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

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

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

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

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

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

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

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

212.22 (k) The commissioner shall seek a federal waiver, authorized under section 1115 of the
212.23 Social Security Act, to obtain federal financial participation at the 100 percent federal

212.24 matching percentage available to facilities of the Indian Health Service or tribal organization
212.25 in accordance with section 1905(b) of the Social Security Act for expenditures made to
212.26 organizations dually certified under Title V of the Indian Health Care Improvement Act,
212.27 Public Law 94-437, and as a federally qualified health center under paragraph (a) that
212.28 provides services to American Indian and Alaskan Native individuals eligible for services
212.29 under this subdivision.

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

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

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

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

213.8 (i) general social services and administrative costs;

213.9 (ii) retail pharmacy;

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

213.11 (iv) external lab and x-ray;

213.12 (v) navigation services;

213.13 (vi) health care taxes;

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

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

213.16 (ix) contributions and donations;

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

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

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

213.20 (xiii) research and associated administrative costs;

213.21 (xiv) nonpaid workers;

- 213.22 (xv) lobbying;
- 213.23 (xvi) scholarships and student aid; and
- 213.24 (xvii) nonmedical assistance covered services;
- 213.25 (4) the commissioner shall review the list of nonallowable costs in the years between
213.26 the rebasing process established in clause (5), in consultation with the Minnesota Association
213.27 of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall
213.28 publish the list and any updates in the Minnesota health care programs provider manual;
- 214.1 (5) the initial applicable base year organization encounter rates for FQHCs and rural
214.2 health clinics shall be computed for services delivered on or after January 1, 2021, and:
- 214.3 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
214.4 from 2017 and 2018;
- 214.5 (ii) must be according to current applicable Medicare cost principles as applicable to
214.6 FQHCs and rural health clinics without the application of productivity screens and upper
214.7 payment limits or the Medicare prospective payment system FQHC aggregate mean upper
214.8 payment limit;
- 214.9 (iii) must be subsequently rebased every two years thereafter using the Medicare cost
214.10 reports that are three and four years prior to the rebasing year. Years in which organizational
214.11 cost or claims volume is reduced or altered due to a pandemic, disease, or other public health
214.12 emergency shall not be used as part of a base year when the base year includes more than
214.13 one year. The commissioner may use the Medicare cost reports of a year unaffected by a
214.14 pandemic, disease, or other public health emergency, or previous two consecutive years,
214.15 inflated to the base year as established under item (iv);
- 214.16 (iv) must be inflated to the base year using the inflation factor described in clause (6);
214.17 and
- 214.18 (v) the commissioner must provide for a 60-day appeals process under section 14.57;
- 214.19 (6) the commissioner shall annually inflate the applicable organization encounter rates
214.20 for FQHCs and rural health clinics from the base year payment rate to the effective date by
214.21 using the CMS FQHC Market Basket inflator established under United States Code, title
214.22 42, section 1395m(o), less productivity;
- 214.23 (7) FQHCs and rural health clinics that have elected the alternative payment methodology
214.24 under this paragraph shall submit all necessary documentation required by the commissioner
214.25 to compute the rebased organization encounter rates no later than six months following the
214.26 date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid
214.27 Services;

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

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

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

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

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

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

215.19 (11) for change of scope requests that do not require federal Health Resources Services
215.20 Administration approval, the FQHC and rural health clinic shall submit the request to the
215.21 commissioner before implementing the change, and the effective date of the change is the
215.22 date the commissioner received the FQHC's or rural health clinic's request, or the effective
215.23 start date of the service, whichever is later. The commissioner shall provide a response to
215.24 the FQHC's or rural health clinic's request within 45 days of submission and provide a final
215.25 approval within 120 days of submission. This timeline may be waived at the mutual
215.26 agreement of the commissioner and the FQHC or rural health clinic if more information is
215.27 needed to evaluate the request;

215.28 (12) the commissioner, when establishing organization encounter rates for new FQHCs
215.29 and rural health clinics, shall consider the patient caseload of existing FQHCs and rural
215.30 health clinics in a 60-mile radius for organizations established outside of the seven-county
215.31 metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan
215.32 area. If this information is not available, the commissioner may use Medicare cost reports
215.33 or audited financial statements to establish base rates;

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

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

216.8 (m) Effective July 1, 2022, an enrolled Indian Health Service facility or a Tribal health
216.9 center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC.
216.10 No requirements that otherwise apply to FQHCs covered in this subdivision apply to Tribal
216.11 FQHCs enrolled under this paragraph, except those necessary to comply with federal
216.12 regulations. The commissioner shall establish an alternative payment method for Tribal
216.13 FQHCs enrolled under this paragraph that uses the same method and rates applicable to a
216.14 Tribal facility or health center that does not enroll as a Tribal FQHC.

216.15 Sec. 27. Minnesota Statutes 2021 Supplement, section 256B.0625, subdivision 31, is
216.16 amended to read:

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

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

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

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

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

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

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

217.5 Medicare program's supplier and quality standards and the vendor serves primarily pediatric
217.6 patients.

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

217.8 (1) can withstand repeated use;

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

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

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

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

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

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

217.26 (i) Seizure detection devices are covered as durable medical equipment under this
217.27 subdivision if:

217.28 (1) the seizure detection device is medically appropriate based on the recipient's medical
217.29 condition or status; and

217.30 (2) the recipient's health care provider has identified that a seizure detection device
217.31 would:

218.1 (i) likely assist in reducing bodily harm to or death of the recipient as a result of the
218.2 recipient experiencing a seizure; or

218.3 (ii) provide data to the health care provider necessary to appropriately diagnose or treat
218.4 the recipient's health condition that causes the seizure activity.

218.5 (j) For purposes of paragraph (i), "seizure detection device" means a United States Food
218.6 and Drug Administration approved monitoring device and any related service or subscription
218.7 supporting the prescribed use of the device, including technology that:

218.8 (1) provides ongoing patient monitoring and alert services that detects nocturnal seizure
 218.9 activity and transmits notification of the seizure activity to a caregiver for appropriate
 218.10 medical response; or

218.11 (2) collects data of the seizure activity of the recipient that can be used by a health care
 218.12 provider to diagnose or appropriately treat a health care condition that causes the seizure
 218.13 activity.

218.14 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
 218.15 whichever is later. The commissioner of human services shall notify the revisor of statutes
 218.16 when federal approval is obtained.

218.17 Sec. 28. Minnesota Statutes 2020, section 256B.0625, is amended by adding a subdivision
 218.18 to read:

218.19 Subd. 68. **Tobacco and nicotine cessation.** (a) Medical assistance covers tobacco and
 218.20 nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence,
 218.21 and drugs to help individuals discontinue use of tobacco and nicotine products. Medical
 218.22 assistance must cover services and drugs as provided in this subdivision consistent with
 218.23 evidence-based or evidence-informed best practices.

218.24 (b) Medical assistance must cover in-person individual and group tobacco and nicotine
 218.25 cessation education and counseling services if provided by a health care practitioner whose
 218.26 scope of practice encompasses tobacco and nicotine cessation education and counseling.
 218.27 Service providers include but are not limited to the following:

96.3 Sec. 7. Minnesota Statutes 2020, section 256B.0625, subdivision 39, is amended to read:

96.4 Subd. 39. ~~Childhood Immunizations.~~ (a) Providers who administer pediatric vaccines
 96.5 within the scope of their licensure, and who are enrolled as a medical assistance provider,
 96.6 must enroll in the pediatric vaccine administration program established by section 13631
 96.7 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay for
 96.8 administration of the vaccine to children eligible for medical assistance. Medical assistance
 96.9 does not pay for vaccines that are available at no cost from the pediatric vaccine
 96.10 administration program.

96.11 (b) Medical assistance covers vaccines initiated, ordered, or administered by a licensed
 96.12 pharmacist, according to the requirements of section 151.01, subdivision 27, clause (6), at
 96.13 no less than the rate for which the same services are covered when provided by any other
 96.14 licensed practitioner.

96.15 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
 96.16 whichever is later. The commissioner of human services shall notify the revisor of statutes
 96.17 when federal approval is obtained.

- 218.28 (1) mental health practitioners under section 245.462, subdivision 17;
- 218.29 (2) mental health professionals under section 245.462, subdivision 18;
- 218.30 (3) mental health certified peer specialists under section 256B.0615;
- 218.31 (4) alcohol and drug counselors licensed under chapter 148F;
- 219.1 (5) recovery peers as defined in section 245F.02, subdivision 21;
- 219.2 (6) certified tobacco treatment specialists;
- 219.3 (7) community health workers;
- 219.4 (8) physicians;
- 219.5 (9) physician assistants;
- 219.6 (10) advanced practice registered nurses; or
- 219.7 (11) other licensed or nonlicensed professionals or paraprofessionals with training in
 219.8 providing tobacco and nicotine cessation education and counseling services.
- 219.9 (c) Medical assistance covers telephone cessation counseling services provided through
 219.10 a quitline. Notwithstanding subdivision 3b, quitline services may be provided through
 219.11 audio-only communications. The commissioner may use volume purchasing for quitline
 219.12 services consistent with section 256B.04, subdivision 14.
- 219.13 (d) Medical assistance must cover all prescription and over-the-counter pharmacotherapy
 219.14 drugs approved by the United States Food and Drug Administration for cessation of tobacco
 219.15 and nicotine use or treatment of tobacco and nicotine dependence, and that are subject to a
 219.16 Medicaid drug rebate agreement.
- 219.17 (e) Services covered under this subdivision may be provided by telemedicine.
- 219.18 (f) The commissioner must not:
- 219.19 (1) restrict or limit the type, duration, or frequency of tobacco and nicotine cessation
 219.20 services;
- 219.21 (2) prohibit the simultaneous use of multiple cessation services, including but not limited
 219.22 to simultaneous use of counseling and drugs;
- 219.23 (3) require counseling prior to receiving drugs or as a condition of receiving drugs;
- 219.24 (4) limit pharmacotherapy drug dosage amounts for a dosing regimen for treatment of
 219.25 a medically accepted indication, as defined in United States Code, title 42, section
 219.26 1396r-8(k)(6); limit dosing frequency; or impose duration limits;

- 219.27 (5) prohibit simultaneous use of multiple drugs, including prescription and
219.28 over-the-counter drugs;
- 219.29 (6) require or authorize step therapy; or
- 220.1 (7) require or utilize prior authorization or require a co-payment or deductible for any
220.2 tobacco and nicotine cessation services and drugs covered under this subdivision.
- 220.3 (g) The commissioner must require all participating entities under contract with the
220.4 commissioner to comply with this subdivision when providing coverage, services, or care
220.5 management for medical assistance and MinnesotaCare enrollees. For purposes of this
220.6 subdivision, "participating entity" means any of the following:
- 220.7 (1) a health carrier as defined in section 62A.011, subdivision 2;
- 220.8 (2) a county-based purchasing plan established under section 256B.692;
- 220.9 (3) an accountable care organization or other entity participating as an integrated health
220.10 partnership under section 256B.0755;
- 220.11 (4) an entity operating a county integrated health care delivery network pilot project
220.12 authorized under section 256B.0756;
- 220.13 (5) a network of health care providers established to offer services under medical
220.14 assistance or MinnesotaCare; or
- 220.15 (6) any other entity that has a contract with the commissioner to cover, provide, or
220.16 manage health care services provided to medical assistance or MinnesotaCare enrollees on
220.17 a capitated or risk-based payment arrangement or under a reimbursement methodology with
220.18 substantial financial incentives to reduce the total cost of health care for a population of
220.19 patients that is enrolled with or assigned or attributed to the entity.
- 220.20 **EFFECTIVE DATE.** This section is effective January 1, 2023, or upon federal approval,
220.21 whichever is later. The commissioner of human services shall notify the revisor of statutes
220.22 when federal approval is obtained.
- 220.23 Sec. 29. Minnesota Statutes 2020, section 256B.0631, as amended by Laws 2021, First
220.24 Special Session chapter 7, article 1, section 17, is amended to read:
- 220.25 **256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.**
- 220.26 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
220.27 assistance benefit plan shall include the following cost-sharing for all recipients, effective
220.28 for services provided on or after September 1, 2011, through December 31, 2022:
- 220.29 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
220.30 subdivision, a visit means an episode of service which is required because of a recipient's
220.31 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting

- 221.1 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
221.2 practice nurse, audiologist, optician, or optometrist;
- 221.3 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
221.4 co-payment shall be increased to \$20 upon federal approval;
- 221.5 (3) \$3 per brand-name drug prescription, \$1 per generic drug prescription, and \$1 per
221.6 prescription for a brand-name multisource drug listed in preferred status on the preferred
221.7 drug list, subject to a \$12 per month maximum for prescription drug co-payments. No
221.8 co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;
- 221.9 (4) a family deductible equal to \$2.75 per month per family and adjusted annually by
221.10 the percentage increase in the medical care component of the CPI-U for the period of
221.11 September to September of the preceding calendar year, rounded to the next higher five-cent
221.12 increment; and
- 221.13 (5) total monthly cost-sharing must not exceed five percent of family income. For
221.14 purposes of this paragraph, family income is the total earned and unearned income of the
221.15 individual and the individual's spouse, if the spouse is enrolled in medical assistance and
221.16 also subject to the five percent limit on cost-sharing. This paragraph does not apply to
221.17 premiums charged to individuals described under section 256B.057, subdivision 9.
- 221.18 (b) Recipients of medical assistance are responsible for all co-payments and deductibles
221.19 in this subdivision.
- 221.20 (c) Notwithstanding paragraph (b), the commissioner, through the contracting process
221.21 under sections 256B.69 and 256B.692, may allow managed care plans and county-based
221.22 purchasing plans to waive the family deductible under paragraph (a), clause (4). The value
221.23 of the family deductible shall not be included in the capitation payment to managed care
221.24 plans and county-based purchasing plans. Managed care plans and county-based purchasing
221.25 plans shall certify annually to the commissioner the dollar value of the family deductible.
- 221.26 (d) Notwithstanding paragraph (b), the commissioner may waive the collection of the
221.27 family deductible described under paragraph (a), clause (4), from individuals and allow
221.28 long-term care and waived service providers to assume responsibility for payment.
- 221.29 (e) Notwithstanding paragraph (b), the commissioner, through the contracting process
221.30 under section 256B.0756 shall allow the pilot program in Hennepin County to waive
221.31 co-payments. The value of the co-payments shall not be included in the capitation payment
221.32 amount to the integrated health care delivery networks under the pilot program.
- 222.1 (f) Paragraphs (a) to (e) apply only for services provided through December 31, 2022.
222.2 Effective for services provided on or after January 1, 2023, the medical assistance program
222.3 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
222.4 cost-sharing.
- 222.5 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject, through December
222.6 31, 2022, to the following exceptions:

- 222.7 (1) children under the age of 21;
- 222.8 (2) pregnant women for services that relate to the pregnancy or any other medical
- 222.9 condition that may complicate the pregnancy;
- 222.10 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
- 222.11 intermediate care facility for the developmentally disabled;
- 222.12 (4) recipients receiving hospice care;
- 222.13 (5) 100 percent federally funded services provided by an Indian health service;
- 222.14 (6) emergency services;
- 222.15 (7) family planning services;
- 222.16 (8) services that are paid by Medicare, resulting in the medical assistance program paying
- 222.17 for the coinsurance and deductible;
- 222.18 (9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses,
- 222.19 and nonemergency visits to a hospital-based emergency room;
- 222.20 (10) services, fee-for-service payments subject to volume purchase through competitive
- 222.21 bidding;
- 222.22 (11) American Indians who meet the requirements in Code of Federal Regulations, title
- 222.23 42, sections 447.51 and 447.56;
- 222.24 (12) persons needing treatment for breast or cervical cancer as described under section
- 222.25 256B.057, subdivision 10; and
- 222.26 (13) services that currently have a rating of A or B from the United States Preventive
- 222.27 Services Task Force (USPSTF), immunizations recommended by the Advisory Committee
- 222.28 on Immunization Practices of the Centers for Disease Control and Prevention, and preventive
- 222.29 services and screenings provided to women as described in Code of Federal Regulations,
- 222.30 title 45, section 147.130.
- 223.1 Subd. 3. **Collection.** (a) The medical assistance reimbursement to the provider shall be
- 223.2 reduced by the amount of the co-payment or deductible, except that reimbursements shall
- 223.3 not be reduced:
- 223.4 (1) once a recipient has reached the \$12 per month maximum for prescription drug
- 223.5 co-payments; or
- 223.6 (2) for a recipient who has met their monthly five percent cost-sharing limit.
- 223.7 (b) The provider collects the co-payment or deductible from the recipient. Providers
- 223.8 may not deny services to recipients who are unable to pay the co-payment or deductible.

- 223.9 (c) Medical assistance reimbursement to fee-for-service providers and payments to
223.10 managed care plans shall not be increased as a result of the removal of co-payments or
223.11 deductibles effective on or after January 1, 2009.
- 223.12 (d) Paragraphs (a) to (c) apply only for services provided through December 31, 2022.
- 223.13 Sec. 30. Minnesota Statutes 2020, section 256B.69, subdivision 4, is amended to read:
- 223.14 Subd. 4. **Limitation of choice; opportunity to opt out.** (a) The commissioner shall
223.15 develop criteria to determine when limitation of choice may be implemented in the
223.16 experimental counties, but shall provide all eligible individuals the opportunity to opt out
223.17 of enrollment in managed care under this section. The criteria shall ensure that all eligible
223.18 individuals in the county have continuing access to the full range of medical assistance
223.19 services as specified in subdivision 6.
- 223.20 (b) The commissioner shall exempt the following persons from participation in the
223.21 project, in addition to those who do not meet the criteria for limitation of choice:
- 223.22 (1) persons eligible for medical assistance according to section 256B.055, subdivision
223.23 1;
- 223.24 (2) persons eligible for medical assistance due to blindness or disability as determined
223.25 by the Social Security Administration or the state medical review team, unless:
- 223.26 (i) they are 65 years of age or older; or
- 223.27 (ii) they reside in Itasca County or they reside in a county in which the commissioner
223.28 conducts a pilot project under a waiver granted pursuant to section 1115 of the Social
223.29 Security Act;
- 223.30 (3) recipients who currently have private coverage through a health maintenance
223.31 organization;
- 224.1 (4) recipients who are eligible for medical assistance by spending down excess income
224.2 for medical expenses other than the nursing facility per diem expense;
- 224.3 (5) recipients who receive benefits under the Refugee Assistance Program, established
224.4 under United States Code, title 8, section 1522(e);
- 224.5 (6) children who are both determined to be severely emotionally disturbed and receiving
224.6 case management services according to section 256B.0625, subdivision 20, except children
224.7 who are eligible for and who decline enrollment in an approved preferred integrated network
224.8 under section 245.4682;
- 224.9 (7) adults who are both determined to be seriously and persistently mentally ill and
224.10 received case management services according to section 256B.0625, subdivision 20;
- 224.11 (8) persons eligible for medical assistance according to section 256B.057, subdivision
224.12 10;

224.13 (9) persons with access to cost-effective employer-sponsored private health insurance
224.14 or persons enrolled in a non-Medicare individual health plan determined to be cost-effective
224.15 according to section 256B.0625, subdivision 15; and

224.16 (10) persons who are absent from the state for more than 30 consecutive days but still
224.17 deemed a resident of Minnesota, identified in accordance with section 256B.056, subdivision
224.18 1, paragraph (b).

224.19 Children under age 21 who are in foster placement may enroll in the project on an elective
224.20 basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective
224.21 basis. The commissioner may enroll recipients in the prepaid medical assistance program
224.22 for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending
224.23 down excess income.

224.24 (c) The commissioner may allow persons with a one-month spenddown who are otherwise
224.25 eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly
224.26 spenddown to the state.

224.27 (d) The commissioner may require, subject to the opt-out provision under paragraph (a),
224.28 those individuals to enroll in the prepaid medical assistance program who otherwise would
224.29 have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota
224.30 Rules, part 9500.1452, subpart 2, items H, K, and L.

224.31 (e) Before limitation of choice is implemented, eligible individuals shall be notified and
224.32 given the opportunity to opt out of managed care enrollment. After notification, those
224.33 individuals who choose not to opt out shall be allowed to choose only among demonstration
225.1 providers. The commissioner may assign an individual with private coverage through a
225.2 health maintenance organization, to the same health maintenance organization for medical
225.3 assistance coverage, if the health maintenance organization is under contract for medical
225.4 assistance in the individual's county of residence. After initially choosing a provider, the
225.5 recipient is allowed to change that choice only at specified times as allowed by the
225.6 commissioner. If a demonstration provider ends participation in the project for any reason,
225.7 a recipient enrolled with that provider must select a new provider but may change providers
225.8 without cause once more within the first 60 days after enrollment with the second provider.

225.9 (f) An infant born to a woman who is eligible for and receiving medical assistance and
225.10 who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to
225.11 the month of birth in the same managed care plan as the mother once the child is enrolled
225.12 in medical assistance unless the child is determined to be excluded from enrollment in a
225.13 prepaid plan under this section.

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

225.15 Sec. 31. Minnesota Statutes 2020, section 256B.69, subdivision 5c, is amended to read:

225.16 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
225.17 services shall transfer each year to the medical education and research fund established

225.18 under section 62J.692, an amount specified in this subdivision. The commissioner shall
225.19 calculate the following:

225.20 (1) an amount equal to the reduction in the prepaid medical assistance payments as
225.21 specified in this clause. After January 1, 2002, the county medical assistance capitation base
225.22 rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two
225.23 percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan
225.24 Minnesota counties. Nursing facility and elderly waiver payments and demonstration project
225.25 payments operating under subdivision 23 are excluded from this reduction. The amount
225.26 calculated under this clause shall not be adjusted for periods already paid due to subsequent
225.27 changes to the capitation payments;

225.28 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this section;

225.29 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates paid
225.30 under this section; and

225.31 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid under
225.32 this section.

226.1 (b) This subdivision shall be effective upon approval of a federal waiver which allows
226.2 federal financial participation in the medical education and research fund. The amount
226.3 specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred
226.4 for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph
226.5 (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the
226.6 amount specified under paragraph (a), clause (1).

226.7 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
226.8 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

226.9 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer
226.10 under paragraph (c), the commissioner shall transfer to the medical education research fund
226.11 ~~\$23,936,000 in fiscal years 2012 and 2013~~ and \$49,552,000 in fiscal year 2014 and thereafter.

226.12 (e) If the federal waiver described in paragraph (b) is not renewed, the transfer described
226.13 in paragraph (c) and corresponding payments under section 62J.692, subdivision 7, are
226.14 terminated effective the first month in which the waiver is no longer in effect, and the state
226.15 share of the amount described in paragraph (d) must be transferred to the medical education
226.16 and research fund and distributed according to the provisions of section 62J.692, subdivision
226.17 4a.

SENATE ARTICLE 3, SECTION 8 MOVED TO COMPARE WITH HOUSE
ARTICLE 4.

226.18 Sec. 32. Minnesota Statutes 2020, section 256B.69, subdivision 28, is amended to read:

226.19 Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a)

226.20 The commissioner may contract with demonstration providers and current or former sponsors

226.21 of qualified Medicare-approved special needs plans, to provide medical assistance basic

226.22 health care services to persons with disabilities, including those with developmental

226.23 disabilities. Basic health care services include:

226.24 (1) those services covered by the medical assistance state plan except for ICF/DD services,

226.25 home and community-based waiver services, case management for persons with

226.26 developmental disabilities under section 256B.0625, subdivision 20a, and personal care and

226.27 certain home care services defined by the commissioner in consultation with the stakeholder

226.28 group established under paragraph (d); and

226.29 (2) basic health care services may also include risk for up to 100 days of nursing facility

226.30 services for persons who reside in a noninstitutional setting and home health services related

226.31 to rehabilitation as defined by the commissioner after consultation with the stakeholder

226.32 group.

227.1 The commissioner may exclude other medical assistance services from the basic health

227.2 care benefit set. Enrollees in these plans can access any excluded services on the same basis

227.3 as other medical assistance recipients who have not enrolled.

227.4 (b) The commissioner may contract with demonstration providers and current and former

227.5 sponsors of qualified Medicare special needs plans, to provide basic health care services

227.6 under medical assistance to persons who are dually eligible for both Medicare and Medicaid

227.7 and those Social Security beneficiaries eligible for Medicaid but in the waiting period for

227.8 Medicare. The commissioner shall consult with the stakeholder group under paragraph (d)

227.9 in developing program specifications for these services. Payment for Medicaid services

227.10 provided under this subdivision for the months of May and June will be made no earlier

227.11 than July 1 of the same calendar year.

227.12 (c) ~~Notwithstanding subdivision 4, beginning January 1, 2012,~~ The commissioner shall

227.13 enroll persons with disabilities in managed care under this section, unless the individual

227.14 chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out

227.15 procedures consistent with applicable enrollment procedures under this section.

227.16 (d) The commissioner shall establish a state-level stakeholder group to provide advice

227.17 on managed care programs for persons with disabilities, including both MnDHO and contracts

227.18 with special needs plans that provide basic health care services as described in paragraphs

227.19 (a) and (b). The stakeholder group shall provide advice on program expansions under this

227.20 subdivision and subdivision 23, including:

227.21 (1) implementation efforts;

227.22 (2) consumer protections; and

- 227.23 (3) program specifications such as quality assurance measures, data collection and
227.24 reporting, and evaluation of costs, quality, and results.
- 227.25 (e) Each plan under contract to provide medical assistance basic health care services
227.26 shall establish a local or regional stakeholder group, including representatives of the counties
227.27 covered by the plan, members, consumer advocates, and providers, for advice on issues that
227.28 arise in the local or regional area.
- 227.29 (f) The commissioner is prohibited from providing the names of potential enrollees to
227.30 health plans for marketing purposes. The commissioner shall mail no more than two sets
227.31 of marketing materials per contract year to potential enrollees on behalf of health plans, at
227.32 the health plan's request. The marketing materials shall be mailed by the commissioner
228.1 within 30 days of receipt of these materials from the health plan. The health plans shall
228.2 cover any costs incurred by the commissioner for mailing marketing materials.
- 228.3 **EFFECTIVE DATE.** This section is effective January 1, 2023.
- 228.4 Sec. 33. Minnesota Statutes 2020, section 256B.69, subdivision 36, is amended to read:
- 228.5 Subd. 36. **Enrollee support system.** (a) The commissioner shall establish an enrollee
228.6 support system that provides support to an enrollee before and during enrollment in a
228.7 managed care plan.
- 228.8 (b) The enrollee support system must:
- 228.9 (1) provide access to counseling for each potential enrollee on choosing a managed care
228.10 plan or opting out of managed care;
- 228.11 (2) assist an enrollee in understanding enrollment in a managed care plan;
- 228.12 (3) provide an access point for complaints regarding enrollment, covered services, and
228.13 other related matters;
- 228.14 (4) provide information on an enrollee's grievance and appeal rights within the managed
228.15 care organization and the state's fair hearing process, including an enrollee's rights and
228.16 responsibilities; and
- 228.17 (5) provide assistance to an enrollee, upon request, in navigating the grievance and
228.18 appeals process within the managed care organization and in appealing adverse benefit
228.19 determinations made by the managed care organization to the state's fair hearing process
228.20 after the managed care organization's internal appeals process has been exhausted. Assistance
228.21 does not include providing representation to an enrollee at the state's fair hearing, but may
228.22 include a referral to appropriate legal representation sources.
- 228.23 (c) Outreach to enrollees through the support system must be accessible to an enrollee
228.24 through multiple formats, including telephone, Internet, in-person, and, if requested, through
228.25 auxiliary aids and services.

228.26 (d) The commissioner may designate enrollment brokers to assist enrollees on selecting
228.27 a managed care organization and providing necessary enrollment information. For purposes
228.28 of this subdivision, "enrollment broker" means an individual or entity that performs choice
228.29 counseling or enrollment activities in accordance with Code of Federal Regulations, part
228.30 42, section 438.810, or both.

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

229.1 Sec. 34. Minnesota Statutes 2020, section 256B.692, subdivision 1, is amended to read:

229.2 Subdivision 1. **In general.** County boards or groups of county boards may elect to
229.3 purchase or provide health care services on behalf of persons eligible for medical assistance
229.4 who would otherwise be required to or may elect to participate in the prepaid medical
229.5 assistance program according to section 256B.69, subject to the opt-out provision of section
229.6 256B.69, subdivision 4, paragraph (a). Counties that elect to purchase or provide health
229.7 care under this section must provide all services included in prepaid managed care programs
229.8 according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this
229.9 section is governed by section 256B.69, unless otherwise provided for under this section.

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

229.11 Sec. 35. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

229.12 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
229.13 to each potential enrollee the following information:

229.14 (1) basic features of receiving services through managed care;

229.15 (2) which individuals are excluded from managed care enrollment, subject to ~~mandatory~~
229.16 ~~managed care enrollment~~ the opt-out provision of section 256B.69, subdivision 4, paragraph
229.17 (a), or who may choose to enroll voluntarily;

229.18 (3) ~~for mandatory and voluntary enrollment,~~ the length of the enrollment period and
229.19 information about an enrollee's right to disenroll in accordance with Code of Federal
229.20 Regulations, part 42, section 438.56;

229.21 (4) the service area covered by each managed care organization;

229.22 (5) covered services, including services provided by the managed care organization and
229.23 services provided by the commissioner;

229.24 (6) the provider directory and drug formulary for each managed care organization;

229.25 (7) cost-sharing requirements;

229.26 (8) requirements for adequate access to services, including provider network adequacy
229.27 standards;

229.28 (9) a managed care organization's responsibility for coordination of enrollee care; and

229.29 (10) quality and performance indicators, including enrollee satisfaction for each managed
229.30 care organization, if available.

230.1 Sec. 36. Minnesota Statutes 2020, section 256B.6925, subdivision 1, is amended to read:

230.2 Subdivision 1. **Information provided by commissioner.** The commissioner shall provide
230.3 to each potential enrollee the following information:

230.4 (1) basic features of receiving services through managed care;

230.5 (2) which individuals are excluded from managed care enrollment, subject to mandatory
230.6 managed care enrollment, or who may choose to enroll voluntarily;

230.7 (3) for mandatory and voluntary enrollment, the length of the enrollment period and
230.8 information about an enrollee's right to disenroll in accordance with Code of Federal
230.9 Regulations, part 42, section 438.56;

230.10 (4) the service area covered by each managed care organization;

230.11 (5) covered services, including services provided by the managed care organization and
230.12 services provided by the commissioner;

230.13 (6) the provider directory and drug formulary for each managed care organization;

230.14 ~~(7) cost-sharing requirements;~~

230.15 ~~(8) (7)~~ requirements for adequate access to services, including provider network adequacy
230.16 standards;

230.17 ~~(9) (8)~~ a managed care organization's responsibility for coordination of enrollee care;
230.18 and

230.19 ~~(10) (9)~~ quality and performance indicators, including enrollee satisfaction for each
230.20 managed care organization, if available.

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

230.22 Sec. 37. Minnesota Statutes 2020, section 256B.6925, subdivision 2, is amended to read:

230.23 Subd. 2. **Information provided by managed care organization.** The commissioner
230.24 shall ensure that managed care organizations provide to each enrollee the following
230.25 information:

230.26 (1) an enrollee handbook within a reasonable time after receiving notice of the enrollee's
230.27 enrollment. The handbook must, at a minimum, include information on benefits provided,
230.28 how and where to access benefits, ~~cost-sharing requirements~~, how transportation is provided,
230.29 and other information as required by Code of Federal Regulations, part 42, section 438.10,
230.30 paragraph (g);

231.1 (2) a provider directory for the following provider types: physicians, specialists, hospitals,
231.2 pharmacies, behavioral health providers, and long-term supports and services providers, as

- 231.3 appropriate. The directory must include the provider's name, group affiliation, street address,
231.4 telephone number, website, specialty if applicable, whether the provider accepts new
231.5 enrollees, the provider's cultural and linguistic capabilities as identified in Code of Federal
231.6 Regulations, part 42, section 438.10, paragraph (h), and whether the provider's office
231.7 accommodates people with disabilities;
- 231.8 (3) a drug formulary that includes both generic and name brand medications that are
231.9 covered and each medication tier, if applicable;
- 231.10 (4) written notice of termination of a contracted provider. Within 15 calendar days after
231.11 receipt or issuance of the termination notice, the managed care organization must make a
231.12 good faith effort to provide notice to each enrollee who received primary care from, or was
231.13 seen on a regular basis by, the terminated provider; and
- 231.14 (5) upon enrollee request, the managed care organization's physician incentive plan.
- 231.15 **EFFECTIVE DATE.** This section is effective January 1, 2023.
- 231.16 Sec. 38. Minnesota Statutes 2020, section 256B.6928, subdivision 3, is amended to read:
- 231.17 Subd. 3. **Rate development standards.** (a) In developing capitation rates, the
231.18 commissioner shall:
- 231.19 (1) identify and develop base utilization and price data, including validated encounter
231.20 data and audited financial reports received from the managed care organizations that
231.21 demonstrate experience for the populations served by the managed care organizations, for
231.22 the three most recent and complete years before the rating period;
- 231.23 (2) develop and apply reasonable trend factors, including cost and utilization, to base
231.24 data that are developed from actual experience of the medical assistance population or a
231.25 similar population according to generally accepted actuarial practices and principles;
- 231.26 (3) develop the nonbenefit component of the rate to account for reasonable expenses
231.27 related to the managed care organization's administration; taxes; licensing and regulatory
231.28 fees; contribution to reserves; risk margin; cost of capital and other operational costs
231.29 associated with the managed care organization's provision of covered services to enrollees;
- 231.30 ~~(4) consider the value of cost sharing for rate development purposes, regardless of~~
231.31 ~~whether the managed care organization imposes the cost sharing on the enrollee or the~~
231.32 ~~cost sharing is collected by the provider;~~
- 232.1 ~~(5)~~ (4) make appropriate and reasonable adjustments to account for changes to the base
232.2 data, programmatic changes, changes to nonbenefit components, and any other adjustment
232.3 necessary to establish actuarially sound rates. Each adjustment must reasonably support the
232.4 development of an accurate base data set for purposes of rate setting, reflect the health status
232.5 of the enrolled population, and be developed in accordance with generally accepted actuarial
232.6 principles and practices;

232.7 ~~(5)~~ consider the managed care organization's past medical loss ratio in the development
232.8 of the capitation rates and consider the projected medical loss ratio; and

232.9 ~~(7)~~ (6) select a prospective or retrospective risk adjustment methodology that must be
232.10 developed in a budget-neutral manner consistent with generally accepted actuarial principles
232.11 and practices.

232.12 (b) The base data must be derived from the medical assistance population or, if data on
232.13 the medical assistance population is not available, derived from a similar population and
232.14 adjusted to make the utilization and price data comparable to the medical assistance
232.15 population. Data must be in accordance with actuarial standards for data quality and an
232.16 explanation of why that specific data is used must be provided in the rate certification. If
232.17 the commissioner is unable to base the rates on data that are within the three most recent
232.18 and complete years before the rating period, the commissioner may request an approval
232.19 from the Centers for Medicare and Medicaid Services for an exception. The request must
232.20 describe why an exception is necessary and describe the actions that the commissioner
232.21 intends to take to comply with the request.

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

232.23 Sec. 39. Minnesota Statutes 2020, section 256B.76, subdivision 1, is amended to read:

232.24 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after
232.25 October 1, 1992, the commissioner shall make payments for physician services as follows:

232.26 (1) payment for level one Centers for Medicare and Medicaid Services' common
232.27 procedural coding system codes titled "office and other outpatient services," "preventive
232.28 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical
232.29 care," cesarean delivery and pharmacologic management provided to psychiatric patients,
232.30 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower
232.31 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

232.32 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
232.33 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

233.1 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
233.2 percentile of 1989, less the percent in aggregate necessary to equal the above increases
233.3 except that payment rates for home health agency services shall be the rates in effect on
233.4 September 30, 1992.

233.5 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician
233.6 and professional services shall be increased by three percent over the rates in effect on
233.7 December 31, 1999, except for home health agency and family planning agency services.
233.8 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

233.9 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
233.10 and professional services shall be reduced by five percent, except that for the period July
233.11 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical

233.12 assistance and general assistance medical care programs, over the rates in effect on June
233.13 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
233.14 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
233.15 advanced practice nurses, or physician assistants in a family planning agency or in one of
233.16 the following primary care practices: general practice, general internal medicine, general
233.17 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
233.18 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
233.19 Indian health services. Effective October 1, 2009, payments made to managed care plans
233.20 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
233.21 reflect the payment reduction described in this paragraph.

233.22 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician
233.23 and professional services shall be reduced an additional seven percent over the five percent
233.24 reduction in rates described in paragraph (c). This additional reduction does not apply to
233.25 physical therapy services, occupational therapy services, and speech pathology and related
233.26 services provided on or after July 1, 2010. This additional reduction does not apply to
233.27 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in
233.28 mental health. Effective October 1, 2010, payments made to managed care plans and
233.29 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
233.30 the payment reduction described in this paragraph.

233.31 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
233.32 payment rates for physician and professional services shall be reduced three percent from
233.33 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy
233.34 services, occupational therapy services, and speech pathology and related services.

234.1 (f) Effective for services rendered on or after September 1, 2014, payment rates for
234.2 physician and professional services, including physical therapy, occupational therapy, speech
234.3 pathology, and mental health services shall be increased by five percent from the rates in
234.4 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
234.5 include in the base rate for August 31, 2014, the rate increase provided under section
234.6 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
234.7 rural health centers, and Indian health services. Payments made to managed care plans and
234.8 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

234.9 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical
234.10 therapy, occupational therapy, and speech pathology and related services provided by a
234.11 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
234.12 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments
234.13 made to managed care plans and county-based purchasing plans shall not be adjusted to
234.14 reflect payments under this paragraph.

234.15 (h) Any ratables effective before July 1, 2015, do not apply to early intensive
234.16 developmental and behavioral intervention (EIDBI) benefits described in section 256B.0949.

234.17 (i) Medical assistance may reimburse for the cost incurred to pay the Department of
234.18 Health for metabolic disorder testing of newborns who are medical assistance recipients
234.19 when the sample is collected outside of an inpatient hospital setting or freestanding birth
234.20 center setting because the newborn was born outside of a hospital or freestanding birth
234.21 center or because it is not medically appropriate to collect the sample during the inpatient
234.22 stay for the birth.

234.23 Sec. 40. Minnesota Statutes 2020, section 256L.03, subdivision 5, is amended to read:

234.24 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
234.25 children under the age of 21 and to American Indians as defined in Code of Federal
234.26 Regulations, title 42, section 600.5.

234.27 (b) The commissioner shall adjust co-payments, coinsurance, and deductibles for covered
234.28 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
234.29 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
234.30 services exempt from cost-sharing under state law. The cost-sharing changes described in
234.31 this paragraph shall not be implemented prior to January 1, 2016, or after December 31,
234.32 2022.

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

235.4 (d) Paragraphs (a) to (c) apply only to services provided through December 31, 2022.
235.5 Effective for services provided on or after January 1, 2023, the MinnesotaCare program
235.6 shall not require deductibles, co-payments, coinsurance, or any other form of enrollee
235.7 cost-sharing.

235.8 Sec. 41. Minnesota Statutes 2020, section 256L.04, subdivision 1c, is amended to read:

235.9 Subd. 1c. **General requirements.** To be eligible for MinnesotaCare, a person must meet
235.10 the eligibility requirements of this section. A person eligible for MinnesotaCare ~~shall~~ with
235.11 an income less than or equal to 200 percent of the federal poverty guidelines must not be
235.12 considered a qualified individual under section 1312 of the Affordable Care Act, and is not
235.13 eligible for enrollment in a qualified health plan offered through MNSure under chapter
235.14 62V.

235.15 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
235.16 whichever is later, but only if the commissioner of human services certifies to the legislature
235.17 that implementation of this section will not result in federal penalties to federal basic health
235.18 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
235.19 the federal poverty guidelines. The commissioner of human services shall notify the revisor
235.20 of statutes when federal approval is obtained.

235.21 Sec. 42. Minnesota Statutes 2020, section 256L.04, subdivision 7a, is amended to read:

235.22 Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under
235.23 this section may not enroll in the MinnesotaCare program, except as provided in subdivision
235.24 15.

235.25 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
235.26 whichever is later, but only if the commissioner of human services certifies to the legislature
235.27 that implementation of this section will not result in federal penalties to federal basic health
235.28 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
235.29 the federal poverty guidelines. The commissioner of human services shall notify the revisor
235.30 of statutes when federal approval is obtained.

236.1 Sec. 43. Minnesota Statutes 2020, section 256L.04, is amended by adding a subdivision
236.2 to read:

236.3 Subd. 15. **Persons eligible for public option.** (a) Families and individuals with income
236.4 above the maximum income eligibility limit specified in subdivision 1 or 7, who meet all
236.5 other MinnesotaCare eligibility requirements, are eligible for MinnesotaCare. All other
236.6 provisions of this chapter apply unless otherwise specified.

236.7 (b) Families and individuals may enroll in MinnesotaCare under this subdivision only
236.8 during an annual open enrollment period or special enrollment period, as designated by
236.9 MNsure in compliance with Code of Federal Regulations, title 45, parts 155.410 and 155.420.

236.10 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
236.11 whichever is later, but only if the commissioner of human services certifies to the legislature
236.12 that implementation of this section will not result in federal penalties to federal basic health
236.13 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
236.14 the federal poverty guidelines. The commissioner of human services shall notify the revisor
236.15 of statutes when federal approval is obtained.

236.16 Sec. 44. Minnesota Statutes 2020, section 256L.07, subdivision 1, is amended to read:

236.17 Subdivision 1. **General requirements.** Individuals enrolled in MinnesotaCare under
236.18 section 256L.04, subdivision 1, and individuals enrolled in MinnesotaCare under section
236.19 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty
236.20 guidelines; are no longer eligible for the program and ~~shall~~ must be disenrolled by the
236.21 commissioner, unless the individuals continue MinnesotaCare enrollment through the public
236.22 option under section 256L.04, subdivision 15. For persons disenrolled under this subdivision,
236.23 MinnesotaCare coverage terminates the last day of the calendar month in which the
236.24 commissioner sends advance notice according to Code of Federal Regulations, title 42,
236.25 section 431.211, that indicates the income of a family or individual exceeds program income
236.26 limits.

236.27 **EFFECTIVE DATE.** This section is effective January 1, 2025, or upon federal approval,
236.28 whichever is later, but only if the commissioner of human services certifies to the legislature

236.29 that implementation of this section will not result in federal penalties to federal basic health
 236.30 program funding for MinnesotaCare enrollees with incomes not exceeding 200 percent of
 236.31 the federal poverty guidelines. The commissioner of human services shall notify the revisor
 236.32 of statutes when federal approval is obtained.

237.1 Sec. 45. Minnesota Statutes 2021 Supplement, section 256L.15, subdivision 2, is amended
 237.2 to read:

237.3 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner
 237.4 shall establish a sliding fee scale to determine the percentage of monthly individual or family
 237.5 income that households at different income levels must pay to obtain coverage through the
 237.6 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly
 237.7 individual or family income.

237.8 ~~(b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according~~
 237.9 ~~to the premium scale specified in paragraph (d).~~

237.10 ~~(e) (b) Paragraph (b) (a) does not apply to:~~

237.11 ~~(1) children 20 years of age or younger; and,~~

237.12 ~~(2) individuals with household incomes below 35 percent of the federal poverty~~
 237.13 ~~guidelines.~~

237.14 ~~(d) The following premium scale is established for each individual in the household who~~
 237.15 ~~is 21 years of age or older and enrolled in MinnesotaCare:~~

237.16	Federal Poverty Guideline	Less than	Individual Premium
237.17	Greater than or Equal to		Amount
237.18	35%	55%	\$4
237.19	55%	80%	\$6
237.20	80%	90%	\$8
237.21	90%	100%	\$10
237.22	100%	110%	\$12
237.23	110%	120%	\$14
237.24	120%	130%	\$15
237.25	130%	140%	\$16
237.26	140%	150%	\$25

237.27	150%	160%	\$37
237.28	160%	170%	\$44
237.29	170%	180%	\$52
237.30	180%	190%	\$61
237.31	190%	200%	\$71
237.32	200%		\$80

237.33 ~~(c)~~ (c) Beginning January 1, ~~2021~~ 2023, the commissioner shall continue to charge
 237.34 premiums in accordance with the simplified premium scale established to comply with the
 238.1 American Rescue Plan Act of 2021, in effect from January 1, 2021, through December 31,
 238.2 2022, for families and individuals eligible under section 256L.04, subdivisions 1 and 7. The
 238.3 commissioner shall adjust the premium scale established under paragraph (d) as needed to
 238.4 ensure that premiums do not exceed the amount that an individual would have been required
 238.5 to pay if the individual was enrolled in an applicable benchmark plan in accordance with
 238.6 the Code of Federal Regulations, title 42, section 600.505 (a)(1).

238.7 (d) The commissioner shall establish a sliding premium scale for persons eligible through
 238.8 the buy-in option under section 256L.04, subdivision 15. Beginning January 1, 2025, persons
 238.9 eligible through the buy-in option shall pay premiums according to the premium scale
 238.10 established by the commissioner. Persons 20 years of age or younger are exempt from
 238.11 paying premiums.

238.12 **EFFECTIVE DATE.** This section is effective January 1, 2023, except that the sliding
 238.13 premium scale established under paragraph (d) is effective January 1, 2025, or upon federal
 238.14 approval, whichever is later, but only if the commissioner of human services certifies to the
 238.15 legislature that implementation of paragraph (d) will not result in federal penalties to federal
 238.16 basic health program funding for MinnesotaCare enrollees with incomes not exceeding 200
 238.17 percent of the federal poverty guidelines. The commissioner of human services shall notify
 238.18 the revisor of statutes when federal approval is obtained.

238.19 Sec. 46. Laws 2015, chapter 71, article 14, section 2, subdivision 5, as amended by Laws
 238.20 2015, First Special Session chapter 6, section 1, is amended to read:

238.21 **Subd. 5. Grant Programs**

238.22 The amounts that may be spent from this
 238.23 appropriation for each purpose are as follows:

238.24 **(a) Support Services Grants**

238.25 Appropriations by Fund

238.26 General 13,133,000 8,715,000

238.27 Federal TANF 96,311,000 96,311,000

238.28 (b) **Basic Sliding Fee Child Care Assistance**

238.29 **Grants** 48,439,000 51,559,000

238.30 **Basic Sliding Fee Waiting List Allocation.**

238.31 Notwithstanding Minnesota Statutes, section

238.32 119B.03, \$5,413,000 in fiscal year 2016 is to

239.1 reduce the basic sliding fee program waiting

239.2 list as follows:

239.3 (1) The calendar year 2016 allocation shall be
239.4 increased to serve families on the waiting list.

239.5 To receive funds appropriated for this purpose,
239.6 a county must have:

239.7 (i) a waiting list in the most recent published
239.8 waiting list month;

239.9 (ii) an average of at least ten families on the
239.10 most recent six months of published waiting
239.11 list; and

239.12 (iii) total expenditures in calendar year 2014
239.13 that met or exceeded 80 percent of the county's
239.14 available final allocation.

239.15 (2) Funds shall be distributed proportionately
239.16 based on the average of the most recent six
239.17 months of published waiting lists to counties
239.18 that meet the criteria in clause (1).

239.19 (3) Allocations in calendar years 2017 and
239.20 beyond shall be calculated using the allocation
239.21 formula in Minnesota Statutes, section
239.22 119B.03.

239.23 (4) The guaranteed floor for calendar year
239.24 2017 shall be based on the revised calendar
239.25 year 2016 allocation.

239.26 **Base Level Adjustment.** The general fund
239.27 base is increased by \$810,000 in fiscal year

239.28 2018 and increased by \$821,000 in fiscal year
239.29 2019.

239.30 (c) **Child Care Development Grants** 1,737,000 1,737,000

239.31 (d) **Child Support Enforcement Grants** 50,000 50,000

239.32 (e) **Children's Services Grants**

240.1 Appropriations by Fund

240.2 General 39,015,000 38,665,000

240.3 Federal TANF 140,000 140,000

240.4 **Safe Place for Newborns.** \$350,000 from the
240.5 general fund in fiscal year 2016 is to distribute
240.6 information on the Safe Place for Newborns
240.7 law in Minnesota to increase public awareness
240.8 of the law. This is a onetime appropriation.

240.9 **Child Protection.** \$23,350,000 in fiscal year
240.10 2016 and \$23,350,000 in fiscal year 2017 are
240.11 to address child protection staffing and
240.12 services under Minnesota Statutes, section
240.13 256M.41. \$1,650,000 in fiscal year 2016 and
240.14 \$1,650,000 in fiscal year 2017 are for child
240.15 protection grants to address child welfare
240.16 disparities under Minnesota Statutes, section
240.17 256E.28.

240.18 **Title IV-E Adoption Assistance.** Additional
240.19 federal reimbursement to the state as a result
240.20 of the Fostering Connections to Success and
240.21 Increasing Adoptions Act's expanded
240.22 eligibility for title IV-E adoption assistance is
240.23 appropriated to the commissioner for
240.24 postadoption services, including a
240.25 parent-to-parent support network.

240.26 **Adoption Assistance Incentive Grants.**
240.27 Federal funds available during fiscal years
240.28 2016 and 2017 for adoption incentive grants
240.29 are appropriated to the commissioner for

240.30 postadoption services, including a
240.31 parent-to-parent support network.

240.32 (f) **Children and Community Service Grants** 56,301,000 56,301,000

240.33 (g) **Children and Economic Support Grants** 26,778,000 26,966,000

241.1 **Mobile Food Shelf Grants.** (a) \$1,000,000
241.2 in fiscal year 2016 and \$1,000,000 in fiscal
241.3 year 2017 are for a grant to Hunger Solutions.
241.4 This is a onetime appropriation and is
241.5 available until June 30, 2017.

241.6 (b) Hunger Solutions shall award grants of up
241.7 to \$75,000 on a competitive basis. Grant
241.8 applications must include:

241.9 (1) the location of the project;

241.10 (2) a description of the mobile program,
241.11 including size and scope;

241.12 (3) evidence regarding the unserved or
241.13 underserved nature of the community in which
241.14 the project is to be located;

241.15 (4) evidence of community support for the
241.16 project;

241.17 (5) the total cost of the project;

241.18 (6) the amount of the grant request and how
241.19 funds will be used;

241.20 (7) sources of funding or in-kind contributions
241.21 for the project that will supplement any grant
241.22 award;

241.23 (8) a commitment to mobile programs by the
241.24 applicant and an ongoing commitment to
241.25 maintain the mobile program; and

241.26 (9) any additional information requested by
241.27 Hunger Solutions.

241.28 (c) Priority may be given to applicants who:

241.29 (1) serve underserved areas;

241.30 (2) create a new or expand an existing mobile
241.31 program;

242.1 (3) serve areas where a high amount of need
242.2 is identified;

242.3 (4) provide evidence of strong support for the
242.4 project from citizens and other institutions in
242.5 the community;

242.6 (5) leverage funding for the project from other
242.7 private and public sources; and

242.8 (6) commit to maintaining the program on a
242.9 multilayer basis.

242.10 **Homeless Youth Act.** At least \$500,000 of
242.11 the appropriation for the Homeless Youth Act
242.12 must be awarded to providers in greater
242.13 Minnesota, with at least 25 percent of this
242.14 amount for new applicant providers. The
242.15 commissioner shall provide outreach and
242.16 technical assistance to greater Minnesota
242.17 providers and new providers to encourage
242.18 responding to the request for proposals.

242.19 **Stearns County Veterans Housing.** \$85,000
242.20 in fiscal year 2016 and \$85,000 in fiscal year
242.21 2017 are for a grant to Stearns County to
242.22 provide administrative funding in support of
242.23 a service provider serving veterans in Stearns
242.24 County. The administrative funding grant may
242.25 be used to support group residential housing
242.26 services, corrections-related services, veteran
242.27 services, and other social services related to
242.28 the service provider serving veterans in
242.29 Stearns County.

242.30 **Safe Harbor.** \$800,000 in fiscal year 2016
242.31 and \$800,000 in fiscal year 2017 are from the
242.32 general fund for emergency shelter and
242.33 transitional and long-term housing beds for
242.34 sexually exploited youth and youth at risk of
243.1 sexual exploitation. Of this appropriation,
243.2 \$150,000 in fiscal year 2016 and \$150,000 in
243.3 fiscal year 2017 are from the general fund for

243.4 statewide youth outreach workers connecting
 243.5 sexually exploited youth and youth at risk of
 243.6 sexual exploitation with shelter and services.

243.7 **Minnesota Food Assistance Program.**
 243.8 Unexpended funds for the Minnesota food
 243.9 assistance program for fiscal year 2016 do not
 243.10 cancel but are available for this purpose in
 243.11 fiscal year 2017.

243.12 **Base Level Adjustment.** The general fund
 243.13 base is decreased by \$816,000 in fiscal year
 243.14 2018 and is decreased by \$606,000 in fiscal
 243.15 year 2019.

243.16 (h) **Health Care Grants**

243.17	Appropriations by Fund		
243.18	General	536,000	2,482,000
243.19	Health Care Access	3,341,000	3,465,000

243.20 **Grants for Periodic Data Matching for**
 243.21 **Medical Assistance and MinnesotaCare.** Of
 243.22 the general fund appropriation, \$26,000 in
 243.23 fiscal year 2016 and \$1,276,000 in fiscal year
 243.24 2017 are for grants to counties for costs related
 243.25 to periodic data matching for medical
 243.26 assistance and MinnesotaCare recipients under
 243.27 Minnesota Statutes, section 256B.0561. The
 243.28 commissioner must distribute these grants to
 243.29 counties in proportion to each county's number
 243.30 of cases in the prior year in the affected
 243.31 programs.

243.32 **Base Level Adjustment.** The general fund
 243.33 base is ~~increased by \$1,637,000 in fiscal year~~
 243.34 ~~2018 and increased by \$1,229,000 in fiscal~~
 244.1 ~~year 2019~~ maintained in fiscal years 2020 and
 244.2 2021.

244.3	(i) Other Long-Term Care Grants	1,551,000	3,069,000
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244.4 **Transition Populations.** \$1,551,000 in fiscal
 244.5 year 2016 and \$1,725,000 in fiscal year 2017
 244.6 are for home and community-based services
 244.7 transition grants to assist in providing home
 244.8 and community-based services and treatment
 244.9 for transition populations under Minnesota
 244.10 Statutes, section 256.478.

244.11 **Base Level Adjustment.** The general fund
 244.12 base is increased by \$156,000 in fiscal year
 244.13 2018 and by \$581,000 in fiscal year 2019.

244.14 (j) Aging and Adult Services Grants	28,463,000	28,162,000
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244.15 **Dementia Grants.** \$750,000 in fiscal year
 244.16 2016 and \$750,000 in fiscal year 2017 are for
 244.17 the Minnesota Board on Aging for regional
 244.18 and local dementia grants authorized in
 244.19 Minnesota Statutes, section 256.975,
 244.20 subdivision 11.

244.21 (k) Deaf and Hard-of-Hearing Grants	2,225,000	2,375,000
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244.22 **Deaf, Deafblind, and Hard-of-Hearing**
 244.23 **Grants.** \$350,000 in fiscal year 2016 and
 244.24 \$500,000 in fiscal year 2017 are for deaf and
 244.25 hard-of-hearing grants. The funds must be
 244.26 used to increase the number of deafblind
 244.27 Minnesotans receiving services under
 244.28 Minnesota Statutes, section 256C.261, and to
 244.29 provide linguistically and culturally
 244.30 appropriate mental health services to children
 244.31 who are deaf, deafblind, and hard-of-hearing.
 244.32 This is a onetime appropriation.

245.1 **Base Level Adjustment.** The general fund
 245.2 base is decreased by \$500,000 in fiscal year
 245.3 2018 and by \$500,000 in fiscal year 2019.

245.4 (l) Disabilities Grants	20,820,000	20,858,000
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245.5 **State Quality Council.** \$573,000 in fiscal
 245.6 year 2016 and \$600,000 in fiscal year 2017
 245.7 are for the State Quality Council to provide

245.8 technical assistance and monitoring of
 245.9 person-centered outcomes related to inclusive
 245.10 community living and employment. The
 245.11 funding must be used by the State Quality
 245.12 Council to assure a statewide plan for systems
 245.13 change in person-centered planning that will
 245.14 achieve desired outcomes including increased
 245.15 integrated employment and community living.

245.16 (m) **Adult Mental Health Grants**

245.17	Appropriations by Fund		
245.18	General	69,992,000	71,244,000
245.19	Health Care Access	1,575,000	2,473,000
245.20	Lottery Prize	1,733,000	1,733,000

245.21 **Funding Usage.** Up to 75 percent of a fiscal
 245.22 year's appropriation for adult mental health
 245.23 grants may be used to fund allocations in that
 245.24 portion of the fiscal year ending December
 245.25 31.

245.26 **Culturally Specific Mental Health Services.**
 245.27 \$100,000 in fiscal year 2016 is for grants to
 245.28 nonprofit organizations to provide resources
 245.29 and referrals for culturally specific mental
 245.30 health services to Southeast Asian veterans
 245.31 born before 1965 who do not qualify for
 245.32 services available to veterans formally
 245.33 discharged from the United States armed
 245.34 forces.

246.1 **Problem Gambling.** \$225,000 in fiscal year
 246.2 2016 and \$225,000 in fiscal year 2017 are
 246.3 from the lottery prize fund for a grant to the
 246.4 state affiliate recognized by the National
 246.5 Council on Problem Gambling. The affiliate
 246.6 must provide services to increase public
 246.7 awareness of problem gambling, education,
 246.8 and training for individuals and organizations
 246.9 providing effective treatment services to

246.10 problem gamblers and their families, and
246.11 research related to problem gambling.

246.12 **Sustainability Grants.** \$2,125,000 in fiscal
246.13 year 2016 and \$2,125,000 in fiscal year 2017
246.14 are for sustainability grants under Minnesota
246.15 Statutes, section 256B.0622, subdivision 11.

246.16 **Beltrami County Mental Health Services**
246.17 **Grant.** \$1,000,000 in fiscal year 2016 and
246.18 \$1,000,000 in fiscal year 2017 are from the
246.19 general fund for a grant to Beltrami County
246.20 to fund the planning and development of a
246.21 comprehensive mental health services program
246.22 under article 2, section 41, Comprehensive
246.23 Mental Health Program in Beltrami County.
246.24 This is a onetime appropriation.

246.25 **Base Level Adjustment.** The general fund
246.26 base is increased by \$723,000 in fiscal year
246.27 2018 and by \$723,000 in fiscal year 2019. The
246.28 health care access fund base is decreased by
246.29 \$1,723,000 in fiscal year 2018 and by
246.30 \$1,723,000 in fiscal year 2019.

246.31 (n) **Child Mental Health Grants** 23,386,000 24,313,000

246.32 **Services and Supports for First Episode**
246.33 **Psychosis.** \$177,000 in fiscal year 2017 is for
246.34 grants under Minnesota Statutes, section
247.1 245.4889, to mental health providers to pilot
247.2 evidence-based interventions for youth at risk
247.3 of developing or experiencing a first episode
247.4 of psychosis and for a public awareness
247.5 campaign on the signs and symptoms of
247.6 psychosis. The base for these grants is
247.7 \$236,000 in fiscal year 2018 and \$301,000 in
247.8 fiscal year 2019.

247.9 **Adverse Childhood Experiences.** The base
247.10 for grants under Minnesota Statutes, section
247.11 245.4889, to children's mental health and
247.12 family services collaboratives for adverse
247.13 childhood experiences (ACEs) training grants
247.14 and for an interactive Web site connection to

247.15 support ACEs in Minnesota is \$363,000 in
247.16 fiscal year 2018 and \$363,000 in fiscal year
247.17 2019.

247.18 **Funding Usage.** Up to 75 percent of a fiscal
247.19 year's appropriation for child mental health
247.20 grants may be used to fund allocations in that
247.21 portion of the fiscal year ending December
247.22 31.

247.23 **Base Level Adjustment.** The general fund
247.24 base is increased by \$422,000 in fiscal year
247.25 2018 and is increased by \$487,000 in fiscal
247.26 year 2019.

247.27 **(o) Chemical Dependency Treatment Support**
247.28 **Grants**

1,561,000

1,561,000

247.29 **Chemical Dependency Prevention.** \$150,000
247.30 in fiscal year 2016 and \$150,000 in fiscal year
247.31 2017 are for grants to nonprofit organizations
247.32 to provide chemical dependency prevention
247.33 programs in secondary schools. When making
247.34 grants, the commissioner must consider the
247.35 expertise, prior experience, and outcomes
248.1 achieved by applicants that have provided
248.2 prevention programming in secondary
248.3 education environments. An applicant for the
248.4 grant funds must provide verification to the
248.5 commissioner that the applicant has available
248.6 and will contribute sufficient funds to match
248.7 the grant given by the commissioner. This is
248.8 a onetime appropriation.

248.9 **Fetal Alcohol Syndrome Grants.** \$250,000
248.10 in fiscal year 2016 and \$250,000 in fiscal year
248.11 2017 are for grants to be administered by the
248.12 Minnesota Organization on Fetal Alcohol
248.13 Syndrome to provide comprehensive,
248.14 gender-specific services to pregnant and
248.15 parenting women suspected of or known to
248.16 use or abuse alcohol or other drugs. This
248.17 appropriation is for grants to no fewer than
248.18 three eligible recipients. Minnesota
248.19 Organization on Fetal Alcohol Syndrome must

248.20 report to the commissioner of human services
248.21 annually by January 15 on the grants funded
248.22 by this appropriation. The report must include
248.23 measurable outcomes for the previous year,
248.24 including the number of pregnant women
248.25 served and the number of toxic-free babies
248.26 born.

248.27 **Base Level Adjustment.** The general fund
248.28 base is decreased by \$150,000 in fiscal year
248.29 2018 and by \$150,000 in fiscal year 2019.

248.30 Sec. 47. Laws 2020, First Special Session chapter 7, section 1, subdivision 1, as amended
248.31 by Laws 2021, First Special Session chapter 7, article 2, section 71, is amended to read:

248.32 Subdivision 1. **Waivers and modifications; federal funding extension.** When the
248.33 peacetime emergency declared by the governor in response to the COVID-19 outbreak
248.34 expires, is terminated, or is rescinded by the proper authority, the following waivers and
249.1 modifications to human services programs issued by the commissioner of human services
249.2 pursuant to Executive Orders 20-11 and 20-12 that are required to comply with federal law
249.3 may remain in effect for the time period set out in applicable federal law or for the time
249.4 period set out in any applicable federally approved waiver or state plan amendment,
249.5 whichever is later:

249.6 (1) CV15: allowing telephone or video visits for waiver programs;

249.7 (2) CV17: preserving health care coverage for Medical Assistance and MinnesotaCare
249.8 as needed to comply with federal guidance from the Centers for Medicare and Medicaid
249.9 Services, and until the enrollee's first renewal following the resumption of medical assistance
249.10 and MinnesotaCare renewals after the end of the COVID-19 public health emergency
249.11 declared by the United States Secretary of Health and Human Services;

249.12 (3) CV18: implementation of federal changes to the Supplemental Nutrition Assistance
249.13 Program;

249.14 (4) CV20: eliminating cost-sharing for COVID-19 diagnosis and treatment;

249.15 (5) CV24: allowing telephone or video use for targeted case management visits;

249.16 (6) CV30: expanding telemedicine in health care, mental health, and substance use
249.17 disorder settings;

249.18 (7) CV37: implementation of federal changes to the Supplemental Nutrition Assistance
249.19 Program;

249.20 (8) CV39: implementation of federal changes to the Supplemental Nutrition Assistance
249.21 Program;

- 249.22 (9) CV42: implementation of federal changes to the Supplemental Nutrition Assistance
249.23 Program;
- 249.24 (10) CV43: expanding remote home and community-based waiver services;
- 249.25 (11) CV44: allowing remote delivery of adult day services;
- 249.26 (12) CV59: modifying eligibility period for the federally funded Refugee Cash Assistance
249.27 Program;
- 249.28 (13) CV60: modifying eligibility period for the federally funded Refugee Social Services
249.29 Program; and
- 249.30 (14) CV109: providing 15 percent increase for Minnesota Food Assistance Program and
249.31 Minnesota Family Investment Program maximum food benefits.
- 250.1 Sec. 48. Laws 2021, First Special Session chapter 7, article 1, section 36, is amended to
250.2 read:
- 250.3 Sec. 36. **RESPONSE TO COVID-19 PUBLIC HEALTH EMERGENCY.**
- 250.4 (a) Notwithstanding Minnesota Statutes, section 256B.057, subdivision 9, 256L.06,
250.5 subdivision 3, or any other provision to the contrary, the commissioner shall not collect any
250.6 unpaid premium for a coverage month ~~that occurred during~~ until the enrollee's first renewal
250.7 after the resumption of medical assistance renewals following the end of the COVID-19
250.8 public health emergency declared by the United States Secretary of Health and Human
250.9 Services.
- 250.10 (b) Notwithstanding any provision to the contrary, periodic data matching under
250.11 Minnesota Statutes, section 256B.0561, subdivision 2, may be suspended for up to ~~six~~ 12
250.12 months following the last day of resumption of medical assistance and MinnesotaCare
250.13 renewals after the end of the COVID-19 public health emergency declared by the United
250.14 States Secretary of Health and Human Services.
- 250.15 (c) Notwithstanding any provision to the contrary, the requirement for the commissioner
250.16 of human services to issue an annual report on periodic data matching under Minnesota
250.17 Statutes, section 256B.0561, is suspended for one year following the last day of the
250.18 COVID-19 public health emergency declared by the United States Secretary of Health and
250.19 Human Services.
- 250.20 (d) The commissioner of human services shall take necessary actions to comply with
250.21 federal guidance pertaining to the appropriate redetermination of medical assistance enrollee
250.22 eligibility following the end of the COVID-19 public health emergency declared by the
250.23 United States Secretary of Health and Human Services and may waive currently existing
250.24 Minnesota statutes to the minimum level necessary to achieve federal compliance. All
250.25 changes implemented must be reported to the chairs and ranking minority members of the
250.26 legislative committees with jurisdiction over human services within 90 days.

250.27 Sec. 49. **DENTAL HOME PILOT PROJECT.**

250.28 Subdivision 1. **Establishment; requirements.** (a) The commissioner of human services
250.29 shall establish a dental home pilot project to increase access of medical assistance and
250.30 MinnesotaCare enrollees to dental care, improve patient experience, and improve oral health
250.31 clinical outcomes, in a manner that sustains the financial viability of the dental workforce
250.32 and broader dental care delivery and financing system. Dental homes must provide
251.1 high-quality, patient-centered, comprehensive, and coordinated oral health services across
251.2 clinical and community-based settings, including virtual oral health care.

251.3 (b) The design and operation of the dental home pilot project must be consistent with
251.4 the recommendations made by the Dental Services Advisory Committee to the legislature
251.5 under Laws 2021, First Special Session chapter 7, article 1, section 33.

251.6 (c) The commissioner shall establish baseline requirements and performance measures
251.7 for dental homes participating in the pilot project. These baseline requirements and
251.8 performance measures must address access and patient experience and oral health clinical
251.9 outcomes.

251.10 Subd. 2. **Project design and timeline.** (a) The commissioner shall issue a preliminary
251.11 project description and a request for information to obtain stakeholder feedback and input
251.12 on project design issues, including but not limited to:

251.13 (1) the timeline for project implementation;

251.14 (2) the length of each project phase and the date for full project implementation;

251.15 (3) the number of providers to be selected for participation;

251.16 (4) grant amounts;

251.17 (5) criteria and procedures for any value-based payments;

251.18 (6) the extent to which pilot project requirements may vary with provider characteristics;

251.19 (7) procedures for data collection;

251.20 (8) the role of dental partners, such as dental professional organizations and educational
251.21 institutions;

251.22 (9) provider support and education; and

251.23 (10) other topics identified by the commissioner.

251.24 (b) The commissioner shall consider the feedback and input obtained in paragraph (a)
251.25 and shall develop and issue a request for proposals for participation in the pilot project.

251.26 (c) The pilot project must be implemented by July 1, 2023, and must include initial pilot
251.27 testing and the collection and analysis of data on baseline requirements and performance
251.28 measures to evaluate whether these requirements and measures are appropriate. Under this

- 251.29 phase, the commissioner shall provide grants to individual providers and provider networks
251.30 in addition to medical assistance and MinnesotaCare payments received for services provided.
- 252.1 (d) The pilot project may test and analyze value-based payments to providers to determine
252.2 whether varying payments based on dental home performance measures is appropriate and
252.3 effective.
- 252.4 (e) The commissioner shall ensure provider diversity in selecting project participants.
252.5 In selecting providers, the commissioner shall consider: geographic distribution; provider
252.6 size, type, and location; providers serving different priority populations; health equity issues;
252.7 and provider accessibility for patients with varying levels and types of disability.
- 252.8 (f) In designing and implementing the pilot project, the commissioner shall regularly
252.9 consult with project participants and other stakeholders, and as relevant shall continue to
252.10 seek the input of participants and other stakeholders on the topics listed in paragraph (a).
- 252.11 Subd. 3. **Reporting.** (a) The commissioner, beginning February 15, 2023, and each
252.12 February 15 thereafter for the duration of the demonstration project, shall report on the
252.13 design, implementation, operation, and results of the demonstration project to the chairs
252.14 and ranking minority members of the legislative committees with jurisdiction over health
252.15 care finance and policy.
- 252.16 (b) The commissioner, within six months from the date the pilot project ceases operation,
252.17 shall report to the chairs and ranking minority members of the legislative committees with
252.18 jurisdiction over health care finance and policy on the results of the demonstration project,
252.19 and shall include in the report recommendations on whether the demonstration project, or
252.20 specific features of the demonstration project, should be extended to all dental providers
252.21 serving medical assistance and MinnesotaCare enrollees.
- 252.22 **Sec. 50. SMALL EMPLOYER PUBLIC OPTION.**
- 252.23 The commissioner of human services, in consultation with representatives of small
252.24 employers, shall develop a small employer public option that allows employees of businesses
252.25 with fewer than 50 employees to receive employer contributions toward MinnesotaCare.
252.26 The commissioner shall determine whether the employer makes contributions to the
252.27 commissioner directly or the employee makes contributions through a qualified small
252.28 employer health reimbursement arrangement account or other arrangement. In determining
252.29 the structure of the small employer public option, the commissioner shall consult with
252.30 federal officials to determine which arrangement will result in the employer contributions
252.31 being tax deductible to the employer and not being considered taxable income to the
252.32 employee. The commissioner shall present recommendations for a small employer public
252.33 option to the chairs and ranking minority members of the legislative committees with
252.34 jurisdiction over health and human services policy and finance by December 15, 2023.
- 253.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

253.2 Sec. 51. **TRANSITION TO MINNESOTACARE PUBLIC OPTION.**

253.3 (a) The commissioner of human services shall continue to administer MinnesotaCare
253.4 as a basic health program in accordance with Minnesota Statutes, section 256L.02,
253.5 subdivision 5, and shall seek federal waivers, approvals, and law changes necessary to
253.6 implement this act.

253.7 (b) The commissioner shall present an implementation plan for the MinnesotaCare public
253.8 option under Minnesota Statutes, section 256L.04, subdivision 15, to the chairs and ranking
253.9 minority members of the legislative committees with jurisdiction over health care policy
253.10 and finance by December 15, 2023. The plan must include:

253.11 (1) recommendations for any changes to the MinnesotaCare public option necessary to
253.12 continue federal basic health program funding or to receive other federal funding;

253.13 (2) recommendations for implementing any small employer option in a manner that
253.14 would allow any employee payments toward premiums to be pretax;

253.15 (3) recommendations for ensuring sufficient provider participation in MinnesotaCare;

253.16 (4) estimates of state costs related to the MinnesotaCare public option;

253.17 (5) a description of the proposed premium scale for persons eligible through the public
253.18 option, including an analysis of the extent to which the proposed premium scale:

253.19 (i) ensures affordable premiums for persons across the income spectrum enrolled under
253.20 the public option; and

253.21 (ii) avoids premium cliffs for persons transitioning to and enrolled under the public
253.22 option; and

253.23 (6) draft legislation that includes any additional policy and conforming changes necessary
253.24 to implement the MinnesotaCare public option and the implementation plan
253.25 recommendations.

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

253.27 Sec. 52. **REQUEST FOR FEDERAL APPROVAL.**

253.28 (a) The commissioner of human services shall seek any federal waivers, approvals, and
253.29 law changes necessary to implement this act, including but not limited to those waivers,
253.30 approvals, and law changes necessary to allow the state to:

254.1 (1) continue receiving federal basic health program payments for basic health
254.2 program-eligible MinnesotaCare enrollees and to receive other federal funding for the
254.3 MinnesotaCare public option; and

254.4 (2) receive federal payments equal to the value of premium tax credits and cost-sharing
254.5 reductions that MinnesotaCare enrollees with household incomes greater than 200 percent
254.6 of the federal poverty guidelines would otherwise have received.

254.7 (b) In implementing this section, the commissioner of human services shall consult with
254.8 the commissioner of commerce and the Board of Directors of MNsure and may contract
254.9 for technical and actuarial assistance.

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

254.11 Sec. 53. **DELIVERY REFORM ANALYSIS REPORT.**

254.12 (a) The commissioner of human services shall present to the chairs and ranking minority
254.13 members of the legislative committees with jurisdiction over health care policy and finance,
254.14 by January 15, 2024, a report comparing service delivery and payment system models for
254.15 delivering services to medical assistance enrollees for whom income eligibility is determined
254.16 using the modified adjusted gross income methodology under Minnesota Statutes, section
254.17 256B.056, subdivision 1a, paragraph (b), clause (1), and MinnesotaCare enrollees eligible
254.18 under Minnesota Statutes, chapter 256L. The report must compare the current delivery
254.19 model with at least two alternative models. The alternative models must include a state-based
254.20 model in which the state holds the plan risk as the insurer and may contract with a third-party
254.21 administrator for claims processing and plan administration. The alternative models may
254.22 include but are not limited to:

254.23 (1) expanding the use of integrated health partnerships under Minnesota Statutes, section
254.24 256B.0755;

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

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

254.29 (b) The report must include:

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

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

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

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

255.2 (iv) reimbursement of providers for high-quality, value-based care at levels sufficient
255.3 to sustain or increase enrollee access to care; and

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

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

255.6 (3) an implementation timeline for each model that includes the earliest date by which
255.7 each model could be implemented if authorized during the 2024 legislative session and a
255.8 discussion of barriers to implementation.

255.9 **Sec. 54. RECOMMENDATIONS; OFFICE OF PATIENT PROTECTION.**

255.10 (a) The commissioners of human services, health, and commerce and the MNsure board
255.11 shall submit to the health care affordability board and the chairs and ranking minority
255.12 members of the legislative committees with primary jurisdiction over health and human
255.13 services finance and policy and commerce by January 15, 2023, a report on the organization
255.14 and duties of the Office of Patient Protection, to be established under Minnesota Statutes,
255.15 section 62J.89, subdivision 4. The report must include recommendations on how the office
255.16 shall:

255.17 (1) coordinate or consolidate within the office existing state agency patient protection
255.18 activities, including but not limited to the activities of ombudsman offices and the MNsure
255.19 board;

255.20 (2) enforce standards and procedures under Minnesota Statutes, chapter 62M, for
255.21 utilization review organizations;

255.22 (3) work with private sector and state agency consumer assistance programs to assist
255.23 consumers with questions or concerns relating to public programs and private insurance
255.24 coverage;

255.25 (4) establish and implement procedures to assist consumers aggrieved by restrictions on
255.26 patient choice, denials of services, and reductions in quality of care resulting from any final
255.27 action by a payer or provider; and

255.28 (5) make health plan company quality of care and patient satisfaction information and
255.29 other information collected by the office readily accessible to consumers on the board's
255.30 website.

255.31 (b) The commissioners and the MNsure board shall consult with stakeholders as they
255.32 develop the recommendations. The stakeholders consulted must include but are not limited
256.1 to organizations and individuals representing: underserved communities; persons with
256.2 disabilities; low-income Minnesotans; senior citizens; and public and private sector health
256.3 plan enrollees, including persons who purchase coverage through MNsure, health plan
256.4 companies, and public and private sector purchasers of health coverage.

256.5 (c) The commissioners and the MNsure board may contract with a third party to develop
256.6 the report and recommendations.

256.7 **Sec. 55. REPEALER.**

256.8 Minnesota Statutes 2020, section 256B.063, is repealed.

256.9 EFFECTIVE DATE. This section is effective January 1, 2023.

97.14 Sec. 9. DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;
97.15 ENTERAL NUTRITION AND SUPPLIES.

97.16 Notwithstanding Minnesota Statutes, section 256B.766, paragraph (i), but subject to
97.17 Minnesota Statutes, section 256B.766, paragraph (l), effective for dates of service on or
97.18 after the effective date of this section through June 30, 2023, the commissioner of human
97.19 services shall not adjust rates paid for enteral nutrition and supplies.

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

97.21 Sec. 10. TEMPORARY TELEPHONE-ONLY TELEHEALTH AUTHORIZATION.

97.22 Beginning July 1, 2021, and until the COVID-19 federal public health emergency ends
97.23 or July 1, 2023, whichever is earlier, telehealth visits, as described in Minnesota Statutes,
97.24 section 256B.0625, subdivision 3b, provided through telephone may satisfy the face-to-face
97.25 requirements for reimbursement under the payment methods that apply to a federally qualified
97.26 health center, rural health clinic, Indian health service, 638 Tribal clinic, and certified
97.27 community behavioral health clinic, if the service would have otherwise qualified for
97.28 payment if performed in person.

97.29 EFFECTIVE DATE. This section is effective retroactively from July 1, 2021, and
97.30 expires when the COVID-19 federal public health emergency ends or July 1, 2023, whichever
98.1 is earlier. The commissioner of human services shall notify the revisor of statutes when this
98.2 section expires.

98.3 Sec. 11. NONEMERGENCY MEDICAL TRANSPORTATION SPENDING
98.4 REQUIREMENTS.

98.5 (a) At least 80 percent of the marginal increase in revenue from the implementation of
98.6 rate increases in this act under Minnesota Statutes, section 256B.0625, subdivision 17,
98.7 paragraph (m), clauses (3) to (5), for services rendered on or after the day of implementation
98.8 of the rate increases must be used to increase compensation-related costs for drivers.

98.9 (b) For the purposes of this subdivision, compensation-related costs include:

98.10 (1) wages and salaries;

98.11 (2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment
98.12 taxes, workers' compensation, and mileage reimbursement;

98.13 (3) the employer's paid share of health and dental insurance, life insurance, disability
98.14 insurance, long-term care insurance, uniform allowance, pensions, and contributions to
98.15 employee retirement accounts; and

98.16 (4) benefits that address direct support professional workforce needs above and beyond
 98.17 what employees were offered prior to the implementation of the rate increases.

98.18 (c) Compensation-related costs for persons employed in the central office of a corporation
 98.19 or entity that has an ownership interest in the provider or exercises control over the provider,
 98.20 or for persons paid by the provider under a management contract, do not count toward the
 98.21 80 percent requirement under this subdivision.

98.22 (d) A provider or individual provider that receives additional revenue subject to the
 98.23 requirements of this subdivision shall prepare, and upon request submit to the commissioner,
 98.24 a distribution plan that specifies the amount of money the provider expects to receive that
 98.25 is subject to the requirements of this section, including how that money was or will be
 98.26 distributed to increase compensation-related costs for drivers. Within 60 days of final
 98.27 implementation of the new phase-in proportion or adjustment to the base wage indices
 98.28 subject to the requirements of this subdivision, the provider must post the distribution plan
 98.29 and leave it posted for a period of at least six months in an area of the provider's operation
 98.30 to which all drivers have access. The posted distribution plan must include instructions
 98.31 regarding how to contact the commissioner, or the commissioner's representative, if a driver
 98.32 has not received the compensation-related increase described in the plan.

99.1 **Sec. 12. PRESCRIPTION DIGITAL THERAPEUTICS PILOT PROGRAM.**

99.2 (a) The commissioner of human services shall allocate \$8,091,000 in round three of the
 99.3 federal opioid response grant program to be used to establish a pilot program to explore the
 99.4 effectiveness of using FDA authorized prescription digital therapeutics for the treatment of
 99.5 substance use disorders within the medical assistance program. The pilot program shall
 99.6 include at least one clinic or practice site located within the seven county metropolitan area
 99.7 and at least one clinic or practice site located outside the seven county metropolitan area.
 99.8 The clinic or practice site must be capable of incorporating in the pilot program a minimum
 99.9 of 1,000 patients enrolled in medical assistance who represent different demographics and
 99.10 who are receiving or are eligible to receive substance use disorder services, including
 99.11 treatment with medication or behavioral health services, or both. Participation in the pilot
 99.12 program by a patient is voluntary. The clinic or practice site must obtain informed consent
 99.13 from each patient before enrolling the patient in the pilot program.

99.14 (b) By July 1, 2024, the commissioner of human services shall submit a report to the
 99.15 chairs and ranking minority members of the legislative committee with jurisdiction over
 99.16 health and human services policy and finances on the prescription digital therapeutics pilot
 99.17 program. The report must include the following:

99.18 (1) a description of each clinic or practice site and the demographics of the patient
 99.19 population included in the pilot program;

99.20 (2) the successes and challenges of the pilot program, including but not limited to patient
 99.21 access to treatment; patient satisfaction; and successful completion of patient treatment
 99.22 goals;

99.23 (3) the impact of the pilot program on health equity issues;

99.24 (4) a comparison of hospitalization rates for the pilot program patient population as
 99.25 compared to the medical assistance population at large and as compared to patients who
 99.26 did not chose to participate in the pilot program; and

99.27 (5) any recommendations on providing medical assistance coverage for prescription
 99.28 digital therapeutics for the treatment of substance use disorders.

99.29 (c) Of the allocation in paragraph (a), up to \$810,000 may be used by the commissioner
 99.30 for the administration of the pilot program. Any funds allocated under this section are
 99.31 available until expended or until March 1, 2024, whichever occurs first.

SENATE ARTICLE 3, SECTIONS 13 AND 15 MOVED TO COMPARE WITH HOUSE ARTICLE 22.

SENATE ARTICLE 3, SECTION 14 MOVED TO COMPARE WITH HOUSE ARTICLE 24.